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ISSUES IN LAW & MEDICINE

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VOL. 31, NO. 1 **SPRING 2016**

Preface

This edition features an article by David L. Rosenthal, M.B.A., J.D., which chronicles Supreme Court jurisprudence on abortion and examines how the current circuit split surrounding FDA-protocol legislation on medicinal abortions fits within the larger framework. It applies the proper version of the undue burden test to FDA-protocol legislation, which resolves the circuit split and provides lower courts with a clear means of analyzing abortion issues moving forward.

The second article in this edition, by attorney Paul Benjamin Linton, attempts to determine, first, whether emergency exceptions in statutes regulating abortion have been abused and, second, whether the standard used in such an exception – subjective or objective – makes a difference in the reported incidence of such emergencies. A review of the statistical data supports two conclusions. First, physicians who perform abortions and have complied with state reporting requirements have not relied upon the medical emergency exceptions in state abortion statutes to evade the requirements of those statutes. Second, the use of an objective standard for evaluating medical emergencies ("reasonable medical judgment") has not been associated with fewer reported emergencies (per number of abortions performed) than the use of a subjective standard ("good faith clinical judgment"). Both of these conclusions may be relevant in drafting other abortion statutes including prohibitions (e.g., post-viability abortions).

The *Verbatim* section includes (1) an introductory memorandum on the Petition for Writ of Certiorari in *Stormans v. Wiesman*, S. Ct. No. 15862; and (2) the Petition for Writ of Certiorari in *Stormans*. In 2007, in response to intense lobbying by national and state pro-abortion groups, Washington became the only state to make conscience-based referrals illegal. The State of Washington banned conscience-based referrals even though no customer has ever been denied timely access to any drug due to such a referral. And it did so even though it stipulated that conscience-based referral is "a time honored pharmacy practice" that "do[es] not pose a threat to timely access to lawfully prescribed medications." The trial court ruled in favor of the pharmacy, enjoining the new regulation. The Ninth Circuit Court of Appeals reversed. This petition asks the United States Supreme Court to grant certiorari and uphold the long established right of pharmacies to make conscience-based referrals.

Barry A. Bostrom, J.D.
Editor-in-Chief

Articles

Refocusing the Undue Burden Test: Inconsistent Interpretations Pose a Substantial Obstacle to Constitutional Legislation

David L. Rosenthal, M.B.A., J.D.*

ABSTRACT: Decades after *Roe*, debate over abortion remains as contentious as ever. States continue to pass regulations burdening the abortion right, but lack clear guidance on how to evaluate such regulations using the undue burden test. This Article chronicles Supreme Court jurisprudence on abortion and examines how the current circuit split surrounding FDA-protocol legislation fits within the larger framework. Finally, this Article applies the proper version of the undue burden test to FDA-protocol legislation, which resolves the circuit split and provides lower courts with a clear means of analyzing abortion issues moving forward.

In August of 2003, Holly Patterson was a beautiful young girl living in the suburbs of San Francisco.[1] She was an over-achiever who graduated a year early from high school and "enjoyed writing…, loved music, cooking, eating and playing softball and Powder Puff football."[2] Tragically, Holly's life must be described in the past tense because Holly Patterson died on September 17, 2003. She was only eighteen years old.[3]

* J.D., University of Arizona James E. Rogers College of Law, 2016; I am very grateful to Professor Toni Massaro for her guidance throughout the writing process, as well as the *Arizona Law Review* editorial staff. I would also like to thank those who passionately demonstrate truth for inspiring me to tackle the topic of this Article.

[1] Brief of Women and Families Hurt by RU-486 as Amici Curiae Supporting Petitioners, Cline v. Okla. Coalition for Reproductive Justice, 133 S. Ct. 2887 (2013) (No. 12–1094), 2013 WL 1450985, at *1 [hereinafter *Cline Amici Brief*].

[2] *Holly Patterson Dead from Safe & Legal Abortion*, PregnantPause (Oct. 16, 2013), http://www.pregnantpause.org/safe/patterson.htm.

[3] *Cline Amici Brief*, *supra* note 1, at app. 32.

In the weeks leading up to her death, Holly learned she was pregnant and sought a purely elective medicinal abortion at Planned Parenthood.[4] The clinic provided a non-FDA approved dosage of Mifeprex (also known as mifepristone or RU-486) and its companion drug, misoprostol, to terminate her early pregnancy. However, Holly experienced severe health complications. This forced her to twice visit an emergency room, which she only walked out of once.[5] Holly's untimely death was the result of septic shock, due to endomyometritis, a uterus-related blood infection.[6] For Holly, this complication occurred seven days after the termination of her pregnancy was initiated through the use of a non-FDA approved medicinal abortion regimen prescribed to her by Planned Parenthood.[7] As her father, Monty, put it, "medical abortion is promoted as safe and effective," however "[t]he information [Holly] was able to obtain about medical abortion cost her life."[8]

Unfortunately, Holly's story is not as uncommon as one might think. The United States Food and Drug Administration ("FDA") reported in 2011 that 14 women in the United States died from using the mifepristone abortion drug and an additional 2,207 women have been injured by it since the drug's approval in 2000.[9] In response to these events, five states passed laws prohibiting the off-label use of mifepristone in the past decade.[10] The legislation (known as "FDA-protocol legislation") restricts the use of the abortion pill regimen to only what is approved by the FDA in terms of dosage, time of use, and required physician oversight.[11]

The purpose of this Article is to examine those five state regulations within the larger abortion debate, as well as the resulting legal challenges that are currently pending. In this Article, I will argue that the undue burden test, under current United States

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[4] *Id*. at app. 27; Medicinal abortion can also be referred to as a "medical" abortion or "chemical" abortion.

[5] *Id*. at app. 29-30.

[6] Sepsis is a medical condition triggering widespread inflammation as a result of an overwhelming immune response to infection. In the most severe sepsis cases, infection leads to a life-threatening drop in blood pressure, called septic shock. Over one million Americans are affected by severe sepsis each year with up to half of those cases resulting in death. *See Sepsis (Blood Infection) and Septic Shock*, WebMD, http://www.webmd.com/a-to-z-guides/sepsis-septicemia-blood-infection. More information on abortion with septic shock can be found here: http://www.healthline.com/health/abortion-with-septic-shock#Causes2.

[7] *Cline Amici Brief, supra* note 1, at app. 33-34.

[8] Monty L. Patterson, *Just the Facts,* Abortion Pill Risks, http://abortionpillrisks.org/?doing_wp_cron=1413181968.6179850101470947265625.html (last updated Sept. 17, 2012).

[9] *Cline Amici Brief, supra* note 1, at *9.

[10] Ams. United for Life, Abortion-inducing Drugs Safety Act (RU-486 & Response to "Telemed" Abortions) at 12 (2012), http://www.aul.org/wp-content/uploads/2012/11/Abortion-Inducing-Drugs-Safety-Act-2013-LG.pdf. As of November 1, 2014, these states are Arizona, North Dakota, Ohio, Oklahoma, and Texas.

[11] *The Abortion Pill (Also Known as RU-486 or Mifeprex)*, Center For Arizona Policy (Jan., 2014), http://azpolicypages.com/life/the-abortion-pill-also-known-as-ru-486-or-mifeprex/ ("Despite the pill only being approved for use through the first seven weeks of pregnancy, Planned Parenthood prescribes it through nine weeks of pregnancy, does not require a follow-up visit, and uses non-doctors to prescribe the abortion pill[.]").

Supreme Court jurisprudence, provides that abortion regulations are valid unless they place a substantial obstacle on a woman's ability to obtain a safe abortion and the proper standard of review is heightened rational basis.[12] This standard gives states broad latitude to regulate the means of abortion in order to protect patient health and safety, while also advancing their legitimate interest in fetal life.[13]

Part I outlines the abortion debate and explores why this is such a hotly contested issue. Part II analyzes Supreme Court jurisprudence on abortion and the inconsistent standards of review that the Court has applied. Part III explores the specifics of abortion-inducing drugs, while Part IV explains state legislation targeted at regulating those drugs. Part V identifies the inconsistent holdings in challenges to those state regulations, which create a circuit split ripe for Supreme Court review. Finally, Part VI clarifies the present state of the undue burden test and applies the test before concluding with the potential consequences of the judicial response. Here, the restrictions placed on medicinal abortions advance the government's interest in protecting women's health and do not pose a substantial obstacle to a woman's right to an abortion. Surgical abortions remain legally available, even when medicinal abortions are subject to regulatory scrutiny. As a result, the Court must uphold FDA-protocol legislation as constitutional at a level of scrutiny most similar to rational basis.[14]

I. Framing the Abortion Debate

For many, the approach to the abortion issue is derived from one's ideology, definition of a "human-being," and values regarding life at the different stages of a pregnancy.[15] Although Supreme Court justices decide cases based on law, they too are not immune from allowing ideological preferences to interplay with rational thought in guiding their decisions.[16] Therefore, through understanding the mainstream ideological leanings and biases that come into play when examining abortion, one can best examine the issue from a more rational perspective.

For the purposes of this Article, "abortion" refers to the deliberate termination of a human pregnancy; excluding miscarriages and negligent acts that result in termination.

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[12] Planned Parenthood Ariz., Inc. v. Humble, 753 F.3d 905 (9th Cir. 2014), *petition for cert. filed*, 2014 WL 4467076 at 24 (U.S. Sept. 2, 2014) (No. 14-284).

[13] *Id*. at 23-24.

[14] The rational basis test, in its traditional form, is extremely deferential to any proffered governmental interest. As the Supreme Court has noted, a classification "must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *See* Jeremy B. Smith, *The Flaws of Rational Basis with Bite: Why the Supreme Court Should Acknowledge Its Application of Heightened Scrutiny to Classifications Based on Sexual Orientation*, 73 Fordham L. Rev. 2769, 2773 (2005) (citing FCC v. Beach Communications, Inc., 508 U.S. 307, 313 (1993)).

[15] Before entering into the abortion debate, it is necessary to frame the discussion and to define commonly used terms. This Article does not attempt to scrutinize every wrinkle in the abortion debate that could impact judicial review, but to provide a general understanding of the main stakeholders and commonly held positions.

[16] Carolyn Shapiro, *The Context of Ideology: Law, Politics, and Empirical Legal Scholarship,* 75 Mo. L. Rev. 79,126 (2010).

Abortion is the use of any means to terminate a diagnosable pregnancy, thus intentionally causing, with reasonable likelihood, the death of the unborn child.[17] Proponents ("pro-choice") of the controversial procedure argue that choosing to have an abortion is a fundamental right of an expectant mother; derived from the rights to privacy and of personal autonomy.[18] On the other hand, opponents ("pro-life") argue that abortion is the immoral killing of an innocent human-being, wherein the State's interest in protecting the life of the pre-born baby outweighs that of the mother's interest in choosing whether to carry the baby to term.[19]

The divide has traditionally centered on the definition of personhood; the crux of *Roe v. Wade*.[20] The more universal understanding that a fetus is undoubtedly alive shifts the debate to the value of a life-in-formation.[21] Pro-choice advocates, thus, also now argue that although a fetus is a living organism, "it" is not yet developed enough to be considered "human."[22] This argument rests on scientific evidence that fetuses cannot feel pain and are entirely dependent on a single, specific individual from which they cannot be physically separated or live without until after at least 20 weeks of gestational development.[23] Pro-life supporters, on the other hand, argue that a life is a life, regardless of neurological development. Therefore, the argument follows that fetuses should be protected under the law to a similar extent to that of all other living human beings.[24] Thus, a significant divide exists over the meaning of "alive," which has created irreconcilable differences within the two main camps in the abortion debate.

Furthermore, the value of a life in the womb relative to the interests of the mother is debated with extreme fervor. As one pro-choice leader put it, "I would put the life of a mother over the life of a fetus every single time—even if I still need to acknowledge my conviction that the fetus is indeed a life. A life worth sacrificing."[25] To counter that perspective, pro-life advocates assert that the rights of the unborn trump an expectant

[17] Ariz. Rev. Stat. § 36-2151 (2012).

[18] *See* Michael Tooley, *A Defense of Abortion and Infanticide, in* The Problem of Abortion 51, 51-52 (Joel Feinberg ed., 1973); Mary Anne Warren, *On the Moral and Legal Status of Abortion,* 57 Monist 43, 57-59 (1973).

[19] *See* John Finnis, *The Rights and Wrongs of Abortion: A Reply to Judith Thomson*, 2 Phil. & Pub. Aff. 117, 144-45 (1973); Patrick Lee & Robert P. George, *The Wrong of Abortion, in* Contemp. Debates in applied Ethics 13 (Andrew I. Cohen & Christopher Health Wellman eds., 2005).

[20] Roe v. Wade, 410 U.S. 113, 156 (1973).

[21] Mary Elizabeth Williams, *So what if abortion ends life?* Salon (Jan. 23, 2013, 8:43 AM), http://www.salon.com/2013/01/23/so_what_if_abortion_ends_life/.html ("I believe that's what a fetus is: a human life. And that doesn't make me one iota less solidly pro-choice.").

[22] Joyce Arthur, *Personhood: Is a Fetus a Human Being?* Pro-Choice Action Network (Aug. 2001), http://www.prochoiceactionnetwork-canada.org/articles/fetusperson.shtml.

[23] *See generally* Sheila Page, D.O., AOBNMM, *The Neuroanatomy and Physiology of Pain Perception in the Developing Human*, 30 Issues L. & Med. 227 (2015); I. Glenn Cohen, Sadath Sayeed, *Fetal Pain, Abortion, Viability, and the Constitution*, 39 J.L. Med. & Ethics 235 (2011); K.J.S. Anand & P.R. Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 New Eng. J. Med. 1321 (1987).

[24] Kevin Kelly, *The consequences of treating a fetus as a human being*, No Violence Period (June 22, 1986), http://groups.csail.mit.edu/mac/users/rauch/nvp/consistent/whole-earth.html.

[25] Williams, *supra* note 21.

mother's right to have an abortion. Thus, the right to an abortion should "collapse" under the belief that a fetus is indeed a human life and that there is an inherent interest in preserving human life whenever possible.[26] Spurred by this re-framing of a contentious debate is a flood of state legislation restricting abortion, which is now under the microscope of federal courts.[27]

In summary, there is a substantial chasm between pro-choice and pro-life supporters. The split stems from what one considers an existing life—whether a fetus is a human-being or something less. This valuation, in turn, determines the requisite legal protections that are due to fetal life and the latitude that a mother is given to make choices relating to her own privacy and personal autonomy. This necessarily impacts the fate of the life forming inside of her. Therefore, because these distinct and irreconcilable ideological viewpoints are always lurking in the background behind any Supreme Court decision relating to abortion, it is important to understand each of these interests and how they impact the overall discussion.

II. The Murky Waters of Supreme Court Abortion Jurisprudence

The Supreme Court's reasoning in past abortion cases is essential to any discussion regarding the current undue burden test and how it applies to recently enacted abortion restrictions. From at least 1900 until the 1970s, every single state penal code included a section banning abortion except in certain narrowly defined instances.[28] In 1965, the Court recognized marital privacy as a fundamental right, which would later be used to create the right of a woman to have an abortion.[29] The Court attempted to refine abortion rights throughout the 20th century, which produced ambiguity as to the strength and legal sustainability of the right.

*A. Pre-*Roe *Privacy Rights*

A constitutional right to privacy, from which the right to have an abortion arises, was first recognized in *Griswold v. Connecticut*. In *Griswold*, the Court created a constitutional privacy right that protected the right of married couples to use contraception to prevent pregnancy or for therapeutic purposes.[30] In doing so, the Court found that there were a number of guarantees found within the penumbras of the Bill of Rights,

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[26] Rachel Warren, Note, *Pro (Whose?) Choice: How the Growing Recognition of A Fetus' Right to Life Takes the Constitutionality Out of Roe*, 13 Chap. L. Rev. 221, 247 (2009).

[27] Elizabeth Nash et al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review,* Guttmacher Institute, http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html (last visited Nov. 2014) (asserting that more state abortion restrictions were enacted between 2011 and 2013—205 in total—than were adopted during the whole previous decade—189 in total).

[28] Mark A. Graber, *The Ghost of Abortion Past: Pre-Roe Abortion Law in Action*, 1 Va. J. Soc. Pol'y & L. 309, 313 (1994).

[29] Griswold v. Connecticut, 381 U.S. 479, 479 (1965) (holding that the substantive due process right of privacy includes at least privacy of marriage relations in the marital bedroom).

[30] *Id*. at 480.

thus creating zones of privacy.[31] The Court then extended that zone of privacy in 1972 to protect unmarried individuals' right to use contraception in *Eisenstadt v. Baird*.[32] There, the Court redefined the right of privacy recognized in *Griswold* to necessarily apply to unmarried individuals: "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[33] Consequently, *Griswold* and *Eisenstadt* introduced the idea that the Court could extend a newly recognized zone of privacy to protect an individual's procreative decision, which could include the decision to terminate a pregnancy.[34]

B. The Fundamentals of Roe v. Wade

In 1970, a woman appealed to the Supreme Court when she was denied the right to have an abortion in her home state of Texas.[35] Her case, *Roe v. Wade,* is touted as the landmark case wherein the Court expanded the right of women to have an abortion.[36] In *Roe*, the Court held that women's access to abortion procedures involve an unenumerated, fundamental right to privacy under the 14th Amendment's Due Process Clause.[37] A "fundamental" right ordinarily requires that any regulation limiting that right must be justified by a compelling state interest and narrowly tailored as the least restrictive alternative to express only the actual, legitimate state interest at stake.[38] *Roe* indicated that strict scrutiny would apply to abortion restrictions going forward; a high bar for any restriction on abortion to be upheld as constitutional.[39] However, the Court later narrowed its holding in *Roe* and applied a lower level of scrutiny to abortion regulations, thus confusing the standard of review in abortion cases.[40]

C. The Companion of Roe*:* Doe v. Bolton

This muddling of the standard of review in abortion cases began in *Roe*'s companion case, *Doe v. Bolton*. There, the Court indicated that any restrictions on access to abortions must include a health exception, whereby the restriction would be lifted if necessary to preserve the health of the mother.[41] In providing guidance on when the exception may apply, the Court explained that a doctor's medial judgment as to the health of the mother may be "exercised in the light of all factors—physical, emotional, psychological, familial,

[31] Jennifer L. George, *The United States Supreme Court Failed to Follow over Thirty Years of Precedent by Replacing Individualized Medical Judgment with Congressional Findings*, 41 Creighton L. Rev. 219, 224-25 (2008) (citing Griswold v. Connecticut, 381 U.S. 479, 484 (1965)).

[32] Eisenstadt v. Baird, 405 U.S. 438, 483 (1972).

[33] *Id*. at 453.

[34] Emily Blistein, Esq., *Revisiting* Roe*: The Language of Privacy and Isolation in U.S. and Vermont Case Law*, 34 SPG Vt. B.J. 42, 42 (2008).

[35] *Roe*, 410 U.S. at 113.

[36] *Id*. at 170.

[37] *Id*.

[38] *Id*. at 155. (citing *Griswold*, 381 U.S. at 485).

[39] *Id*. at 170.

[40] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 839 (1992).

[41] Doe v. Bolton, 410 U.S. 179, 191-92 (1973).

and the woman's age—relevant to the wellbeing of the patient."[42] Therefore, through the inclusion of "emotional" and "psychological" well-being as legitimate factors, the health exception established in *Doe* may be interpreted in a sweepingly broad manner.[43] As such, the exception could seemingly be used to justify an abortion as "necessary in order to preserve the life or health of the mother" in nearly *any* unwanted pregnancy.[44] This seemed to foreshadow the Court's desire to create a nearly unfettered right to abortion.[45] However, the Court did not maintain this position for long.

D. Changing the Standard in Casey

Nearly two decades after *Doe*, the Supreme Court narrowed its broader holdings in *Roe* and *Doe* in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. There, the Court also established the modern framework for evaluating abortion restrictions. In *Casey*, the Court affirmed the core of *Roe*, but reclassified the abortion right from a fundamental right to only a "protected liberty interest."[46] This decision signaled a dramatic shift in the standard of review for abortion regulations—if abortion was no longer a fundamental right, then courts need not apply strict scrutiny when reviewing intrusions upon it.[47] As a result, legislation that might be struck down under strict scrutiny could be upheld, so long as the legislation maintains a valid purpose and has only an incidental, not purposeful, effect on a woman's decision to procure an abortion.[48] As the Court explained in its joint opinion:

> Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a *valid purpose*, one not designed to strike at the right itself, has the *incidental effect* of making it more difficult or more expensive to procure an abortion *cannot be enough to invalidate it.* Only where state regulation imposes an *undue burden* on a woman's ability to make this decision does the power of the State reach into the heart of the *liberty protected* by the Due Process Clause.[49]

Thus, *Casey* did not overturn *Roe*—as pro-lifers hoped it would—but it did soften the Court's stance against regulation by indicating that a state could discourage abortion with a valid purpose.[50] Many wondered if *Casey* would allow for new constitutional

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[42] *Id*. at 192.

[43] *Judicial Activism*: Doe v. Bolton, The Heritage Foundation, http://www.heritage.org/initiatives/rule-of-law/judicial-activism/cases/doe-v-bolton.html (last visited Oct. 12, 2014).

[44] *Id*.

[45] *Id*.

[46] *Casey*, 505 U.S. at 859 (while also implementing pre and post-viability distinctions).

[47] *Id*. at 874.

[48] Gonzales v. Carhart, 550 U.S. 124, 157-58, (2007) (citing *Casey*, 505 U.S. at 871).

[49] *Casey*, 505 U.S. at 874 (emphasis added).

[50] Mark H. Woltz, *A Bold Reaffirmation?* Planned Parenthood v. Casey *Opens the Door for States to Enact New Laws to Discourage Abortion*, 71 N.C. L. Rev. 1787, 1788 (1993).

abortion regulations, but the Court took several years before revisiting *Casey*'s newly introduced "Undue Burden Test."[51]

E. The Importance of Women's Health in Stenberg v. Carhart

Surprisingly, in the next seminal abortion case, *Stenberg v. Carhart*, the Court strengthened *Casey*; further confusing the standard of review.[52] In *Stenberg*, the Court invalidated Nebraska's criminal ban on intact dilation and evacuation ("D&E") abortions and declared that the Court would not "revisit those legal principles" determined by *Roe* and reaffirmed in *Casey*.[53] The rationale for striking down the law was due to its vagueness and absence of a health exception,[54] harkening back to the focal point of *Doe*.[55] With the Court now indicating that an explicit statutory health exception was a per se requirement of abortion regulations, dissenters claimed that the Court opened an "ever-expanding loophole" in abortion jurisprudence; giving the doctor unconstrained discretion to perform any procedure deemed necessary for any imaginable patient health reason.[56]

Also, in *Stenberg* the Court designated women's health as the main interest that a state regulation cannot infringe upon—substantially constraining the power of the state.[57] The Court further applied a standard of review that appeared to be similar to strict scrutiny, as in *Roe*, with any substantial burden being grounds for invalidation.[58] Had *Stenberg* been the last time the Court spoke on abortion, it would appear that the status of a woman's right to an abortion as a fundamental right would have been re-conferred and that regulations, such as FDA-protocol legislation, would be struck down by the Court. But once again, the Court would soon revisit the abortion issue and change course on the standard of review for abortion restrictions.

F. Court Reverses Course in Gonzales v. Carhart

Following a change in membership on the Court, and with Justice Kennedy now joining the majority, the Court reversed course on abortion once again.[59] The last time the Court examined a major abortion restriction, in *Gonzales v. Carhart*, the Court upheld the Partial Birth Abortion Ban Act of 2003 in the face of familiar challenges for vague-

[51] *Id*. at 1788.

[52] Linda J. Wharton et. al., *Preserving the Core of* Roe*: Reflections on* Planned Parenthood v. Casey, 18 Yale J.L. & Feminism 317, 346 (2006).

[53] Stenberg v. Carhart, 530 U.S. 914, 921 (2000).

[54] In *Doe*, the Court seemed to mandate that all statutory abortion restrictions include a health exception to allow a mother to have the contemplated abortion if medically necessary for her health. Barbara Jean Bailey, *Congress Ignores the Parameters of the Health Exception Judicial Responses to Congressional Evidence and Partial-Birth Abortion in the Wake of* Stenberg v. Carhart, 27 J. Legal Med. 71, 73 (2006) (citing *Doe*, 410 U.S. at 192).

[55] *Stenberg*, 530 U.S. at 916.

[56] Wharton *supra* note 52, at 347.

[57] *Id*. at 348.

[58] *Id*. at 347.

[59] Katia Desrouleaux, *Banning Partial-Birth Abortion at all Costs—Gonzales v. Carhart: Three Decades of Supreme Court Precedent "Down the Drain,"* 35 S.U. L. Rev. 543, 561 (2008).

ness and the absence of a health exception.[60] The Court reasoned that the Act would be unconstitutional "if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability," but that was not the case.[61] The *Gonzales* result came about, in part, due to the fact that women seeking the type of abortion prohibited by the 2003 Act—although a popular method—had alternative abortion procedures available.[62] Thus, in upholding the law, the Court quashed the idea that a health exception is a requirement for facially constitutional abortion regulations.[63]

Instead, the Court explained that, while women's health is still a primary concern, the State is not required to account for every possible scenario wherein a certain type of abortion could be in the best interest of a woman's health when deciding whether a law restricting a certain type of abortion would be upheld.[64] Therefore, *Gonzales* demonstrated that when alternative, safe abortion methods remain available to women, restricting access to another method of abortion does not necessarily create a substantial obstacle.[65] Abortion restrictions can, indeed, co-exist with the right to an abortion as recognized by the Court.[66]

Additionally, the Court in *Gonzales* made it a point to explain that the State may use its regulatory authority to show its profound respect for the life of the unborn.[67] The Court even went so far as to say that the government's "legitimate, substantial interest in preserving and promoting fetal life" was a central premise of *Casey*, which could not be repudiated.[68] As such, regulations which only create a structural mechanism by which the State may express profound respect for the life of the unborn are permitted, so long as they are not a substantial obstacle to a woman's right to choose.[69] The joint authors[70] in *Casey* defined a "substantial obstacle" as one that *prohibits a woman from making the ultimate decision* to terminate her pregnancy before viability.[71] Therefore, so long as the decision as to whether a woman wants to terminate a pre-viability pregnancy is not usurped, and a woman still has access to a legitimate abortion method, the State has not imposed a substantial obstacle on the right to an abortion.[72] And thus, the undue burden test proffered by the Court in *Casey* was encapsulated in abortion jurisprudence.[73]

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[60] *Gonzales*, 550 U.S. at 168.

[61] *Id*. at 156 (quoting *Casey*, 505 U.S. at 878).

[62] Transcript of Argument, Gonzales v. Carhart, No 05-380 (Nov 6, 2006), 20.

[63] *Gonzales*, 550 U.S. at 167.

[64] *Id*. at 167.

[65] *Id*. at 129.

[66] *See generally* Id.

[67] *Id*. at 157.

[68] *Id*. at 126-27.

[69] *Id*. at 126.

[70] The joint authors in *Casey* were Justice O'Conner, Justice Kennedy, and Justice Souter. *Casey*, 505 U.S. at 833.

[71] *Casey*, 505 U.S. at 879.

[72] C. Elaine Howard, *The Roe'd to Confusion: Planned Parenthood v. Casey*, 30 Hous. L. Rev. 1457, 1466 (1993).

[73] Desrouleaux *supra* note 59, at 571.

The holding in *Gonzales,* paired with the significant deference the Court gave to the states, fueled a steady stream of abortion regulations in order to limit the abortion right created in *Roe*.[74] *Roe* need not be overturned in order to uphold abortion-pill protocol legislation.[75] A court's holding must be consistent with *Gonzales* and utilize that standard of review most similar to rational basis. Under *Gonzales*, the states are given much more latitude to constitutionally regulate the right to an abortion.

G. Looking Ahead from Gonzales

In sum, the Court applied the undue burden test from *Casey* in upholding state laws that prohibited a specific method of abortion, but left safe, alternative methods available.[76] As such, the regulation was not held, on a facial challenge, to create an undue burden, and was therefore constitutional.[77] Thus, the Court provided an alternative for states attempting to regulate abortions by allowing states to respect the life of the unborn fetus if the regulation does not impose a substantial obstacle on most women's right to choose.[78] Since *Gonzales*, state and federal circuit courts have been inconsistently applying the undue burden test—with some using a rational-basis standard of review, while others use a more heightened scrutiny, and some examining both the purpose and effect of the legislation, while others only inquire into the effect.[79] This distinction is critical because the standard of review used by a court can easily determine the outcome of a case.[80] Nevertheless, it is clear that abortion, as a hot-button issue, has come roaring back to life in the wake of *Gonzales*.[81]

Consequently, the next major abortion-related issue could center on states' regulation of abortion-inducing drugs and how the *Casey-Gonzales* undue burden test should be applied. Given that multiple state laws regulating the use of abortion-inducing drugs have already been examined by circuit courts with differing results, this issue is ripe for

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[74] *Id*. at 571-72.

[75] *See infra* Section IV.

[76] *Gonzales*, 550 U.S. at 126.

[77] *Id*. at 126.

[78] *Id*. at 126.

[79] *Compare* Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 799 (7th Cir. 2013) (striking down a statute under heightened rationality review without reaching, but acknowledging, the purpose and effects tests), *with* Richmond Med. Ctr. for Women v. Herring, 570 F.3d 165, 179 (4th Cir. 2009) (upholding a statute criminalizing partial birth infanticide by applying a rational basis standard of review and only analyzing the effect, not the purpose of the statute in question). This split will be discussed at length in Part VI.

[80] *See* Eric Heinze, *The Logic of Standards of Review in Constitutional Cases: A Deontic Analysis*, 28 Vt. L. Rev. 121, 147 (2003). When strict scrutiny is triggered as the standard of review in cases involving a fundamental right, the government restriction will typically be struck down. However, rational basis review is very deferential and the government will almost always win. Even rational basis with bite–an intermediate standard–shows some deference to the government and provides that legislation will survive a challenge, as long as it serves a valid purpose and only incidentally infringes upon a protected liberty interest (e.g., abortion).

[81] Michael Valpy, *The abortion issue comes back to life*, The Globe and Mail (Mar. 26, 2010), http://www.theglobeandmail.com/globe-debate/the-abortion-issue-comes-back-to-life/article565366/.

consideration by the Court.[82] The Supreme Court is likely to apply the undue burden test in a way that comports with its most recent holding in *Gonzales*. The reasoning in *Gonzales* is critical to arguments supporting FDA-protocol legislation because the idea of restricting access to a certain type of abortion, while alternative methods remain, is the precise effect of protocol legislation. Upon recognizing the state's interest in the health of the mother and promoting fetal life, compared to the slight obstacle posed by restricting only one abortion method, the Court should rule in favor of the constitutionality of abortion-pill restrictions as consistent with both *Casey* and *Gonzales*.

III. The Problem with non-FDA Approved Abortion-Inducing Drug Regimens

In September of 2000, the FDA approved mifepristone, which is used alongside misoprostol, to terminate a pregnancy within 49 days of the start of a woman's last menstrual period.[83] The approved Mifeprex regimen for a medicinal abortion through 49 day's pregnancy involves the administration of 600 mg of Mifeprex on day one, 400 mcg misoprostol tablets on day three, and a post-treatment doctor's visit on day 14 to confirm the termination of the pregnancy.[84] However, Planned Parenthood and the Center for Reproductive Rights have argued that "the medical community has found that it is safe to use the two drugs in different quantities than recommended by the FDA and up to nine weeks in pregnancy."[85]

When Planned Parenthood is conducting a medicinal abortion, the organization dispenses Mifeprex in one-third the normal dose (200 mg), but then doubles the dose of the second drug, misoprostol, to 800 mcg.[86] The effect of the medicinal abortion on the user's body is described by Planned Parenthood as follows:

> The second medicine—misoprostol—will cause you to have cramps and bleed heavily. . . . It usually lasts a few hours. You may see large blood clots or tissue at the time of the abortion. More than half of women abort within four or five hours after taking the second medicine. For others, it takes longer. But most women abort within a few days.[87]

[82] *Compare* Planned Parenthood Sw. Ohio Region v. DeWine, 696 F.3d 490 (6th Cir. 2012) (upholding legislation that banned abortion-inducing drugs for the time and dosage not outside of FDA-labeling guidelines), *with* Planned Parenthood Ariz., Inc. v. Humble, 753 F.3d 905 (9th Cir. 2014) (striking down a strikingly similar regulation on the use of abortion-inducing drugs).

[83] FDA, *Mifepristone U.S. Post-marketing Adverse Events Summary Through 04/30/2011* (July, 2011), *available at* http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf.

[84] *Id*.

[85] Dave Andrusko, *9th Circuit overturns Arizona RU-486 law, state vows to keep fighting* (Dec. 4, 2012), http://www.nationalrighttolifenews.org/news/2014/06/9th-circuit-overturns-arizona-ru-486-law-state-vows-to-keep-fighting/#.U9Xik3x0zIV.

[86] Joanne Moudy, *9th Circuit Court Trashes Arizona Law: Puts Women at Risk*, Townhall Magazine (June 5, 2014), http://townhall.com/columnists/joannemoudy/2014/06/05/9th-circuit-court-trashes-arizona-law-puts-women-at-risk-n1848137/page/full.

[87] *The Abortion Pill*, Planned Parenthood (2014), http://www.plannedparenthood.org/health-info/abortion/the-abortion-pill.

Planned Parenthood uses this procedure, where allowed by law, through the first 63 days of pregnancy and claims it to be effective "97 out of every 100 times."[88]

Unfortunately, this expanded use of the abortion pill comes with great cost. Since approving the Mifeprex regimen in September of 2000, the FDA "has received reports of serious adverse events, including several deaths, in the United States following medicinal abortion with mifepristone and misoprostol."[89] According to a 2011 FDA report, there were 2,207 adverse events (complications) in the United States related to the use of mifepristone.[90] These adverse events included 14 deaths, 612 hospitalizations, 339 blood transfusions, and 256 infections (including 48 "severe infections") endangering women.[91] The primary cause of death for those suffering complications from the use of the drug combination is sepsis, which is caused by an infection of the bloodstream, and typically causes death approximately one week after the initiation of the medicinal abortion.[92]

The international community has also begun to take note of the dangers of off-label use: an Australian study reported that medicinal abortion complications are "much more frequent" than those due to surgical abortion, based upon a study involving 7,000 medicinal abortions.[93] The Italian government made a statement reiterating that patients should follow the approved guidelines for medicinal abortions to "better [ ] safeguard women's health."[94] Thus, a variety of different governmental entities are realizing the legitimate threat to women's health that off-label use of abortion-inducing medication may cause, signaling a need to further regulate the use of these dangerous drugs.

In spite of the harm to users of abortion-inducing drugs, the manufacturer of mifepristone insists that the drug, which has been used for medicinal abortions by over two million women in the United States, is "safe and effective" because there are bound to be some complications when any drug is used at such a high frequency.[95] This assertion is offered along with the admission that "5-8% of women [who use mifepristone] will need a surgical procedure to end the pregnancy or stop heavy bleeding."[96] Given the 98-99% surgical abortion 'success' rate, medicinal abortions are comparatively several times more risky than surgical abortions.[97] Although it is not certain that the timing and dosage of the medicinal abortion cocktail were the direct cause of injury, women have

[88] *Id*.

[89] FDA, *supra* note 83.

[90] *Id*.

[91] *Id*..

[92] *Id*.

[93] Steven Ertelt, *Abortion Drug Kills Girl in Portugal, Caused Deadly Infection*, LifeNews (May 16, 2011, 10:56 AM), http://www.lifenews.com/2011/05/16/abortion-drug-kills-girl-in-portugal-caused-deadly-infection/.

[94] *Id*.

[95] Renate Klein et al., *RU-486: Misconceptions, Myths, and Morals ix*, 31 (2nd ed. 2013); *see also More Facts About Mifeprex*, Danco Laboratories. http://earlyoptionpill.com/is-mifeprex-right-for-me/more-facts-about-mifeprex/.

[96] *More Facts About Mifeprex*, *supra* note 95; *see also* Klein, *supra* note 95, at xviii, xxxvii.

[97] Klein, *supra* note 95, at 111.

spoken up to encourage states to take action to restrict what they see as a dangerous medical practice.[98]

Many lives have been affected by the use of an unapproved medicinal abortion regimen.[99] For example, in 2003, Abby Johnson, at the time a 23-year-old Planned Parenthood volunteer, elected to undergo a medicinal abortion, using the off-label regimen.[100] Shortly after ingesting her prescribed medication, Abby experienced severe hemorrhaging. She contacted Planned Parenthood regarding why she was losing so much blood:

> [T]he Planned Parenthood nurse [] told Abby, that it "'is not abnormal.' I was shocked. She could not be serious. All of the bleeding, the clotting, the pain . . . that was NORMAL! 'Yes,' she said . . . I was angry. How could they not tell me the side effects? I felt so betrayed."[101]

Abby, was fortunate enough to survive this horrific experience after enduring eight weeks of blood clots, excruciating cramps, nausea, and heavy bleeding.[102] Upon returning to her post at Planned Parenthood, she shared her traumatic experience with patients, but, in her own words, "Planned Parenthood did not want [her] influencing women considering the RU-486 regimen."[103] Abby has since left Planned Parenthood and now spends her time sharing her experience with women, so that they can make fully informed decisions and be aware of the dangers caused by off-label use of a medicinal abortion regimen.[104]

Abby Johnson and Holly Patterson are not alone. There are other stories—like that of Manon Jones, an 18-year-old who died in London after taking the off-label regimen—or of a 16-year-old Portuguese girl who died from taking the same regimen from the same type of sepsis infection.[105] And, there are many others, both domestic and abroad, who have experienced the same deadly side effects from the off-label use of abortion-inducing medication.

In addition, the unapproved use of the Mifeprex regimen has also been tied to eight deaths arising from a severe bacterial infection.[106] No women have died from severe bacterial infection after using RU-486 in the way approved by the FDA.[107] Thus, state legislatures and the judicial system may feel compelled to protect women's health by restricting the use of the medicinal abortion regimen to only the FDA approved dosage.

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[98] *See Cline Amici Brief*, *supra* note 1, at *1.

[99] Ertelt, *supra* note 93.

[100] *Cline Amici Brief*, *supra* note 1, at app. 9-10.

[101] *Id.* at *27.

[102] *Id.* at app. 13.

[103] *Id.* at *25.

[104] *Id.*

[105] Monty L. Patterson, *Manon Jones' Story*, Abortion Pill Risks, http://abortionpillrisks.org/?doing_wp_cron=1413181968.6179850101470947265625.html (last updated Dec. 4, 2011); Ertelt, *supra* note 93.

[106] Jill Stanek, *The abortion industry's looming RU-486 legal crisis*, LifeSiteNews, https://www.lifesitenews.com/pulse/the-abortion-industrys-looming-ru-486-legal-crisis (last updated Oct. 7, 2014).

[107] *Id.*

In this way, a state may be able to end the harm that the unapproved administration of abortion-inducing medication may cause to women, who are often already in a very vulnerable position. So far, five states have passed these types of restrictions on the use of abortion-inducing drugs in light of the safety concerns posed by off-label usage of Mifeprex.[108]

IV. State Legislatures Respond with Regulations

In passing comprehensive regulations of abortion-inducing drugs that limit their administration to the protocol approved by the FDA, five states—Arizona, North Dakota, Ohio, Oklahoma, and Texas—have responded to Planned Parenthood's expanded use of the abortion pill.[109] Each of those pieces of legislation has been challenged, resulting in the emergence of a circuit split within the federal courts.[110] While the legislation at issue has been upheld by the Sixth (Ohio) and Fifth Circuits (Texas), state courts in North Dakota and Oklahoma, as well as the Ninth Circuit (Arizona), have called it into question, illustrating the level of confusion in the court system.

A. Ohio

Ohio was the first state to pass FDA-protocol legislation in 2004.[111] The law, modeled after the Americans United for Life model legislation, provides that FDA (or other United States federal) regulations govern and limit the use of mifepristone for the purpose of inducing abortions.[112] The legislation was immediately challenged by Planned Parenthood, with the controversy eventually being decided by the U.S. Court of Appeals for the Sixth Circuit in 2012.[113] In that case, the law survived Planned Parenthood's claims that it was unconstitutionally vague, violated patients' right to bodily integrity, and posed an undue burden on women seeking an abortion within the state of Ohio.[114] This was because the Sixth Circuit concluded that a ban on a specific method of abortion would not impose an undue burden on "a woman's ability to make the decision to have an abortion;" in line with both *Casey* and *Gonzales*.[115] Here, the Sixth Circuit explicitly held that limiting the use of mifepristone to FDA regulations was consistent with the *Casey-Gonzales* standard.

B. North Dakota

In North Dakota, abortion-pill regulations are also modeled after the Americans United for Life model legislation. However, North Dakota's regulations are currently

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[108] Ams. United for Life, Abortion-inducing Drugs Safety Act (RU-486 & Response to "Telemed" Abortions) at 12 (2012), http://www.aul.org/wp-content/uploads/2012/11/Abortion-Inducing-Drugs-Safety-Act-2013-LG.pdf.

[109] *Id.* at 12.

[110] *Id.*

[111] Ohio Rev. Code Ann. § 2919.123 (West 2004).

[112] *Id.*

[113] *See DeWine*, 696 F.3d at 490.

[114] *Id.* at 494.

[115] *Id.*

enjoined by court order and are not in effect while the litigation is ongoing.[116] Judge Corwin of the North Dakota County of Cass District Court enjoined North Dakota's law using a standard of strict scrutiny, based upon his understanding that abortion is still considered by the Supreme Court to be a fundamental right.[117] Judge Corwin directly disputed the findings of the Sixth Circuit in holding that the North Dakota statute was not the most narrow alternative in satisfying the compelling state interest of citizen's health due to the low percentage rate of risk.[118] This holding does not comport with that from the Sixth Circuit due to the use of an inappropriate standard of review.

C. Texas

On the other hand, the Fifth Circuit supported Texas' regulations on medicinal abortions, concluding that the regulations do not facially require a court-imposed exception for the life and health of a woman.[119] The language of the Texas legislation is only slightly distinguishable from that of other states, because it allows abortion providers to use the dosages approved by FDA protocol or advocated for by the American College of Obstetricians and Gynecologists—however, the drugs must be administered according to FDA protocol, thus having the same effect.[120] The Fifth Circuit noted that Texas' regulations did not facially require a full, court-imposed health exception in light of *Gonzales*, nor did the regulations facially impose an undue burden on the life and health of the mother.[121] Although the result is the same as in the Sixth Circuit, the reasoning is slightly different. The Fifth Circuit came to its conclusion based on the reasoning that there is no longer a requirement for a health exception on the face of an abortion regulation that prohibits a particular method of abortion, whereas the Sixth Circuit focused its holding on the availability of alternative methods. The Fifth Circuit also specified that its holding did not detract from *Casey*, implying that it does not consider abortion to be a fundamental right deserving of strict scrutiny.[122] This level of scrutiny used is consistent with Supreme Court jurisprudence under *Gonzales*, but conflicts with North Dakota's adverse finding on similar legislation.[123]

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[116] MKB Mgmt. Corp. v. Burdick, No. 09-2011-CV-02205 (Cass Cnty. Ct. N.D. 2012), available at http:// reproductiverights.org/sites/crr.civicactions.net/files/documents/MKB%20v%C20Burdick%C200rder%C2021612%(2).pdf.; N.D. Cent. Code Ann. § 14-02.1-03.5 (West 2011); Lindsay D. Houser, *Hindering Webcam Outreach on the Women's Healthcare Frontier: Why Abortion-Specific Restrictions on Telemedicine Are Unconstitutional*, 42 Stetson L. Rev. 169, 205 (2012).

[117] *MKB Mgmt. Corp.*, No. 09-2011-CV-02205, at 60; *see also* Laurah J. Samuels, *Mifepristone Protocol Legislation-the Anti-Choice Movement's Disingenuous Method of Attack on the Reproductive Rights of Women and How Courts Should Respond*, 26 Colum. J. Gender & L. 316, 333 (2014).

[118] *MKB Mgmt. Corp.*, No. 09-2011-CV-02205, at 60; Samuels, *supra* note 117, at 333.

[119] Planned Parenthood of Tex. v. Abbott, 748 F.3d 583, 604 (5th Cir. 2014).

[120] Tex. Health & Safety Code Ann. § 171.063 (West); Samuels, *supra* note 117, at 330.

[121] *Abbott*, 748 F.3d at 603.

[122] *Id.* at 603.

[123] *Compare Abbott*, 748 F.3d at 603, *with* MKB Mgmt. Corp., No. 09-2011-CV-02205, at 60.

D. Oklahoma

In a case which never reached federal courts—a challenge to Oklahoma's medicinal abortion regulations—the initial legislative restrictions were ruled facially unconstitutional by the Oklahoma Supreme Court based upon an interpretation that the act attempted to ban the use of misoprostol in its entirety.[124] Thus, the court held that the possibility of an effective ban of all medicinal abortions failed the undue burden test under *Casey*.[125] After the Oklahoma Supreme Court's findings, the State of Oklahoma appealed to the United States Supreme Court to revive the law. Initially, the Court granted certiorari in the case;[126] however, the Court later removed the case from its docket in a one-sentence order declaring the petition of certiorari as "improvidently granted."[127] As a result, the Court put off the abortion-pill issue for at least one more term.[128]

E. Arizona

With Oklahoma no longer in a position to bring their case to the Supreme Court, it became unclear which state's regulations would next be challenged in order to confront the issue. However, when the Ninth Circuit struck down Arizona's medicinal abortion legislation, many anticipated that the Supreme Court would hear the case originating in Arizona and finally resolve the differing approaches in applying the undue burden test to abortion-pill regulations.[129]

The Ninth Circuit ruled on Arizona's abortion-pill restrictions in June of 2014.[130] Although the Arizona law was not substantially different from other versions of the model legislation authored by the Americans United for Life, the Ninth Circuit found that the law imposed an undue burden on women seeking an abortion.[131] This holding is in direct contradiction with the Fifth and Sixth Circuit's earlier findings that strikingly similar Ohio and Texas laws (respectively) are facially constitutional based upon the state's interest in protecting women's health and wide availability of alternatives to off-label medicinal abortions.[132] Upon examination of each of these cases, each state statute required that abortion-inducing drugs be prescribed or administered in compliance with

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[124] Okla. Coalition for Reproductive Justice v. Cline, 292 P.3d 27, 27 (Okla. 2012).

[125] *Id.* at 27.

[126] Casey Mattox, *Cline symposium: Another correction of the abortion distortion coming?*, SCOTUSBLOG (Oct. 1, 2013), http://www.scotusblog.com/2013/10/cline-symposium-another-correction-of-the-abortion-distortion-coming/html.

[127] Lyle Denniston, *Court won't rule on RU-486 abortions*, SCOTUSBLOG (Nov. 4, 2013), http://www.scotusblog.com/2013/11/court-wont-rule-on-ru-486-abortion/.

[128] *Id.* Oklahoma since amended its law and approved the legislation, with an effective date of November 1, 2014. As amended, the law includes a stated purpose to limit the use of misoprostol to FDA guidelines, but not to ban the drug entirely, which was the main reason it was initially declared unconstitutional. 2014 Okla. Sess. Laws Ch. 121 (H.B. 2684).

[129] *Humble*, 753 F.3d at 907.

[130] *Id.* at 907.

[131] *Id.*

[132] *Compare Humble*, 753 F.3d at 907 (9th Cir. 2014), *with DeWine*, 696 F.3d at 490 (6th Cir. 2012).

federal law, as outlined by the FDA.[133] Therefore, the difference in the outcomes of these cases was not due to any discrepancies between the two state's laws, but rather due to an inconsistent application of the *Casey-Gonzales* undue burden test. This inconsistent application created the current circuit split.

F. The Need for Clarification

Courts are inconsistently applying the undue burden test by using varying standards of judicial scrutiny, which results in differing outcomes. The Fifth and Sixth Circuits correctly decided the issue under the *Casey-Gonzales* undue burden test, which allows for regulation when it does not place a substantial obstacle in the way of a women's ultimate decision to get an abortion.[134]

However, in North Dakota, the court incorrectly applied strict scrutiny to enjoin FDA-protocol legislation.[135] The Court has long since abandoned strict scrutiny as the standard of review in abortion cases, so as long as legislation is advancing a legitimate government interest and does not serve as a complete bar to access to abortions—either in purpose or effect—the Court should uphold the legislation.[136] Even if some form of heightened scrutiny is merited, abortion no longer receives strict scrutiny after *Casey*.[137] It is instead considered a protected liberty interest, which may fall short of a fundamental right, but is still subject to significant state limitations.[138] Furthermore, the Ninth Circuit decision striking down Arizona's protocol legislation inconsistently applied their interpretation of the *Casey-Gonzales* undue burden test, which desperately requires the Supreme Court to provide a remedy on appeal.[139] However, the Supreme Court once again skirted the issue by denying certiorari in December of 2014.[140]

V. At an Impasse and Ripe for Supreme Court Review

Abortion jurisprudence is now at a stand-still. However, the abortion-pill predicament adds a new twist to the abortion debate.[141] In an effort to boost its case, the Arizona legislature specifically adopted and enumerated several women's-health interests as rea-

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[133] *Compare* Ariz. Rev. Stat. § 36-449.03(E)(6) (2012) *with* Ohio Rev. Code Ann. § 2919.123 (West). However, the Arizona statute is slightly broader because it applies to any abortion-inducing medication, which could include drugs beyond the currently used mifepristone, whereas mifepristone is singled out by the Ohio law.

[134] *Abbott*, 748 F.3d at 593-95; *DeWine*, 696 F.3d at 513-18.

[135] *MKB Mgmt. Corp.*, No. 09-2011-CV-02205, at 60.

[136] The strict scrutiny standard of review is applied when legislation will infringe upon a fundamental right; such legislation will be upheld only if the law furthers a "compelling governmental interest" and is necessary or "narrowly tailored" to achieve that interest. *See* Richard H. Fallon, Jr., *Strict Judicial Scrutiny*, 54 UCLA L. Rev. 1267, 1268-69 (2007) (citing Johnson v. California, 543 U.S. 499, 505 (2005)).

[137] *Casey*, 505 U.S. at 859.

[138] *Id.*

[139] *See* Mailee Smith, *Why the Supreme Court Could Soon Review Regulations on Chemical Abortion*, Nat'l Review Online (June 9, 2014), http://www.nationalreview.com/corner/379901/why-supreme-court-could-soon-review-regulations-chemical-abortion-mailee-smith.

[140] *Humble*, 753 F.3d at 905 (9th Cir. 2014), *cert. denied*, 135 S.Ct. 870 (2014).

[141] *See Patterson*, *supra* note 2.

sons to regulate these drugs.[142] In focusing on women's health as one of the underlying purposes of the regulations, instead of only relying on the State's interest in protecting the unborn, Arizona and similarly situated states are attempting to shift the dynamics in abortion litigation and improve their chances of litigation success.[143] Typically, protecting fetal life has been the government's primary motivation for abortion restrictions.[144] Even in states where fetal life is not protected by law, *Gonzales* dictates that "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman."[145] When the health of the mother interest is sincere, abortion *regulations*—if not effective bans—that promote the legitimate state interest in women's health should satisfy *Gonzales*.[146] Still, the State is faced with serious opposition from those who argue that the restrictions are outdated, restrictive, and simply mask an unstated purpose to discourage women from having an abortion.[147]

Opponents of the Arizona law also question the necessity of the regulations on the grounds that scientific advancements make the dangers posed by the use outside of FDA protocol moot. For example, opponents argue that it is only "marginally possible" that vaginal use of misoprostol contributed to deaths following medicinal abortions and that providers now found a way to avoid this risk by giving women misoprostol buccally (by mouth) instead of vaginally.[148] Furthermore, opponents argue that the legislation does not protect the unborn fetus because it does not necessarily prevent an abortion from occurring.[149] Surgical abortions are still readily available to women past 49 days of gestation (the end of the FDA approved timeframe). Therefore, protocol legislation does not stop abortions; it just makes them "less convenient."[150]

Proponents of the law respond that that there is mounting evidence that the heightened risk to women remains after 49 days of gestation, even when the drugs are taken through different methods.[151] Personhood arguments also may come into play as proponents of the law defend the protocol legislation. However, the persuasiveness of each factor for the Court will likely be determined by its application of the undue burden test.

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[142] Smith, *supra* note 139.

[143] Erica A. Phillips, *Arizona's Limits on 'Abortion Pills' Struck Down by Court*, Wall St. J. (June 3, 2014), http://online.wsj.com/articles/arizona-limits-on-so-called-abortion-pills-overturned-1401827960.

[144] *See* Khiara M. Bridges, *"Life" in the Balance: Judicial Review of Abortion Regulations*, 46 U.C. Davis L. Rev. 1285, 1335-36 (2013).

[145] *Gonzales*, 550 U.S. at 145 (citing *Casey*, 505 U.S. at 846).

[146] Morgan Arnett, *Update: Phasing Out Abortion: One Step Closer to Terminating a Woman's Constitutional Right, in Gonzales v. Carhart*, 24 T.M. Cooley L. Rev. 597, 613 (2007).

[147] Phillips, *supra* note 143.

[148] Samuels, *supra* note 117, at 330.

[149] *Id.* at 340.

[150] *Id.*

[151] *Know the Risks of the Abortion Pill*, AbortionPill.CA, http://www.abortionpills.ca/risks1.html (last visited Nov. 11, 2014).

VI. The Weight of the Undue Burden Test

Ultimately, the Court must reconcile inconsistent applications of the undue burden test to resolve the circuit split on the regulation of abortion-inducing drugs. Currently, the test is being applied in two ways: (1) the "Traditional Approach" in which a court first ensures that legislation has a rational basis and then assesses whether it creates a substantial obstacle to an abortion for a large fraction of the women; and (2) the "Balancing Test" method where a court looks at the purpose and effect of legislation separately to balance the State's interests against the burden levied on women seeking an abortion.[152] While the Traditional Approach finds its origins in *Casey* and was cemented in *Gonzales*, the Balancing Test is a new invention of lower courts, which has no basis in Supreme Court precedent, and is therefore incorrect.[153]

A. The Flaws of the Balancing Test

Before weighing the considerations in protocol-legislation, the Court will first have to clarify the proper use of the undue burden test. Judge Posner of the Seventh Circuit recently introduced a two-part test requiring that "legislation regulating abortions must pas[s] muster under rational basis review and must not have the 'practical effect of imposing an undue burden' on the ability of women to obtain abortions."[154] This interpretation separates the test into two parts, examining both the legislative purpose and practical effect of the law.[155] Then, under this framework, a court should strike down a regulation when "the extent of the burden a law imposes on a woman's right to abortion outweighs the strength of the state's justification for the law."[156] Although this test still should not pose any additional barriers to upholding abortion protocol-legislation, it was relied upon to do just that by the Ninth Circuit and is not the appropriate standard under *Gonzales*.[157]

Under this test, legislation is often assumed to pass rational basis.[158] However, in weighing the State interest with the resulting burden, the test encourages some courts to improperly scrutinize the medical evidence and legislative intent behind abortion regulations.[159] This comes from the notion that undue burden analysis is context-specific and that the severity of a burden and the strength of the state's justification can vary depending on the circumstances.[160] The Balancing Test argument follows that the

[152] *Compare Van Hollen*, 738 F.3d at 799 *with DeWine*, 696 F.3d at 514; *Abbott*, 748 F.3d at 590.

[153] Karen A. Jordan, *The Emerging Use of a Balancing Approach in Casey's Undue Burden Analysis* (forthcoming 2016) (manuscript at 10) (on file with author).

[154] *Van Hollen*, 738 F.3d at 799 (7th Cir. 2013) (quoting Karlin v. Foust, 188 F.3d 446, 481 (7th Cir.1999)).

[155] *Van Hollen*, 738 F.3d at 799.

[156] *Humble*, 753 F.3d 905, *petition for cert. filed*, 2014 WL 4467076 (U.S. Sept. 2, 2014) (No. 14-284), 20-21.

[157] *Humble*, 753 F.3d at 912.

[158] *Id.*

[159] *Van Hollen*, 738 F.3d at 800.

[160] *Humble*, 753 F.3d 905, *petition for cert. filed*, 2014 WL 4467076 (U.S. Sept. 2, 2014) (No. 14-284), 16.

stronger the state's justification for the legislation, the greater the burden imposed must be before it is found to be "undue"; and, the more substantial the burden imposed, the stronger the state's justification for the law must be for the legislation to pass the undue burden test.[161]

This context-specific approach does not give proper deference to the state and results in valid laws being struck down after an improper inquiry into the medical evidence that legislatures rely upon to form the intent of the law.[162] The Seventh Circuit addressed this specific issue and concluded that the notion that abortion legislation is unconstitutional because some medical evidence contradicts the state's claim that an abortion restriction furthers women's health is a "misguided argument."[163] As a result, an abortion restriction that is rationally related to a state's legitimate interests should be considered valid, regardless of medical evidence presented to undermine that state's medical justification for the law, in so far as it does not impose a substantial obstacle to an abortion.[164]

On the other hand, even when examining the purpose of a law, "states have 'broad latitude' to regulate abortion doctors, 'even if an objective assessment might suggest that' the regulation is not medically necessary."[165] Thus, an abortion regulation that simply "may be helpful" or "can be useful" still should pass the requirement that it have a legitimate purpose and be upheld as long as it does not create a substantial obstacle for a large fraction of women.[166]

This interpretation is consistent with the Supreme Court's reasoning in *Mazurek v. Armstrong*, which held that an impermissible purpose will only be found if the law succeeds in achieving an impermissible effect; therefore, there need not be an analysis of the legislative purpose before examining the effect of the law.[167] Even the fact that a law was drafted by an anti-abortion group, "says nothing significant" about the state's purpose in passing the abortion restriction.[168] Therefore, the relational inquiry in the *Casey* analysis should be deferential to state legislatures and the Balancing Approach is an inappropriate dilution of the Traditional Approach.[169] The undue burden test does not allow courts to balance the burden imposed by a law against its medical justification.[170]

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[161] *Id.* at 48.

[162] *Id.* at 16.

[163] *Van Hollen*, 738 F.3d at 800 (citing *Mazurek*, 520 U.S. at 971-75).

[164] *Id.* at 807.

[165] *Id.* at 800 (quoting Mazurek v. Armstrong, 520 U.S. 968, 973 (1997)).

[166] *Van Hollen*, 738 F.3d at 800 (quoting Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, (1976)).

[167] Ctr. for Reproductive Rights, The Undue Burden Standard: Abortion Jurisprudence after Casey at 164, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Updated_UB_Module.pdf.

[168] *Id.* at 164 (citing Mazurek v. Armstrong, 520 U.S. 968, 973, (1997)).

[169] Jordan, *supra* note 153.

[170] Brief for Appellants at 13-14, Whole Women's Health v. Lakey, 135 S. Ct. 399 (2014) (No. 14-50928), 2014 WL 5802849, at *1-2 (citing *Abbott*, 748 F.3d at 597).

Instead, "once a law passes rational-basis review, the sole remaining question is whether it imposes a 'substantial obstacle' in the path of abortion patients."[171]

B. The Traditional Approach Controls

Although the Court has indicated that legislative intent need not be heavily scrutinized in abortion regulations, such scrutiny is not likely to invalidate a law. Still, the simplicity of the Traditional Approach, taken from *Casey*, is the predominant test used in operation.[172] Following rational basis review, the traditional test simply asks whether the requirement is "likely to prevent a significant number of women [affected by the regulation] from obtaining an abortion."[173] It does not suggest that a court should weigh the state interest with the burden imposed by the legislation.[174] This assertion is validated by recent cases, including *Mazurek* and *Gonzales*, which hold that only when a regulation creates a substantial obstacle to obtaining an abortion is an undue burden imposed by the legislation.[175]

Furthermore, a regulation only imposes an undue burden on women under *Casey* when it prohibits a woman from making the ultimate decision to terminate her pregnancy; an incidental interference with that decision will not suffice.[176] *Gonzales* further clarified that even the elimination of a popular abortion method is not enough to constitute an undue burden when a safe, alternative method exists.[177] A health exception is also not a constitutional requirement either, following *Gonzales*.[178] There must be a substantial obstacle hindering the right to choose that will prevent a large fraction of women from obtaining an abortion before striking down an abortion restriction on a facial challenge. Such an obstacle is not present in FDA-protocol legislation.[179]

C. As Applied

An abortion restriction which simply regulates the means by which a woman can have an abortion is not an undue burden in and of itself.[180] There is a legitimate interest in women's health being protected by greater regulation of mifepristone, following the 2,207 complications, 612 hospitalizations, and 14 deaths resulting from its use.[181] FDA-protocol legislation could—although not certainly would—have prevented eight of those 14 deaths from occurring from a severe bacterial infection after unapproved

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[171] *Id.* at *2.

[172] *Humble*, 753 F.3d at 911.

[173] *Casey*, 505 U.S. at 893.

[174] *Humble*, 753 F.3d 905, *petition for cert. filed*, 2014 WL 4467076 (U.S. Sept. 2, 2014) (No. 14-284), 20-21.

[175] *Id.* at 21.

[176] *Casey*, 505 U.S. at 879.

[177] Transcript of Argument, Gonzales v, Carhart, No 05-380 (Nov 6, 2006), 20.

[178] *Gonzales*, 550 U.S. at 167.

[179] *Humble*, 753 F.3d 905, *petition for cert. filed*, 2014 WL 4467076 (U.S. Sept. 2, 2014) (No. 14-284), 12.

[180] Transcript of Argument, Gonzales v. Carhart, No 05-380 (Nov 6, 2006), 20.

[181] FDA, *supra* note 83.

mifepristone use.[182] Even though the precise cause of death in those cases is unknown, the state is allowed to use its "broad latitude" in regulating drug use.[183] This is because protecting women's health through FDA-protocol legislation "may be helpful," but need not be proven medically necessary in order to be upheld as constitutional.[184] This justification is clearly enough to satisfy rational basis review because the state has a legitimate interest (if not a duty) to neutralize this threat to women's health, but the effect of the regulation should also be scrutinized under the *Casey-Gonzales* test.

Here, the state has an interest in protecting women's health and legitimate concerns provide a legitimate purpose for upholding FDA-protocol legislation; thus satisfying the rational basis requirement. Next, the restrictions still must not effectively place a substantial obstacle in the path of a woman seeking an abortion to be valid.[185] The court in *Gonzales* described such an obstacle as one that imposes an undue burden on a woman's ultimate decision to have an abortion.[186] Just as a ban on D&E abortions in *Gonzales* did not substantially interfere with a woman's right, the narrow restrictions placed on medicinal abortions here also do not interfere with a woman's ultimate right.[187]

The legislation in *Gonzales* even banned a specific procedure in its entirety, whereas FDA-protocol legislation only restricts the dosage and timeframe of an otherwise legal procedure.[188] If the regulation of medicinal abortion means a woman cannot have one because she's past gestational dates, she still has the option of surgical abortion; which is the most commonly used abortion method.[189] According to the most recently available reports, 76.9% of all abortions are of the surgical variety (whereas 23.1% are medicinal)[190] and there is peer-reviewed evidence that surgical abortions are safer than medicinal abortions.[191] As a result, FDA-protocol legislation should be upheld, in line with the Fifth and Sixth Circuits' reasoning. This legislation leaves a more popular, safer alternative for women and is by no means a de facto ban on abortion, making such legislation consistent with both *Casey* and *Gonzales*.[192] Nowhere has the Supreme Court

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[182] Stanek, *supra* note 106.

[183] *Van Hollen*, 738 F.3d at 800 (quoting *Mazurek*, 520 U.S. at 973).

[184] *Id.* at 800 (quoting *Danforth*, 428 U.S. at 52).

[185] *Gonzales*, 550 U.S. at 156 (quoting *Casey*, 505 U.S. at 878).

[186] *Id.* at 146.

[187] *Id.*

[188] *Id. at* 128.

[189] Stanek, *supra* note 106.

[190] CDC, *Abortion Surveillance — United States, 2012* (November 27, 2015), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s_cid=ss6410a1_e.

[191] Reply Brief for Petitioners, Cline v. Okla. Coalition for Reproductive Justice, 133 S. Ct. 2887 (2013) (No. 12–1094), 2013 WL 2428978, at *11 (citing M. Niinimaki et al., *Immediate Complications after Medical compared with Surgical Termination of Pregnancy*, Obstet. Gynecol. 114:795 (Oct. 2009)); *see also Comparison of Medical and Surgical Abortion*, Feminist Women's Health Center, http://www.fwhc.org/abortion/abpill-compare-surgical.htm (last updated Oct. 5, 2010); *Medical Versus Surgical Abortion*, UCSF Medical Center, http://www.ucsfhealth.org/education/medical_versus_surgical_abortion/ (last updated 2015).

[192] *DeWine*, 696 F.3d at 494.

found a fundamental right to medicinal abortions—only to an accessible abortion option; a right which remains viable, even with FDA-protocol legislation in place.

Opponents of abortion regulations will argue that the special autonomy enjoyed within the doctor-patient relationship should serve as a stronger shield to the abortion right.[193] If autonomy is the paramount value when preserving both a woman's and her doctor's right to control medical decisions, then how can the state encroach upon that autonomy by denying a woman the right to a certain means of abortion that a doctor is willing to perform? But, even in *Roe*, the Court rejected autonomy as the primary value at stake in abortion cases by adopting rules that limit a woman's abortion options.[194] Justice Blackmun himself, the author of *Roe*, later reiterated his support for regulating abortion after the first trimester in the interest of maternal health; thus illuminating that the autonomy of the mother is not the supreme value in abortion jurisprudence.[195] Instead, the interest of public health allows for the state to hold a legitimate interest from the onset of a pregnancy in the health of the mother and pass restrictions to preserve that interest.[196]

However, states are now more than ever promoting patient autonomy and limiting barriers to treatment posed by FDA regulations. Arizona recently became the fifth state to pass a "right-to-try" statute, which allows terminally ill patients to request access to treatment that has not yet been approved by the FDA.[197] It is understood that the requested treatment might not be safe or effective, but access is granted based on the value of patient autonomy.[198] On a philosophical level, the promotion of a right-to-try statute might seem to conflict with FDA-protocol legislation in the abortion context, which restricts patient autonomy, but the aims of the two types of legislation are vastly different.

On one hand, right-to-try legislation builds off the FDA's compassionate use program, which expands access to unapproved treatments only *after* a patient has exhausted all available alternatives.[199] Consequently, the right-to-try is based on the assumption that there are no known, safe alternatives that can accomplish the desired health outcome. FDA-protocol legislation is supported by the exact opposite reasoning because surgical abortion remains the safe, popular alternative that accomplishes the same outcome as a medicinal abortion without heightened risk. Therefore, state legislatures (including

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[193] Peter M. Ladwein, *Discerning the Meaning of Gonzales v. Carhart: The End of the Physician Veto and the Resulting Change in Abortion Jurisprudence*, 83 Notre Dame L. Rev. 1847, 1853 (2008).

[194] Roger B. Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 Health Matrix 235, 255-56 (2003) (citing *Roe*, 410 U.S. at 154).

[195] *Id.* at 256 (citing Webster v. Reprod. Health Servs., 492 U.S. 490, 538 (1989) (Blackmun, J., concurring in part and dissenting in part)).

[196] *Id.* (citing *Casey*, 505 U.S. at 846).

[197] Kimberly Leonard, *Seeking the Right to Try,* U.S. News (Nov. 18, 2014), http://www.usnews.com/news/articles/2014/11/18/right-to-try-laws-allowing-patients-to-try-experimental-drugs-bypass-fda.

[198] *Id.*

[199] *Id.; Expanded Access: Information for Patients*, U.S. Food & Drug Admin. (April 17, 2015), http://www.fda.gov/ForPatients/Other/ExpandedAccess/ucm20041768.htm.

Arizona) that pass both right-to-try and FDA-protocol legislation are not promoting contradictory messages, but a unified policy position in favor of promoting patient health. After all, right-to-try legislation gives patients the opportunity to take a risk for the goal of preserving life. The off-label medicinal abortions put the life of the mother in unnecessary danger and, deliberately, end the life of another, which should not be overlooked.

With the interest of promoting life in mind, the Court previously held that the State may use its regulatory authority to show profound respect for the life of the unborn.[200] The government's "legitimate, substantial interest in preserving and promoting fetal life," is still outweighed by a woman's right to privacy and personal autonomy, but should not be discounted as irrelevant.[201] Prenatal life is recognized in criminal statutes providing that wrongdoers stand trial for crimes which prevent the unborn from reaching their full potential—including mothers who use drugs while pregnant.[202] Although not enough in its own right, when combined with an interest in women's health, the State's interest in protecting the unborn weighs heavily in favor of legislation restricting, but not eliminating, access to certain abortion procedures.[203] Ultimately, a woman's autonomy is not overburdened by specific procedural restrictions on abortion that advance legitimate state interests in both women's health and the life of the unborn.

Conclusion

Although the State of Arizona's petition asking the Supreme Court to make the final determination on the validity of abortion-inducing drug restrictions was denied, this issue is far from resolved. In fact, the issue is ripe for Supreme Court consideration in light of the recent circuit split. States need further clarification on the proper test for abortion regulations and a specific resolution on FDA-protocol legislation.

While the Supreme Court first recognized a woman's right to an abortion 43 years ago, the Court significantly modified the way in which that right was recognized over time.[204] What was once identified as a fundamental right has since been downgraded to a protected liberty interest, which may be regulated.[205] *Casey* remains valid law—providing the framework through which the Court may interpret abortion restrictions—while indicating that the State may show profound respect for the life of a pre-viability fetus and even attempt to discourage a woman from exercising her right to abortion.[206]

Casey is most efficiently interpreted to proffer a simple requirement that a law, having rational basis, must not impose a substantial obstacle to a woman's right to an

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[200] *Gonzales*, 550 U.S. at 157.

[201] *Id.* at 126-27.

[202] Amy Lotierzo, *The Unborn Child, A Forgotten Interest: Reexamining Roe in Light of Increased Recognition of Fetal Rights*, 79 Temp. L. Rev. 279, 291 (2006).

[203] *Id.* at 310.

[204] *Roe*, 410 U.S. at 170.

[205] *Casey*, 505 U.S. at 859.

[206] *Id.* at 867.

abortion in a large fraction of relevant cases.[207] The Court need not conduct an ad hoc balancing test to weigh a woman's right to privacy and autonomy against the purposes behind State regulation; but regardless of how one interprets *Casey*, it offers a standard of review more lenient than *Roe*.[208] Furthermore, the nearly unfettered right to abortion created by the discretion shown to doctors through the health exception requirement in *Doe* has been rendered impotent through the upholding of an abortion method ban without a health exception in *Gonzales*.[209] Thus, *Gonzales* remains the controlling case for abortion regulations and indicates that the undue burden test is much more similar to traditional rational basis than strict scrutiny.

Finally, *Gonzales* turns *Roe* on its head, while providing a specific example of a constitutional burden on the right to an abortion.[210] *Gonzalez* supports the idea that the abortion right does not mean that every method must go unrestricted.[211] So long as there is "a commonly used and generally accepted method," a restriction does not present a substantial obstacle.[212] Therefore, under *Gonzales*, the Ninth Circuit erred in finding FDA-protocol legislation unconstitutional. To the extent that it might restrict some women from obtaining a medicinal abortion, FDA-protocol legislation does not pose *any* obstacle to prevent a woman from obtaining a surgical abortion.[213] As such, FDA-protocol legislation is constitutional and consistent with the holdings of the Fifth and Sixth Circuits.

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[207] *Id.* at 837; *Gonzales*, 550 U.S. at 168.

[208] *Id.* at 855.

[209] *Gonzales*, 550 U.S. at 161.

[210] *Id.* at 164-65.

[211] *Id.* at 165.

[212] *Id.*

[213] *Humble*, 753 F.3d 905, *petition for cert. filed*, 2014 WL 4467076 (U.S. Sept. 2, 2014) (No. 14-284), 30.

Medical Emergency Exceptions in State Abortion Statutes: The Statistical Record

Paul Benjamin Linton, J.D.*

ABSTRACT: This article attempts to determine, first, whether emergency exceptions in statutes regulating abortion have been abused and, second, whether the standard used in such an exception – subjective or objective – makes a difference in the reported incidence of such emergencies. A review of the statistical data supports two conclusions. First, physicians who perform abortions and have complied with state reporting requirements have not relied upon the medical emergency exceptions in state abortion statutes to evade the requirements of those statutes. Second, the use of an objective standard for evaluating medical emergencies ("reasonable medical judgment") has not been associated with fewer reported emergencies (per number of abortions performed) than the use of a subjective standard ("good faith clinical judgment"). Both of these conclusions may be relevant

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Mr. Linton has published nineteen law review articles on a variety of topics, including the history of abortion regulation and the Supreme Court's abortion jurisprudence, state equal rights amendments, criminal law, sex discrimination, same-sex marriage and assisted suicide, as well as multiple articles in journals of opinion. He has also published the only comprehensive analysis of abortion rights claims under state constitutions, Abortion under State Constitutions *A State-by-State Analysis* (Carolina Academic Press) (2d ed. 2012). He received his undergraduate (B.A. Honors) and law (J.D.) degrees from Loyola University of Chicago.

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in drafting other abortion statutes including prohibitions (e.g., post-viability abortions).

In *Planned Parenthood v. Casey*,[1] the United States Supreme Court considered the constitutionality of multiple provisions of the Pennsylvania Abortion Control Act of 1982, as amended in 1988 and 1989.[2] These include, *inter alia*, provisions mandating detailed informed consent requirements and a twenty-four waiting period,[3] informed parental consent[4] and spousal notice.[5] Each provision is subject to an exception which excuses compliance therewith in case of a medical emergency.[6] A "medical emergency" is defined as

> That condition which, on the basis of the physician's good faith clinical judgment, so complicates a medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function.[7]

Because it was "central to the operation of various other requirements," the Court began its analysis of the challenged provisions "with the statute's definition of medical emergency."[8] The plaintiffs in *Casey* argued that the definition was "too narrow, contending that it forecloses the possibility of an immediate abortion despite some significant health risks."[9] The Court acknowledged that if this contention were correct, "we would

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[1] 505 U.S. 833 (1992).

[2] 18 Pa. Cons. Stat. § 3201 *et seq.* (1990).

[3] *Id.* § 3205. The statute requires either the physician who is to perform the abortion or the referring physician orally to inform the pregnant woman at least twenty-four hours prior to the abortion of the nature of the proposed procedure or treatment and the attendant risks and alternatives; the probable gestational age of the unborn child at the time the abortion is to be performed; and the medical risks associated with carrying the child to term. *Id.* § 3205(a)(1). The statute also requires the attending or referring physician or another qualified health care professional or social worker to inform the woman at least twenty-four hours prior to the abortion that the state department of health has prepared printed materials for her to review that describe the unborn child and identify agencies that offer alternatives to abortion; that medical assistance may be available for prenatal care, childbirth and neonatal care; and that the father of the unborn child is liable to assist in the support her child (which information may be omitted in the case of rape). *Id.* § 3205(a)(2). Some States have imposed additional conditions. For example, the information that Pennsylvania requires in § 3205(a)(1) may be provided in Texas only by the physician who is to perform the abortion, not by a referring physician. Tex. Health & Safety Code § 171.012(a)(1). And all of the information that Texas requires a pregnant woman to be given before undergoing an abortion (which is similar to the information mandated by §§ 3205(a)(1) and 3205(a)(2) of the Pennsylvania Abortion Control Act) must be provided orally and in person in a private and confidential setting, at least twenty-four hours before the abortion. Tex. Health & Safety Code §§ 171.012(a)(1), 1710.012(a)(2), 171.012(b)(1).

[4] *Id.* § 3206.

[5] *Id.* § 3209.

[6] *Id.* § 3205(a), § 3206(a), 3209(c).

[7] *Id.* § 3203 (definitions).

[8] *Casey*, 505 U.S. at 879.

[9] *Id.* at 880 (summarizing plaintiffs' argument).

be required to invalidate the restrictive operation of the provision, for the essential holding of *Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health."[10] The district court had found that the statutory definition of medical emergency failed to cover three serious conditions: pre-eclampsia, inevitable abortion and premature ruptured membrane.[11] However, as the court of appeals observed, "under some circumstances each of these conditions could lead to an illness with substantial and irreversible consequences."[12] Although the definition of medical emergency *could* be interpreted in an unconstitutional manner, the court of appeals construed the phrase "serious risk" to include those circumstances.[13] The court stated, "[W]e read the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman."[14] The Supreme Court deferred to the court of appeals' interpretation of state law and concluded that, as construed by the court of appeals, "the medical emergency definition imposes no undue burden on a woman's abortion right."[15]

In a subsequent case, *Ayotte v. Planned Parenthood of Northern New England*,[16] the Court unanimously held that a State may not limit the circumstances in which compliance with a statute regulating abortion is excused to situations when the life, but not the health, of the patient is at risk.[17] The holding in *Ayotte* basically stands for the proposition that whenever compliance with an abortion regulation may delay the performance of the procedure, it must include exceptions for the life or health of the pregnant woman.[18]

Following the Supreme Court's decision in *Planned Parenthood v. Casey*, many States either amended their pre-*Casey* statutes to include an exception for medical emergencies that conformed to the definition upheld in *Casey* or enacted new statutes with such an exception.[19]

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[10] *Id*. (citing, *inter alia, Roe v. Wade*, 410 U.S. 113, 164 (1973)).

[11] *Planned Parenthood v. Casey,* 744 F. Supp. 1323, 1378 (E.D. Pa. 1990).

[12] *Casey*, 505 U.S. at 880 (citing *Planned Parenthood v. Casey*, 947 F.2d 682, 700-01 (3rd Cir. 1991)).

[13] *Planned Parenthood v. Casey*, 947 F.2d at 701.

[14] *Id*.

[15] *Casey*, 505 U.S. at 880. On the merits, the Court upheld the informed consent and waiting period requirements, *id*. at 881-87, and the informed parental consent requirement, *id*. at 899-900, but struck down the spousal notice requirement, *id*. at 887-98.

[16] 546 U.S. 320 (2006).

[17] *Id*. at 327-28.

[18] When compliance with a given regulation would not delay the procedure or otherwise jeopardize the woman's health, however, a health exception is not required. *See Gonzales v. Carhart*, 550 U.S. 124,161-67 (2007) (no health exception required in statute prohibiting a rarely used second trimester abortion technique where other techniques were commonly available and just as safe). Under *Casey*, the scope of a health exception in the definition of a medical emergency may be restricted to serious risks to the woman's physical health.

[19] In addition to these post-*Casey* developments, many States had enacted pre-*Casey* parental consent or notice statutes that excused compliance in case of an emergency. The data discussed in this article includes both medical emergency statutes based on the provision upheld in *Casey*, as well as statutes that have defined such emergencies in other terms.

These statutes cover a range of abortion regulations, the most common of which mandate detailed informed consent requirements (and, in some States, a waiting period, usually twenty-four hours) for all women seeking an abortion; and, in the case of minors, consent of and/or notice to one or both of their parents or guardian (and, again in some States, a waiting period, typically twenty-four or forty-eight hours). States that have enacted abortion regulations that include a medical emergency exception generally require physicians to record in the patient's medical record the circumstances in which an emergency has excused compliance with a given regulation. Not all of those States, however, also require physicians to report such emergencies to the state health department, and even fewer States make such statistical data, when reported, available to the public. Nevertheless, it appears that at least twelve States publish on-line or otherwise produce upon request statistical data on how often a medical emergency has excused compliance with an abortion regulation.[20] That data is the subject of this article.

What has been the experience with medical emergency abortions? How frequent are they? Does the incidence of medical emergency abortions suggest that the statutes regulating abortion are being evaded? And does the phrasing of the medical emergency exception – whether an objective or subjective standard is used – make a difference in how many medical emergencies are being reported? The answers to these questions are important.

Both Americans United for Life (AUL) and the National Right to Life Committee (NRLC) which, between them, draft much of the pro-life legislation enacted in the United States, have raised concerns with respect to medical emergency exceptions. Although AUL includes a "*Casey*-style" medical emergency exception in its model legislation regulating abortion,[21] it identifies "the inappropriate use of a 'medical emergency' exception by an abortion provider" as one of the "potential loopholes" in parental consent or notice statutes.[22] NRLC, for its part, employs an objective "reasonable medical judgment" standard in its model legislation,[23] rather than the subjective "good faith clinic judgment" standard upheld in *Casey*, because of its fear that an exception that allows the physician to form his own subjective judgment as to the existence of a

[20] Alabama, Arkansas, Geogia, Idaho, Kansas, Nebraska, Oklahoma, South Carolina, South Dakota, Texas, West Virginia and Wisconsin.

[21] *See* Parental Notification Of Abortion Act[:] Model Legislation & Policy Guide *For the 2015 Legislative Year*, §§ 3(h), 6(a); Parental Consent for Abortion Act[:] Model Legislation & Policy Guide *For the 2015 Legislative Year*, §§ 3(g), 6(a); Women's Right to Know Act[:] Model Legislation & Policy Guide *For the 2015 Legislative Year*, §§ 2(b)(4), 3(i), 4; Women's Ultrasound Right To Know Act[:] Model Legislation & Policy Guide *For the 2015 Legislative Year*, §§ 2(b)(5), 3(e), 4, 5, Americans United for Life (available on AUL's website, www.aul.org).

[22] Parental Involvement Enhancement Act [:] Model Legislation & Policy Guide *For the 2015 Legislative Year*, p. 2, Americans United for Life (available on AUL's website).

[23] *See, e.g.*, NRLC's "Pain-Capable Unborn Child Protection Act Model[:] Abortion of Unborn Child of Twenty (20) or More Weeks Post-Fertilization Age," § 2(5) (definition of medical emergency), November 18, 2010 (on file with author). The (current) federal version of this legislation, which has passed the House of Representatives and is now pending in the Senate may be found at www.nrlc.org/uphloads/fetalpain/FranksSubstituteAmendentHR36.pdf.

medical emergency is, in effect, no standard at all.[24] The statistical data set forth in this article attempts to determine, first, whether medical emergency exceptions in statutes regulating abortion have been abused and, second, whether the standard used in such an exception – subjective or objective – makes a difference in the reported incidence of such emergencies.

Alabama

Alabama enacted its parental consent statute in 1987.[25] Consent of one of the minor's parents or her guardian is not required "when, in the best clinical judgment of the attending physician on the facts of the case before him, a medical emergency exists that so compromises the health, safety, or well-being of the mother as to require an immediate abortion."[26] "A physician who does not comply with [the parental consent requirement] by reason of this exception shall state in the medical record of the abortion, the medical indications on which his or her judgment was based."[27] Medical emergency abortions must be reported to the Bureau of Vital Statistics (now the Center for Health Statistics),[28] which, in turn, is authorized to keep "statistical records and information so long as the anonymity of the minor is in no way compromised."[29]

Between 1988, the first full year the parental consent law was in effect, and 2013, the last year for which data is available, 26,442 abortions were performed on minors

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[24] Memorandum from Mary Spaulding Balch, JD, Director, State Legislation Department, National Right to Life Committee, addressed to "To Whom It May Concern," regarding the "Constitutionality of the Model Pain-Capable Unborn Child Protection Act," Part V (seventh unnumbered page) (July 2013) (citing Andrew Willis, *Note: The Emergency Exception in Parental Laws and the Necessity of Post-Emergency Notifications*, 4 Ave Maria L. Rev. 171, 196 (2006)). Ms. Balch's memorandum is available on NRLC's website. *See* http://www.nrlc.org/statelegislation (last visited August 5, 2015). It must be noted that neither Ms. Balch in her memorandum nor Mr. Willis in his article cited any statistical data suggesting that a subjective standard in a medical emergency exception is more likely to be abused than an objective standard.

Although the Supreme Court has not yet decided whether an objective, rather than a subjective, standard for evaluating medical emergencies is constitutional, it should be noted that the principal authority on which Mr. Willis relies for that proposition was a decision from the Seventh Circuit upholding a Wisconsin abortion regulation (informed consent and a twenty-four hour waiting period) that did *not* include any criminal penalties. *Id*. at 196-97, citing and quoting *Karlin v. Foust*, 188 F.3d 446 (7th Cir. 1999). Whether the court would have upheld a statute like NRLC's "Pain-Capable Unborn Child Protection Act," which employs an objective standard *and* includes criminal penalties, *id*. § 6, presents an entirely different question, as the court's opinion itself makes clear. *See* 188 F.3d at 464-68.

[25] Ala. Code § 26-21-1 *et seq.* (1992). Parental consent is not required of an emancipated minor. *Id*. § 26-21-3(a). An "emancipated minor" is defined as "[a]ny minor who is or has been married or has by court order otherwise been legally freed from the care, custody, and control of her parents." *Id*. § 26-21-2(2).

[26] *Id*. § 26-21-5.

[27] *Id*.

[28] *Id*. § 26-21-8(c)(3).

[29] *Id*. § 26-21-8(a).

(women < 18 years of age) in Alabama,[30] of which thirteen were reported to have been performed without parental consent because of a medical emergency.[31] In other words, during this twenty-six year period, there was, on average, one medical emergency abortion every other year, or one emergency for every 2,034 abortions performed on minors.

Arkansas

Arkansas has enacted a detailed informed consent statute known as the "Women's Right to Know Act of 2001."[32] The Act requires every woman seeking an abortion in Arkansas to be given certain information no later than the day before the abortion is to be performed.[33] Compliance with the Act, including the waiting period, is excused "in the case of a medical emergency."[34] A "medical emergency" is defined as

> any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of impairment of a major bodily function which is substantial and deemed to be irreversible.[35]

Another section of the statute requires the Center for Health Statistics of the Department of Health to ensure that "all information collected by the center regarding abortions performed in this state shall be available to the public in printed form and on a twenty-four hour basis on the center's website, provided that in no case shall the privacy of a patient or doctor be compromised."[36]

Since 2010, the Arkansas Center for Health Statistics has published an annual report on the "Woman's Right to Know Act." Between 2010 and 2014, a total of 16,420 abortions were performed in Arkansas.[37] In none of these cases were the requirements of the Act excused because of a medical emergency.[38]

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[30] Selected Induced Termination of Pregnancy Data: Women Under 18 Years of Age, January-December 1988, Final Data, Alabama Department of Public Health, Bureau of Vital Statistics; Selected Induced Termination of Pregnancy Data: Women Under 18 Years of Age, Alabama, Final Occurrence Data, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, Alabama Department of Public Health, Center for Health Statistics; Induced Terminations of Pregnancy Occurring in Alabama, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, Alabama Department of Public Health, Center for Health Statistics.

[31] *Id*.

[32] 2001 Ark. Acts, No. 353, *codified as* Ark. Code § 20-16-901 *et seq*. (2015).

[33] *Id*. § 20-16-903.

[34] *Id*. § 20-16-903(b).

[35] *Id*. § 20-16-902(7).

[36] *Id*. § 20-16-906(b).

[37] Induced Abortions Data, 2010, 2011, 2012, 2013, 2014, Arkansas Department of Health, Center for Health Statistics.

[38] Woman's Right to Know Act Report, 2010, 2011, 2012, 2013, 2014, Center for Health Statistics, Arkansas Department of Health.

Georgia

Georgia first enacted a parental notification statute in 1987.[39] Unless one of the minor's parents or her legal guardian personally accompanied her to the facility where the abortion was to be performed, the physician had to provide the minor's parent or guardian with at least twenty-four hours' actual notification or forty-eight hours' constructive notification before proceeding with the abortion.[40] Notification was not required "when, in the in the best clinical judgment of the attending physician on the facts of the case before him or her, a medical emergency exists that so complicates the condition of the minor as to require an immediate abortion."[41] In such circumstances, the physician had to "certify in writing the medical indications on which this judgment was based when filing such reports as are required by law."[42] A new notification statute was enacted in 2013,[43] which contained, in all relevant respects, the same provisions.[44]

Between 2006, the first year for which medical emergencies were reported, and 2014, approximately 12,000 abortions were performed on minors (women < 18 years of age) in Georgia,[45] of which only three were reported to have been performed without parental notice because of a medical emergency.[46] In other words, during this nine-year period, there was, on average, one medical emergency abortion every third year, or one emergency for every 4,000 abortions performed on minors.

Idaho

Idaho enacted its parental consent statute in 2000.[47] As originally enacted, consent of one of the minor's parents, her legal guardian or her conservator was not required when "[a] medical emergency exists for the minor so urgent that there is insufficient time for the physician to obtain the informed consent of a parent or a court order and the attending physician certifies such in the pregnant minor's medical records."[48] For purposes of this exception, a "medical emergency" was defined as

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[39] Ga. Code Ann. § 15-11-110 *et seq*. (1990).

[40] *Id*. § 15-11-112(a)(1)(A)-(C).

[41] *Id*. § 15-11-116.

[42] *Id*.

[43] *Id*. § 15-11-680 *et seq*. (2014).

[44] *See, id*., §§ 15-11-682(a)(1)(A)-(C), 15-11-686. The notification requirement applies only to unemancipated minors. *Id*. § 15-11-682(a). An "unemancipated minor" is defined as "any person under the age of 18 who is not or has not been married, or who is under the care, custody, and control of such person's parent or parents, guardian, or the juvenile court of competent jurisdiction." *Id*. § 15-11-681(3).

[45] Annual Report Abortion – A Woman's Right to Know Report Years 2006 through 2014 Part 1: Parental Notification Requirements, Georgia Department of Public Health. This figure is an approximation because Georgia does not include in its statistical reporting the number of abortions performed in Georgia on residents of other States (occurrence data).

[46] *Id*.

[47] Idaho Code Ann. § 18-609A (2004).

[48] *Id*. § 18-609A(1)(a)(v). Under both former and existing law, the consent requirement applies only to unemancipated minors. *Id*. § 18-609A(1). "Emancipated" is defined as "any minor who has been married or is on active military service." *Id*. § 18-604(3).

> a sudden and unexpected physical condition which, in the reasonable medical judgment of any ordinarily prudent physician acting under the circumstances and conditions then existing, is abnormal and so complicates the medical condition of the pregnant minor as to necessitate the immediate causing or performing of an abortion:
>
> 1. To prevent her death; or
>
> 2. Because delay in causing or performing an abortion will create serious risk of immediate, substantial and irreversible impairment of a major physical bodily function of the patient.[49]

The definition of "medical emergency" was declared unconstitutional in *Planned Parenthood of Idaho, Inc. v. Wasden*,[50] and was later amended to cure the constitutional defects found in the original definition.[51] As amended, "medical emergency" is now defined as

> a condition which, on the basis of the physician's good faith medical clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[52]

Under Idaho law, whenever an abortion is performed "due to a medical emergency and without consent from a parent, guardian or conservator or court order," the attending physician must report to the Department of Health and Welfare "the diagnosis upon which the physician determined that the abortion was immediately necessary due to a medical emergency."[53]

Effective July 1, 2000, the Department of Health and Welfare began to require physicians to report to the Department medical emergencies excusing compliance with the parental consent law.[54] Because of federal court litigation (discussed above), the consent requirement was not enforced between January 1, 2005, and March 26, 2007. According to an analyst with the Idaho Department of Health & Welfare, between July 1, 2000 and December 31, 2014 (and excluding the twenty-seven month period when the law was not in effect), a total of 827 abortions were performed on unemancipated

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[49] *Id*. § 18-609A(5)(c)(I) . The term "medical emergency" did not include "1. Any physical condition that would be expected to occur in normal pregnancies of women of similar age, physical condition and gestation; or 2. Any condition that is predominantly psychological or psychiatric in nature." *Id*. § 18-609A(5)(c)(ii).

[50] 376 F.3d 908, 924-35 (9th Cir. 2004).

[51] 2005 Idaho Sess. Laws, ch. 393, § 2.

[52] Idaho Code Ann. § 18-604(8) (Supp. 2015). Under a subsequent amendment to the parental consent statute, parental consent (or judicial authorization) is not required if "[a] medical emergency exists for the minor and the attending physician records the symptoms and diagnosis upon which such judgment was made in the minor's medical record." *Id*. § 18-609A(7)(b).

[53] *Id*. § 18-609G(1)(b).

[54] "Abortions Occurring in Idaho, Females Aged < 18 Informed Consent by Year 2000-2014," fn. 1. Attachment to e-mail from Pamela Harder, Research Analyst Supervisor, Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics, July 2015, to author (July 24, 2015, 2:13 p.m., CDT) (on file with author).

minors (women < 18 years of age) in Idaho,[55] of which only one (in 2013) was reported to have been performed because of a medical emergency.[56]

Kansas

Kansas enacted a parental consent statute in 2011.[57] Consent of a minor's parents or legal guardian is not required "when a medical emergency exists."[58] A "medical emergency" is defined as

> a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the woman or for which a delay necessary to comply with the applicable statutory requirements will create serious risk of substantial and irreversible physical impairment of a major bodily function. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function.[59]

The Kansas parental consent statute requires a physician acting pursuant to the medical emergency exception of § 65-6705(j)(1) to "state in the medical record of the abortion the medical indications on which the physician's judgment was based," and to include the basis for that determination "as part of the written report made by the physician to the secretary of health and environment" under the abortion reporting statute, as amended.[60] The mandatory reporting of medical emergency abortions began in 2011.[61] Between 2011 and 2014, 1,099 abortions were performed on minors (women

[55] *Id*. (table).

[56] *Id*.

[57] Kan. Stat. Ann. § 65-6705 (West Supp. 2014). This replaced the State's parental notice statute, *Id*. § 65-6705 (West 2008). The consent requirement applies only to unemancipated minors. *Id*. § 65-6705(a). An "unemancipated minor" is defined as "any minor who has never been: (1) Married, or (2) freed, by court order or otherwise, from the care, custody and control of the minor's parents." *Id*. § 65-6705(a).

[58] *Id*. § 65-6705(j)(1).

[59] *Id*. § 65-6701(g). As opposed to the objective standard for determining the existence of a medical emergency under the current parental consent law ("reasonable medical judgment"), the parental notification statute had used a subjective standard. *See* Kan. Stat. Ann. § 65-6701(e) (West 2008) ("good faith clinical judgment").

[60] *Id*. § 65-6705(j)(2) (citing § 65-445). The effective date of the parental consent statute, including the medical emergency reporting requirement, was July 1, 2011. *See* 2011 Kan. Sess. Laws, ch. 44, § 10 (p. 637), 2011 Session Laws of Kansas, Vol. 1 (cover and authentication). The administrative rule implementing the reporting requirement took effect on June 15, 2012. *See* Kan. Admin. Reg. § 28-56-6 (2012).

[61] Kan. Admin. Reg. 28-56-6.

< 18 years of age) in Kansas.[62] During that time, no case of a medical emergency for a minor was reported to the Department of Health and Environment.[63]

Nebraska

Nebraska enacted a parental consent statute in 2011 (replacing an earlier parental notice statute).[64] Consent of one of the minor's parent or her legal guardian is not required in a medical emergency.[65] A "medical emergency" is defined as

> a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[66]

Medical emergencies excusing compliance with the parental consent statute must be reported to the Nebraska Department of Health & Human Services.[67]

For the two years for which data is available (2013-2014), 154 abortions were performed on minors (women < 18 years of age) in Nebraska.[68] In none of these cases was the parental consent requirement excused because of a medical emergency.[69]

Nebraska first enacted an informed consent statute in 1977,[70] including a forty-eight hour waiting period which was declared unconstitutional and permanently enjoined by a

[62] Abortions in Kansas, 2011, 2012, 2013, 2014 (Preliminary Reports), Kansas Department of Health and Environment (KDHE), Division of Public Health, Bureau of Epidemiology and Public Health Information. According to these reports, 1,119 abortions were performed on minors. As the notes to the reports indicate, however, the numbers of abortions include an extremely small number of abortions performed on Kansas residents in other States (which number is not broken down by age category). According to an attorney with the KDHE, twenty abortions were performed on Kansas minors in other States between 2011 and 2014. E-mail from Eugene Lueger, Attorney, KDHE, Legal Services, to author (July 29, 2015, 10:46 a.m., CDT) (on file with author). Thus, the actual number of minors who had abortions in Kansas for these four years was 1,099 (1,119-20). The preliminary reports are used rather than the final reports because the latter do not include data that would enable one to determine the number of abortions performed on minors.

[63] E-mail from Eugene Lueger to author (July 14, 2015, 8:15 a.m., CDT) (on file with author).

[64] Neb. Rev. Stat. § 71-6901 *et seq*. (LexisNexis Supp. 2014). The former parental notice statute, Neb. Rev. Stat. § 28-347 (West Supp. 1981), which was declared unconstitutional and permanently enjoined in an unreported federal district court judgment, *see Knowles v. Kerry*, Nos. CV 81-0-301, CV 81-L-167 (D. Neb. Sept. 16, 1984), was repealed in 1991. 1991 Neb. Laws, L.B. 425, § 11. The consent requirement applies only to a "pregnant woman," Neb. Rev. Stat. § 71-6902(1) (first sentence), which is defined, in relevant part, as "an unemancipated woman under eighteen years of age who is pregnant . . . ." *Id*. § 71-6901(10). "Emancipated," in turn, is defined as "a situation in which a person under eighteen years of age has been married or legally emancipated [pursuant to a judicial decree of emancipation]." *Id*. § 71-6901(5).

[65] *Id*. § 71-6902.

[66] *Id*. § 71-6901(8).

[67] *Id*. § 71-6909.

[68] Table 8, 2013 Nebraska Statistical Report of Abortions, Table 8, 2014 Nebraska Statistical Report of Abortions, Nebraska Department of Health & Human Services.

[69] *Id*. Table 28.

[70] 1977 Neb. Laws, L.B. 38, § 42, as amended by 1979 Neb. Laws, L.B. 316, §§ 1, 2, 6, *codified as* Neb. Rev. Stat. § 28-327 *et seq*. (West Supp. 1980).

federal district court.[71] The statute has been repeatedly amended. Presently, the statute imposes detailed informed consent requirements and a twenty-four hour waiting period before an abortion may be performed.[72] Compliance with the informed consent statute, including the waiting period, is excused "in the case of an emergency situation."[73] An "emergency situation" is defined as

> that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial impairment of a major bodily function.[74]

Emergency situations excusing compliance with the informed consent requirement must be reported to the Department of Health & Human Services.[75] Starting in 1997, the Department has made available to the public statistics on how often an "emergency situation" arises.

Between 1997 and 2014, 59,876 abortions were performed in Nebraska,[76] of which twenty-two were reported to have been performed without complying with the requirements of the informed consent statute because of a medical emergency.[77] In other words, during this eighteen-year period, there was, on average, approximately one medical emergency reported every twenty months, or one emergency for every 2,721 abortions.

Oklahoma

Under current Oklahoma law, an abortion may not be performed upon a minor without at least forty-eight hours' notice to and the consent of one of her parents or

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[71] *Women's Services, P.C. v. Thone*, 483 F. Supp. 1022, 1050 (D. Neb. 1979), *aff'd per curiam*, 636 F.2d 206 (8th Cir. 1980), *judgment vacated and case remanded for further consideration in light of H.L. v. Matheson*, 450 U.S. 398 (1981), 452 U.S. 911 (1981), *judgment reaffirmed on remand from the court of appeals*, May 24, 1982, cons. cases CV 78-L-289, CV 79-L-85 and CV 79-L-100, *aff'd per curiam*, 690 F.2d 667 (8th Cir. 1982).

[72] Neb. Rev. Stat. § 28-327 *et seq*. (Supp. 2014). The 2010 amendments to the statute, 2010 Neb. Laws, L.B. 594, § 4, were declared unconstitutional and permanently enjoined in a consent decree entered by the federal district court in *Planned Parenthood of the Heartland v. Heineman*, Case No. 4:10 CV 3122, Order and Final Judgment, Aug. 24, 2010. That decision did not affect either the twenty-four hour waiting period or other provisions of the statute enacted prior to those amendments.

[73] *Id*. § 28-327 (first sentence).

[74] *Id*. § 28-326(4). This definition is slightly different from the definition of medical emergency in the parental consent statute, *id*. § 71-6901(8), in that the latter requires the risk to include not only "substantial," but also "irreversible" impairment of a major bodily function.

[75] *Id*. § 28-343(10).

[76] Statistical Reports of Abortions, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006. 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014. The data for the total number of abortions performed in Nebraska in a given year may be found in Table 1 of each report.

[77] *Id*. The data for the number of medical emergencies reported to have excused compliance with the informed consent statute may be found in Table 14 of each report.

guardian.[78] These requirements do not apply in the case of a medical emergency.[79] A "medical emergency" is defined as

> the existence of any physical condition, not including any emotional, psychological, or mental condition, which a reasonably prudent physician, with knowledge of the case and treatment possibilities with respect to the medical conditions involved, would determine necessitates the immediate abortion of the pregnancy of the minor in order to avert her death or to avert substantial and irreversible impairment of a major bodily function arising from continued pregnancy . . . .[80]

In addition to the parental notice and consent statutes, Oklahoma requires all women who undergo abortions to give their informed consent at least twenty-four hours before the procedure.[81] The informed consent requirements (and the waiting period requirement) do not apply in the case of a medical emergency,[82] which is defined in the same manner as under the parental notice and consent statutes.[83]

Under Oklahoma law, when a medical emergency excuses compliance with any of the foregoing requirements, the physician must report that information to the Oklahoma Department of Health,[84] which, in turn, is required to publish statistical data on the frequency of such emergencies.[85]

Between April 1, 2012, when Oklahoma began reporting medical emergency abortions, and December 31, 2014, a total of 13,397 abortions were performed in Oklahoma,[86] of which forty-five were reported to have been performed without complying with the twenty-four hour waiting period requirement because of a medical emergency;[87] of the 552 abortions performed on minors (women < 18 years of age) during this time, no medical emergency abortions excusing compliance with the parental consent statute

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[78] Okla. Stat. Ann. tit. 63, §§ 1-740.1 *et seq*., 1-744 *et seq*. (West Supp. 2015). The notice and consent requirements apply only to unemancipated minors. *Id*. §§ 1-740.2(A)(2), 1.744.2. An "unemancipated minor" is defined as "any person less than eighteen (18) years of age who is not or has not been married or who is under the care, custody and control of the person's parent or parents, guardian or juvenile court of competent jurisdiction." *Id*. § 1-740.1(4).

[79] *Id*. §§ 1-740.2(A), 1-740.2(B), 1-740.2(C), 1.744.3.

[80] *Id*. §§ 1-740.1(2), 1-744.1(4).

[81] *Id*. § 1-738.1A *et seq*.

[82] *Id*. § 1-738.2(B).

[83] *Id*. § 1-738.1A(5).

[84] *Id*. §§ 1-738.3a(B)(3), 1-738k(F) (questions 15, 21A, 26, 34 on reporting form), 1-740.4a(A)(9)(b)(C).

[85] *Id*. §§ 1-738.3a(F), 1-738m(C)(22), (24), (27), 1-740.4a(E).

[86] Abortion Surveillance in Oklahoma 2002-2012 Summary Report, Table 1; Abortion Surveillance in Oklahoma 2002-2013 Summary Report, Table 1; Abortion Surveillance in Oklahoma 2002-2014 Summary Report, Table 1, Oklahoma State Department of Health.

[87] *Id*. 2002-2012 Summary Report, Table 28 (nine); 2002-2013 Summary Report, Table 28 (thirty-one); 2002-2014 Summary Report, Table 28 (five), as supplemented by Amber D. Freudenberger, MPH, Program Grant Coordinator, Health Care Information, Oklahoma Department of Health, e-mail from Ms. Freudenberger to author (July 29, 2015, 10:05 a.m., CDT) (on file with author).

were reported.[88] In other words, during this thirty-three month period, slightly more than one medical emergency was reported, on average, every month, or one emergency for every 297 abortions (one-third of one percent), the highest reported incidence of medical emergencies of any of the States studied.

South Carolina

South Carolina enacted its parental consent statute in 1990.[89] Consent of one of the minor's parents, her legal guardian, one of her grandparents or "any person who has been standing in loco parentis to the minor for a period of not less than sixty days,"[90] is not required "if . . . a physician determines that a medical emergency exists involving the life of or grave physical injury to the pregnant woman . . . ."[91] The form which the physician is required to submit to the Department of Health and Environmental Control "must indicate from consent was obtained or [the] circumstances waiving consent."[92]

Between 1990 and 2013, 8,421 abortions were performed on minors (women < 17 years of age[93]) in South Carolina.[94] According to an analyst with the South Carolina Department of Health and Environmental Control, during this twenty-four year period (1990-2013) there were no instances of "excused parental consent because of a reported medical emergency for those less than 17 years old occurring in SC [South Carolina]."[95]

South Dakota

South Dakota enacted a parental notice statute in 1973.[96] Under the current version of the parental notice statute, a physician must provide one of the minor's parents or her

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[88] *Id*. 2002-2012 Summary Report, Tables 31, 32; 2002-2013 Summary Report, Tables 31, 32; 2002-2014 Summary Report, Tables 31, 32, as supplemented by Amber Freudenberger, e-mail from Ms. Freudenberger to author (July 29, 2015, 10:05 a.m., CDT).

[89] 1990 S.C. Acts, No. 341, § 1, *codified as* S.C. Code Ann. § 44-41-31 (2002). The consent requirement does not apply to emancipated minors. *Id*. § 44-41-31(A)(2). An "emancipated minor" is defined as "a minor who is or has been married or has by court order been freed from the care, custody, and control of her parents." *Id*. § 44-41-10(n).

[90] *Id*. § 44-41-31(A)(1).

[91] *Id*. § 44-41-30(C)(1).

[92] *Id*. § 44-41-60.

[93] Unlike the other parental involvement statutes discussed herein, which define a "minor" as a female under the age of eighteen, South Carolina law defines a "minor" as "a female under the age of seventeen." *Id*. § 44-41-10(m).

[94] "Abortions Occurring in SC [South Carolina] for Women Less Than 17 Years Old [1990-1996]." Attachment to e-mail from Thomas Pinner, Statistical and Research Analyst, South Carolina Department of Health and Environmental Control, Office of Public Health Statistics and Information Systems, Division of Biostatistics, to author (August 13, 2015, 4:45 p.m., CDT) (on file with author); South Carolina Vital and Morbidity Statistics 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2012, 2013, South Carolina Department of Health and Environmental Control, Office of Public Health Statistics and Information Systems, Division of Biostatistics. The data may be found in Table 43 for 1997, Table 46 for 1998, Table 48 for 1999 and 2000, and Table E-3 for the years 2001 through 2013.

[95] E-mail from Thomas Pinner to author (July 31, 2015, 5:02 p.m., CDT) (on file with author), supplemented by e-mail from Mr. Pinner to author (August 13, 2015, 4:48 p.m., CDT).

[96] S.D. Codified Laws § 34-23A-7 (1977).

guardian with forty-eight hours' written notice before proceeding with an abortion.[97] Notice is not required, however, "if . . . [t]he attending physician certifies in the pregnant unemancipated minor's medical record that, on the basis of the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time to provide the required notice."[98] In 1980, the State enacted an informed consent statute.[99] The informed consent requirement applies

> unless the physician determines that obtaining an informed consent is impossible due to a medical emergency and further determines that delaying in performing the procedure until an informed consent can be obtained from the pregnant woman or her next of kin . . . is impossible due to the medical emergency, which determinations shall then be documented in the medical records of the patient.[100]

Finally, South Dakota enacted a seventy-two hour waiting period in 2011.[101] The waiting period does not apply when a medical emergency prevents compliance therewith.[102]

For purposes of all three statutes, a "medical emergency" is defined as

> any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[103]

South Dakota began requiring physicians to report to the Department of Health circumstances in which a medical emergency excused compliance with the parental notice and informed consent statutes in 1998,[104] the incidence of which, in turn, must be disclosed in the Department's annual public report.[105] Between 1998 and 2013, 12,091 abortions were performed in South Dakota,[106] of which nine were reported to have been performed without complying with the requirements of the informed consent statutes because of a medical emergency;[107] of the 811 abortions performed on minors (women < 18 years of age), no medical emergency abortions excusing compliance with

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[97] *Id.* § 34-23A-7 (2011). The notice requirement applies only to unemancipated minors. *Id.* (first sentence). An "emancipated minor" under South Dakota law is any person under the age of eight years who "(1) Has entered into a valid marriage, whether or not such marriage was terminated by dissolution; or (2) Is on active duty with the armed forces of the United States of America; or (3) Has received a declaration of emancipation pursuant to § 25-5-26 [a statute authorizing a judicial procedure for declaring a minor emancipated]." *Id.* § 25-5-24.

[98] *Id.* § 34-23A-7(1).

[99] *Id.* § 34-23A-10.1.

[100] *Id.* § 34-23A-10.1 (first paragraph).

[101] *Id.* § 34-23A-56.

[102] *Id.* (first paragraph).

[103] *Id.* § 34-23A-1(5).

[104] *Id.* §§ 34-23A-37, 34-23A-39.

[105] *Id.* § 34-23A-36.

[106] E-mail from Thomas E. Martinec, Deputy Secretary, South Dakota Department of Health, to author (July 28, 2015, 4:55 p.m., CDT) (on file with author).

[107] E-mail from Thomas Martinec to author (July 28, 2015, 10:24 a.m., CDT) (on file with author).

the parental notice statute were reported.[108] In other words, during this sixteen-year period, a medical emergency was reported, on average, every twenty-one months, or one emergency for every 1,343 abortions.

Texas

Texas enacted a parental notice statute in 1999 that took effect on January 1, 2000.[109] Under the statute, a physician must provide one of the minor's parents, her managing conservator or guardian or her court-appointed managing conservator or guardian forty-eight hours actual or constructive notice before proceeding with an abortion.[110] Under the law in effect until January 1, 2016, compliance with the statute was not required when

> the physician performing the abortion: (A) concludes that on the basis of the physician's good faith clinical judgment, a condition exists that complicates the medical condition of the pregnant minor and necessitates the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of substantial and irreversible impairment of a major bodily function; and (B) certifies in writing to the Texas Department of Health [now the Texas Department of State Health Services] and in the patient's medical records the medical indications supporting the physician's judgment that the circumstances described in Paragraph A exist.[111]

In 2005, the State added a parental consent requirement to the parental notice requirement,[112] which included the same medical emergency exception.[113] Effective January 1, 2016, Texas changed the medical emergency exception to the consent and notice statutes to conform to the definition in the Woman's Right to Know Act.[114] A "medical emergency" under that definition means "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed."[115] In the case of a medical emergency, the physician must "certif[y] in writing to the Department of State Health

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[108] E-mail from Thomas Martinec to author (July 31, 2015, 1:50 p.m., CDT) (on file with author).

[109] S.B. No. 30, 76th Reg. Sess., §§ 1, *codified as* Tex. Fam. Code § 33.001 *et seq*., 4 (effective date).

[110] *Id*. § 33.002. The notice requirement applies only to unemancipated minors. *Id*. § 33.002(a). *See also, id*. § 33.001(2) (definition of abortion). An "unemancipated minor" is defined as "a minor who (A) is unmarried; and (B) has not had the disabilities of minority removed under Chapter 31 [a statute authorizing a judicial procedure for declaring a minor emancipated]." *Id*. § 33.001(5).

[111] *Id*. § 33.002(a)(4).

[112] S.B. No. 419, 79th Reg. Sess., pp. 38-39, adding ¶ (19) to Tex. Occ. Code § 1.42(a), effective Sep. 1, 2005.

[113] *Id*. The medical emergency exception under the parental consent statute clarified that the exception applies only when "there is insufficient time to obtain the consent of the minor's parent, managing conservator, or legal guardian." Tex. Occ. Code § 1.42(a)(19).

[114] H.B. No. 3994, 84th Reg. Sess., §§ 2 (adding ¶ (3-a) to Tex. Fam. Code § 33.001), 13 (amending Tex. Occ. Code § 1.42(a)(19)), cross-referencing Tex. Health & Safety Code § 171.002.

[115] Tex. Health & Safety Code § 171.002(3).

Services [DSHS] and in the patient's medical record the medical indications supporting the physician's judgment that a medical emergency exists . . . ."[116]

Between 2000 and 2014, a period of fifteen years, a total of 45,465 abortions were performed on minors (women < 18 years of age) in Texas.[117] In none of these cases was the parental notice and/or consent requirement excused because of a reported medical emergency.[118] And between 2012 (the first full year for which data is available) and 2014, thirty-four abortions were reported to have been performed without compliance with the Woman's Right to Know Act (including the twenty-four hour waiting period) because of a medical emergency,[119] out of 186,400 abortions.[120] In other words, there was, on average, slightly less than one medical emergency reported every month, or one emergency for every 5,482 abortions (less than two-hundredths of one percent) performed monthly in Texas under the Act.

West Virginia

West Virginia enacted a detailed informed consent statute known as the "Women's Right to Know Act" in 2003.[121] The Act imposes detailed informed consent requirements and a twenty-four hour waiting period before an abortion may be performed.[122] Compliance with the Act, including the waiting period, is excused "in the case of a medical emergency."[123] A "medical emergency" is defined as

> any condition which, on the basis of a physician's good-faith clinical judgment, so complicates the medical condition of a pregnant female as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[124]

Under the Act, physicians must report to the Department of Health and Human Resources "[t]he number of abortions performed in cases involving [a] medical emergency,"[125] and the Department, in turn, is required to issue an annual "public report

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[116] Tex. Fam. Code § 33.002(a)(3)(B).

[117] E-mail from Jeff Swanson, Ph.D., Research Specialist, Texas Department of State Health Services (DSHS), Center for Health Statistics, Data Management, to author (August 14, 2015, 3:11 p.m., CDT) (on file with author), supplemented by e-mail from Rachael B. Hendrickson, DSHS, Center for Policy and External Affairs, to Ashley Westenhover, Chief of Staff, State Representative Phil King (Rep. 61st Dist.) (August 25, 2015, 1:40 p.m., CDT) (on file with author) (2014 data is provisional and subject to revision).

[118] E-mail from Ms. Hendrickson to Ms. Westenhover (August 17, 2015, 3:53 p.m., CDT) (on file with author), supplemented by e-mail from Ms. Hendrickson to Ms. Westenhover (August 24, 2015, 10:39 a.m., CDT) (on file with author).

[119] E-mail from Ms. Hendrickson to Ms. Westenhover (August 17, 2015, 3:53 p.m., CDT) (on file with author).

[120] 2012 Texas Vital Statistics, Table 33, 2013 Texas Vital Statistics, Table 33, supplemented by e-mail from from Ms. Hendrickson to Ms. Westenhover (August 24, 2015, 10:39 a.m., CDT) (on file with author) (reporting provisional data for 2014).

[121] W. Va. Acts 2002, ch. 252, eff. May 25, 2003, *codified as* W.Va. Code § 16-2I-1 *et seq.* (2006).

[122] *Id.* § 16-2I-2.

[123] *Id.* (second sentence).

[124] *Id.* § 16-2I-1(c).

[125] *Id.* § 16-2I-7(a)(4).

providing statistics for the previous calendar year from all of the reports covering that year submitted in accordance with [§ 16-21-7(a)], for each of the items listed in subsection (a)," including the number of medical emergency abortions.[126]

Between 2004 and 2012, the most recent year for which data is available, 16,981 abortions were performed in West Virginia, of which thirty-five were reported to have been performed without compliance with the informed consent requirements (including the twenty-four waiting period) because of a medical emergency.[127] In other words, during this nine-year period, there was, on average, slightly less than four medical emergencies per year, or one emergency for every 485 abortions (approximately one-fifth of one percent).

Wisconsin

Wisconsin enacted its parental consent statute in 1991.[128] Consent of one of the minor's parent, her legal custodian, an adult family member or, in certain circumstances, one of her foster parents is not required "if the person who intends to perform or induce the abortion is a physician" and the physician believes, "to the best of his or her medical judgment based on the facts of the case before him or her, that a medical emergency exists that complicates the pregnancy so as to require an immediate abortion."[129] Medical emergency abortions must be reported to the Department of Health.[130]

Since 1998, Wisconsin has required physicians performing abortions to indicate the reason for which parental consent was not obtained in any given case. Between 1998 and 2013, the most recent year for which data is available, 9,333 abortions were performed on minors (women < 18 years of age),[131] of which two were reported to have been performed without parental consent because of a medical emergency.[132] In other words, during this sixteen-year period, there was, on average, one medical emergency abortion every eight years, or one emergency for every 4,666 abortions performed on minors.

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[126] *Id.* § 16-2I-7(e).

[127] West Virginia Women's Right to Know Act, Annual Report 2012, West Virginia Abortion Data, 2004-2012 (July 2013), West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child & Family Health.

[128] Wis. Stat. Ann. § 48.375 (West 2003). The consent requirement does not apply to emancipated minors. *Id.* § 48.375(4)(a). An "emancipated minor" is defined as "a minor who is or has been married; a minor who has previously given birth; or a minor who has been freed from the care, custody and control of her parents, with little likelihood of returning to [their] care, custody and control prior to marriage or prior to reaching the age of majority." *Id.* § 48.375(2)(e).

[129] *Id.* § 48.375(4)(b)(1).

[130] *Id.* § 69.186(1)(j).

[131] Reported Induced Abortions in Wisconsin 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006. 2007, 2008, 2009, 2010, 2011, 2012, 2013, Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. The data for the total number of abortions performed on minors in Wisconsin in a given year may be found in Table 4, Part A, of each report.

[132] *Id.* The data for the numbers of medical emergencies that excused compliance with the parental consent statute may be found in Table 4, Part C(1) of each report.

Conclusion

As the foregoing discussion indicates, there is no statistical evidence that reported medical emergencies have been used to evade the requirements of state statutes mandating parental consent or notice, informed consent or a waiting period. Not a single medical emergency abortion has been reported under the parental notice or consent statutes in Kansas, Nebraska, Oklahoma, South Carolina, South Dakota and Texas, or the informed consent statute in Arkansas, out of hundreds or even thousands of abortions performed in these States over the course of several years. In addition, there has been only one reported medical emergency for every 1,300 abortions performed under South Dakota's informed consent statute, one for every 2,000 abortions performed under Alabama's parental consent statute, one for every 2,700 abortions performed under Nebraska's informed consent statute, one for every 4,000 abortions performed under Georgia's parental notice statute, and one for every 4,600 abortions performed under Wisconsin's parental consent statute, and one for every 5,400 abortions performed under Texas' informed consent statute.[133] Only three States – Idaho (parental consent), Oklahoma (informed consent) and West Virginia (parental consent) – have reported more than one medical emergency abortion for every 1,000 abortions and even in the State with the highest ratio of emergencies to procedures – Oklahoma (one medical emergency, on average, for every 297 abortions) – such emergencies accounted for less than one-third of one percent of all abortions. The data from Texas is particularly striking because Texas is the second most populous State in the country. In a fifteen-year period, there was not a single medical emergency reported out of more than 45,000 abortions performed on minors, and only thirty-four out of 186,400 abortions performed on adults.

Nor is there any evidence that the use of a subjective standard for determining whether a medical emergency exists (either "good faith" or "best clinical judgment") has resulted in any more medical emergencies being reported than an objective standard ("reasonable medical judgment"). Indeed, the ratio of reported medical emergencies to procedures was higher in Oklahoma (one emergency for every 297 abortions), one of the few States to use an objective standard, than in any State using a subjective standard.[134] Moreover, the State with the most open-ended medical emergency exception (Alabama)[135] reported only thirteen emergencies excusing compliance with the parental consent law out of more than 26,000 abortions performed over twenty-six years, the longest period of time for which medical emergency data is available from any State.

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[133] Obviously, except in the extremely rare circumstances where a person is unable to provide consent (*e.g.*, because she is unconscious), no medical or surgical procedure may be performed on anyone without her consent after being informed of the relative risks and benefits of the proposed procedure. Although the medical emergency exceptions discussed in this article would certainly encompass such circumstances, they would also apply to those circumstances in which an emergency precluded compliance with the typically far more detailed requirements of an informed consent statute (*e.g.*, a requirement that the physician or his agent provide the patient with a description of fetal development) or a waiting period.

[134] The next highest ratio was found in West Virginia, one medical emergency for every 485 abortions.

[135] See text accompanying n. 26 for text of emergency exception.

And, as noted above, Texas, another State with a subjective standard (prior to January 1, 2016), reported *no* medical emergencies under its parental notice and consent statutes out of more than 45,000 abortions performed on minors over a fifteen year period (2000-2014).

The statistical data set forth in this article has certain limitations. First, the data is available only from those States which have enacted medical emergency exceptions to their abortion regulations, require physicians to report such emergencies and make such statistics available to the public on-line or upon request. States that have emergency exceptions in their abortion regulations, but which do not require them to be reported or make such reports available to the public are not included. Second, the data includes only what has been reported to the state department of health. Physicians who fail to comply with the reporting law are not included.

Notwithstanding these limitations, a review of the statistical data supports two conclusions. First, physicians who perform abortions and have complied with state reporting requirements have not relied upon the medical emergency exceptions in state abortion statutes to evade the requirements of those statutes. Second, the use of an objective standard for evaluating medical emergencies ("reasonable medical judgment") has not been associated with fewer reported emergencies (per number of abortions performed) than the use of a subjective standard ("good faith clinical judgment"). Both of these conclusions may be relevant in drafting other abortion statutes including, where constitutional, prohibitions (*e.g.*, of post-viability abortions). Carefully drafted medical emergency exceptions are not likely to be abused and a subjective standard for evaluating such emergencies is easier to defend (at least with respect to statutes that impose criminal penalties) when challenged on constitutional grounds than an objective standard.
Finally, every State that has enacted (or may consider enacting) a statute regulating abortion for which a medical emergency exception is constitutionally mandated should include, among other requirements, the following: First, the physician must include in the patient's medical record a careful description of the circumstances on the basis of which he determined that an emergency existed that excused compliance with the statute. Second, the physician must report the emergency to the state department of health. Third, the department of health must make available to the public statistical data on the incidence of such emergencies. As the data set forth in this article indicates, where such requirements have been imposed, very few medical emergencies have been reported.

Verbatim

Memorandum: Petition for Writ of Certiorari in Stormans v. Wiesman, *S. Ct. No. 15-862*

Background

Petitioners are Stormans, Inc. (d/b/a Ralph's Thriftway), a small business owned by the Stormans family for over seventy years, and Rhonda Mesler and Margo Thelen, two pharmacists working at other pharmacies. Petitioners believe that dispensing Plan B or *ella*—two drugs the FDA admits can destroy a human embryo—would be participating in abortion. If Petitioners receive a request for these drugs, they refer the customer to a nearby pharmacy that stocks and dispenses them. There are, for example, over thirty pharmacies that stock and dispense Plan B within five miles of Ralph's. No patient in Washington has ever been denied timely access to any drug due to a conscience-based referral and the State has stipulated that such referrals are a time-honored pharmacy practice that does not pose a threat to patients' timely access to medication.

Conscience-based referrals are legal in all 49 states outside of Washington. Governor Christine Gregoire and Planned Parenthood began pressuring the Washington Pharmacy Commission to prohibit conscience-based referrals in 2005. The Commission held two public hearings and identified no problem of access to Plan B or any other drug. The Commission then considered two draft rules, one of which allowed conscience-based referrals and one that did not. In discussing the Governor's rule, the Commission chair asked whether "a statement that does not allow a pharmacist/pharmacy the right to refuse for moral or religions judgment be clearer?" To pressure the Commission, the governor asked Planned Parenthood to work with the State Human Rights Commission. Together, they sent a letter to Commission members that threatened personal liability under state antidiscrimination laws if they supported a rule that allowed conscience-based referrals. The Commission voted unanimously to allow conscience-based referrals.

The Governor then threatened to remove Commission members, asked Planned Parenthood to draft a new regulation, and asked her advisors to confirm a draft was "clean enough for the advocates [*i.e.*, Planned Parenthood] re: conscious/moral issues." When the Commission Chair seemed resistant, the Governor refused to reappoint him and appointed two new members recommended by Planned Parenthood instead. The new Chair stated that he would never "vote to allow religion as a valid reason for a facilitated referral" and recommended prosecuting conscientious objectors "to the full extent of

the law." In 2007, the Commission voted to approve the Governor's rule. The official notice describing the new rule referred only to Plan B and singled out conscientious objection as the only prohibited reason for referral. The Commission's spokesperson also testified that "the object of the rule was ending refusals for conscientious objection."

The Delivery and Stocking Rules

The new Delivery Rule mandates that pharmacists "deliver lawfully prescribed drugs or devices … in a timely manner" but has seven exceptions that apply where (1) the prescription is erroneous, (2) there are guidelines affecting the availability of the drug, (3) the pharmacy lacks necessary specialized equipment or expertise, (4) the prescription may be fraudulent, (5) the drug is out of stock, (6) the customer is unable to pay, and (7) any circumstances substantially similar to the other exceptions. The fifth stocking exception specially incorporates an older Stocking Rule that requires pharmacies to "maintain at all times a representative assortment of drugs in order to meet the pharmaceutical needs of its patients." The Stocking Rule has long given pharmacies broad discretion not to stock drugs for reasons of business or mere convenience.

The district court found that the Delivery Rule's enumerated exceptions permit pharmacies to refer for a wide variety of common business, economic, and convenience reasons, such as when a drug is unprofitable, falls outside of supplier contracts, requires additional equipment, training, or paperwork, attracts an undesirable clientele, or falls outside a chosen business niche. It also found that the substantially similar exception was designed to allow the Commission "wiggle room" to grant additional exemptions.

Lower Court Rulings

The district court held a 12-day bench trial that involved 22 witnesses and almost 800 exhibits. After reviewing four years worth of experience under the Delivery Rule and over 40 years of experience under the Stocking Rule, the district court found that "the effect of the law in it [*sic*] real operation" was to "exempt pharmacies and pharmacists from stocking and delivery lawfully prescribed drugs for an almost unlimited variety of secular reasons, but fail to provide exemptions for reasons of conscience." It also found that nothing except conscience-based referrals had ever been deemed to violate either rule and that the regulation's goal was barring conscientious objections, while allowing refusals "to dispense for practically any other reason."

A panel of the Ninth Circuit reversed because it deemed the enumerated exemptions to the Delivery Rule necessary for "pharmacies to operate in the normal course of business." Furthermore, the panel held that no selective enforcement occurred because the Commission uses a complaint-driven process and it never received any comparable complaints about secular conduct. The panel also held that the Commission had no "specific intent to disadvantage religious objectors" and that "[t]he collective will of the [Commission] cannot be known, except as expressed in the text" of the rules and official documents explicating them. The Ninth Circuit denied rehearing en banc.

The Cert. Petition

The cert. petition argues that the Supreme Court should either summarily reverse the Ninth Circuit's decision in light of its blatant inconsistence with *Lukumi* or grant plenary review to resolve the Ninth Circuit's conflict with six other circuits on three critical points of free exercise law: (1) a conflict with the Third, Sixth, Tenth, and Eleventh Circuits, and the Iowa Supreme Court on the significance of secular exemptions, (2) a conflict with Third Circuit on the relevance of selective enforcement, and (3) a conflict with the Seventh and Eighth Circuits on the use of a law's history to demonstrate discriminatory intent. The petition concludes by highlighting the significance of the Ninth Circuit holding: "If these Regulations are neutral and generally applicable—when they are riddled with exemptions for secular conduct, when they have never been applied to anything but religious conduct, when the government has stipulated that the religious conduct is harmless, and when there is overwhelming evidence of discriminatory intent— then any law can be upheld as neutral and generally applicable."

Amicus Briefs

A broad spectrum of 75 private groups, 13 states, 4,609 health care professionals, 43 members of Congress, and 29 religious liberty scholars filed 14 *amicus* briefs in support of the petition. Those 75 groups include, *inter alia*, the American Pharmacist Association and 37 other national and state pharmacists' associations, the United States Conference of Catholic Bishops, Agudath Israel of America, the National Committee for Amish Religious Freedom, the Bruderhof, the International Society for Krishna Consciousness, the Church of the Lukumi Babalu Aye, the Union of Orthodox Jewish Congregations of America, the Church of Jesus Christ of Latter-Day Saints, and 6 different protestant denominations. Please find a table summarizing the *amici* who joined each brief, their counsel of record, and the brief's principal arguments attached to this memorandum.

Three of the most remarkable *amicus* briefs were filed by 38 National and State Pharmacists' Associations, 29 Religious Liberty Scholars, and the USCCB. The Pharmacists' Associations brief aptly explains how pharmacies work and the public benefits associated with allowing pharmacists to make their own stocking decisions. The Scholars brief makes a strong case that generally applicability requires the objectively equal treatment of religious and secular conduct without regard to motives, targeting, or the rule's object. And the USCCB brief elucidates the real danger Washington's regulations pose to Catholic hospital systems.

No. 15-862

IN THE

Supreme Court of the United States

STORMANS, INC., DOING BUSINESS AS RALPH'S THRIFTWAY, RHONDA MESLER, AND MARGO THELEN,
Petitioners,

v.

JOHN WIESMAN, SECRETARY OF THE WASHINGTON STATE DEPARTMENT OF HEALTH, ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Congress and all fifty states have long protected the right of health care professionals to decline to participate in the taking of human life. Petitioners are a family-owned pharmacy and two pharmacists who cannot sell abortifacient drugs without violating their religious beliefs. Instead, they refer customers to one of dozens of nearby pharmacies that sell those drugs. No customer in Washington has ever been denied timely access to any drug due to religiously motivated referral.

Nevertheless, in 2007, Washington became the only state to make Petitioners' religious conduct illegal. It did so over the objections of its own Pharmacy Commission, against the recommendation of the American Pharmacists Association and the Washington Pharmacy Association, and despite its own stipulation that Petitioners' conduct "do[es] not pose a threat to timely access to lawfully prescribed medications." After a twelve-day trial, the district court held that the new regulations violate the Free Exercise Clause because they intentionally target religious conduct, have been enforced only against religious conduct, and exempt identical conduct when done for "an almost unlimited variety of secular reasons." The Ninth Circuit reversed.

The question presented is:

Whether a law prohibiting religiously motivated conduct violates the Free Exercise Clause when it exempts the same conduct when done for a host of secular reasons, has been enforced only against religious conduct, and has a history showing an intent to target religion.

PARTIES TO THE PROCEEDING

Petitioners are Stormans, Inc. (doing business as Ralph's Thriftway), Rhonda Mesler, and Margo Thelen.

Respondents are John Wiesman, Secretary of the Washington State Department of Health; Dan Rubin, Elizabeth Jensen, Emma Zavala-Suarez, Sepi Soleimanpour, Christopher Barry, Nancy Hecox, Tim Lynch, Steven Anderson, Albert Linggi, Maureen Simmons Sparks, Maura C. Little, and Kristina Logsdon, Members of the Washington Pharmacy Quality Assurance Commission; Mark Brenman, Executive Director of the Washington Human Rights Commission; Martin Mueller, Assistant Secretary of the Washington State Department of Health, Health Services Quality Assurance; Judith Billings; Rhiannon Andreini; Jeffrey Schouten; Molly Harmon; Catherine Rosman; and Tami Garrard.

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CORPORATE DISCLOSURE STATEMENT

Stormans, Inc., is a privately held corporation with no parent corporation. No publicly held corporation owns 10% or more of its stock.

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APPENDIX:

* The Washington Board of Pharmacy changed its name to the Washington Pharmacy Quality Assurance Commission during the course of litigation.

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TABLE OF AUTHORITIES

***Cases*:**

***Constitutional Provisions*:**

Statutory Provisions:

***Legislative Materials*:**

***Other Authorities*:**

PETITION FOR A WRIT OF CERTIORARI

This Court's unanimous decision in *Church of the Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520 (1993), was clear: Governments may not pass laws that target religious conduct for negative treatment while exempting the same conduct when done for nonreligious reasons. But the Ninth Circuit upheld just such a rule here.

For decades, American pharmacies have made decisions about which drugs to sell based on a wide variety of reasons related to business, economics, convenience, and conscience. When a pharmacy chooses not to sell a drug, it is commonplace to refer a customer to a nearby pharmacy. Such referrals—including referrals for reasons of conscience—are expressly approved by the American Pharmacists Association and have long been legal in all fifty states.

But in 2007, in response to intense lobbying by national and state pro-abortion groups, Washington became the only state to make conscience-based referrals illegal. App121-22a.[1] Washington banned

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[1] One other state—Illinois—adopted the same prohibition in 2010, expanding on an executive order issued by Governor Rod Blagojevich in 2005. But its regulation was struck down in state trial court as a violation of the Free Exercise Clause, *Morr-Fitz, Inc. v. Blagojevich*, 2011 WL 1338081, No. 2005-CH-000495 (Ill. Cir. Ct. Apr. 5, 2011), and on appeal as a violation of Illinois law, *Morr-Fitz, Inc. v. Quinn*, 976 N.E.2d 1160 (Ill. App. Ct. Sept. 20, 2012).

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conscience-based referrals even though no customer has ever been denied timely access to any drug due to such a referral. And it did so even though it has *stipulated* that conscience-based referral is "a time-honored pharmacy practice" that "do[es] not pose a threat to timely access to lawfully prescribed medications." App.335a.

The state's new regulations were primarily drafted by two pro-abortion advocacy groups at the request of Governor Christine Gregoire, who personally boycotted Petitioners because of their conscientious objection to abortifacient drugs. After the State's Pharmacy Commission resisted adopting the Governor's rule, she replaced two members with new ones recommended by the pro-abortion groups. The new Commission Chairman stated that "I for one am never going to vote to allow religion as a valid reason for a facilitated referral" and advocated prosecuting conscience-based referrals "to the full extent of the law." App.145a, 186-87a, 407a.

After nearly five years of litigation and a twelve-day trial, the district court found that the new Regulations target conscientious objections to abortifacient drugs, while exempting referrals for "an almost unlimited variety of secular reasons." App.81a. It found that the Regulations have never been enforced against anything but religious conduct. And it found that "reams of emails, memoranda, and letters between the Governor's representatives, Pharmacy [Commission] members, and advocacy groups" demonstrated that the Regulations were "aimed at [abortifacient drugs] and conscientious objectors from their inception."

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App.57a. The district court enjoined the Regulations as a violation of *Lukumi*.

The Ninth Circuit reversed, ignoring the district court's extensive factual findings and adopting an exceptionally narrow interpretation of the Free Exercise Clause. It held that any law can satisfy the Free Exercise Clause, no matter how clearly it targets religious conduct in practice, as long as it might also be applied to nonreligious conduct in theory. The result is so contrary to *Lukumi* that summary reversal is warranted.

Alternatively, the Ninth Circuit's departure from *Lukumi* also creates stark conflicts with other circuits warranting plenary review. The panel's opinion conflicts with the Third, Sixth, Tenth, and Eleventh Circuits and the Iowa Supreme Court on the significance of secular exemptions; it conflicts with the Third Circuit on the relevance of selective enforcement; and it conflicts with the Seventh and Eighth Circuits on the use of a law's history to demonstrate discriminatory intent.

The Ninth Circuit's decision likewise upsets a longstanding consensus on an issue of immense national importance: conscience protections in health care. For over forty years, Congress and all fifty states have protected the right of pharmacists, doctors, nurses, and other health professionals to step aside when asked to participate in what they consider to be an abortion. The decision below authorizes a dangerous intrusion on this right, which can only exacerbate intense cultural conflict over these issues.

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Whether summary reversal or plenary review is more appropriate, the decision below cannot stand. This Court should intervene to realign the Ninth Circuit with the rest of the country, vindicate Petitioners' right to refrain from taking human life, and reaffirm that the Free Exercise Clause "protects religious observers against unequal treatment." *Lukumi*, 508 U.S. at 542 (quoting *Hobbie v. Unemployment Appeals Comm'n of Fla.*, 480 U.S. 136, 148 (1987)).

OPINIONS BELOW

The Ninth Circuit's opinion is reported at 794 F.3d 1064 (9th Cir. 2015) and reproduced at App.1a. The district court's opinion granting a permanent injunction is reported at 844 F. Supp. 2d 1172 (W.D. Wash. 2012) and reproduced at App.49a. The district court's findings of fact and conclusions of law are reported at 854 F. Supp. 2d 925 (W.D. Wash. 2012) and reproduced at App.112a.

JURISDICTION

The court of appeals entered its judgment on July 23, 2015. It denied a timely petition for rehearing en banc on September 10, 2015. App.261a. Justice Kennedy extended the time in which to file a petition for a writ of certiorari to January 4, 2016. This Court has jurisdiction under 28 U.S.C. 1254(1).

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CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The First Amendment to the United States Constitution provides, in relevant part: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . ." U.S. Const. amend. I.

The relevant portions of the Washington Administrative Code, §§ 246-869-010 and 246-869-150(1) (collectively, the "Regulations"), are reprinted in the Appendix. App.344-47a.

STATEMENT

A. Petitioners and the Practice of Pharmacy

Petitioner Stormans, Inc. is a small family business owned by the three children of Ken Stormans. For over seventy years, the Stormans family has owned and operated Ralph's Thriftway, a grocery store that includes a small retail pharmacy. Petitioners Rhonda Mesler and Margo Thelen are individual pharmacists who have worked at other retail pharmacies for a combined seventy years.

Like most pharmacies, Petitioners stock only a fraction of the roughly 6,000 drugs available on the market. App.116a. A retail pharmacy like Ralph's typically stocks about 15% of available drugs. Br. of American Pharmacists Association 6, Nov. 20, 2012, ECF No.68 ("APhA.Br."). Decisions about which drugs to stock are based on a variety of factors, such

as demand for a drug, cost of a drug, whether a drug is sold only in bulk, shelf space, shelf life, manufacturer or supplier restrictions, insurance requirements and reimbursement rates, administrative costs, monitoring or training costs, and competitors' practices. App.117-18a. Some pharmacies also choose to target a niche market, stocking drugs for geriatric, pediatric, oncological, diabetes, HIV, infusion, compounding, naturopathic, or fertility patients only. App.162a.

When a customer requests a drug that a pharmacy does not stock, standard practice is to refer the customer to another pharmacy. Pharmacies do this many times daily. App.118-19a, 165-68a. Even when a drug is in stock, pharmacies routinely refer customers elsewhere for a variety of reasons—such as when a prescription requires extra time (like simple compounding or unit dosing), or when a customer offers a form of payment that the pharmacy does not accept. App.166-68a. The State has stipulated that referral is standard practice and is often the most effective way to serve a customer. App.141-43a.

Petitioners are Christians who believe that life is sacred from the moment of conception. App.115a. Because of their religious beliefs, Petitioners cannot stock or dispense the morning-after or week-after pills (collectively, "Plan B"), which the FDA has recognized can prevent implantation of an embryo. *Id*. For Petitioners, dispensing these drugs would make them guilty of destroying human life. *Id*.

On the rare occasions when a customer requests Plan B, Petitioners provide the customer with a list of nearby pharmacies that stock Plan B and, upon the patient's request, call to confirm it is in stock. This is called a "facilitated referral." *Id.* Within five miles of Ralph's, over thirty pharmacies carry Plan B. Plan B is also available from nearby doctors' offices, government health centers, emergency rooms, Planned Parenthood, a toll-free hotline, and the Internet. App.146-47a. As of 2013, the morning-after pill is also available on grocery and drug-store shelves without a prescription.[2]

Petitioners' customers have never been denied timely access to any drug. App.147a. The State stipulated below that facilitated referral is "a time-honored pharmacy practice" that "continues to occur for many reasons" and "do[es] not pose a threat to timely access to lawfully prescribed medications," "including Plan B." App.142a. The State also stipulated that facilitated referrals "help assure timely access to lawfully prescribed medications . . . includ[ing] Plan B" and "are often in the best interest of patients." *Id.* Plaintiffs' conscience-based

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[2] *See* Lisa M. Krieger, *'Morning after' pill goes on sale Thursday in pharmacies and grocery stores, available to anyone*, San Jose Mercury News, (July 31, 2013), http://www.mercurynews.com/science/ci_23770130/morning-after-pill-goes-sale-Thursday pharmacies-and. Based on this development, the Ninth Circuit asked for supplemental briefing on whether this case was moot. But all parties agreed that the case is not moot because the week-after pill and some versions of the morning-after pill are still available only by prescription, and Petitioners are required to dispense them.

referrals were legal for decades in Washington. They are approved by the American Pharmacists Association. And they are legal in every other state. App.119-23a, APhA.Br.28-31.

B. The Regulatory Process

Washington is the only state that currently makes conscience-based referrals illegal. App.121-22a. In 2005, Planned Parenthood Public Policy Network of Washington and Legal Voice (collectively, "Planned Parenthood") contacted Governor Christine Gregoire's office and asked for her help in banning conscience-based referrals for Plan B. Governor Gregoire met personally with Planned Parenthood officials, sent a letter to the Washington Pharmacy Quality Assurance Commission ("Commission"), and appointed a former Planned Parenthood board member to the Commission. Shortly thereafter, the Commission initiated a formal rulemaking process. App.123-27a.

The Commission held two public hearings. Prior to these hearings, the Governor urged Planned Parenthood to gather stories of customers who had been refused access to Plan B. App.152a. Planned Parenthood published advertisements soliciting refusal stories, sent test-shoppers to pharmacies throughout the state, and attempted to document any refusals that occurred. App.156-57a. However, during the rulemaking hearings, neither Planned Parenthood nor the Commission were able to identify any problem of access to Plan B or any other drug. App.89a, 152a, 244a. The Commission also conducted a statewide survey of access to Plan B,

finding that 77% of Washington pharmacies stock Plan B. Of the 23% that do not, only 2% cited religious reasons, while 21% cited business or convenience reasons. The Washington State Pharmacy Association conducted two similar surveys, finding no problem of access to any drug and no instance of any patient being denied timely access due to a pharmacist's objection. App.147-49a.

After the rulemaking hearings, the Commission considered two draft rules—one that would prohibit conscience-based referrals as the Governor requested, and one that would protect them. Upon reviewing the Governor's rule, the Executive Director of the Commission asked, "Would a statement that does not allow a pharmacist/ pharmacy the right to refuse for moral or religious judgment be clearer?" App.58a, 131a, 406a. As he understood the rule, the goal was to allow referrals "for most legitimate examples raised; clinical, fraud, business, skill, etc." App.131a. But "the difficulty is trying to draft language to allow facilitating a referral for only these non-moral or non-religious reasons." *Id*. He clarified that "non-religious reasons" included referrals because of expense, shelf-life, low demand, or a pharmacy's chosen business niche. *Id*.

To increase the pressure to adopt her rule, the Governor asked Planned Parenthood to work with the State Human Rights Commission. Together, they drafted a letter threatening Pharmacy Commission members with personal liability under state antidiscrimination laws if they voted for a regulation that permitted conscience-based referrals. App.126-

27a, 374-99a. Nevertheless, the Pharmacy Commission voted unanimously to protect conscience-based referrals.

Governor Gregoire then publicly threatened to remove Commission members. App.129a. She asked Planned Parenthood to prepare a new regulation and, after reviewing the draft, asked her advisors to confirm that it was "clean enough for the advocates [i.e., Planned Parenthood] re: conscious/moral issues." App.129-30a. As the Executive Director of the Commission explained in an email: "the moral issue IS the basis of the concern. . . . [T]he public, legislators and governor are telling us loud and clear that they expect the rule to protect the public from unwarranted intervention based on the moral beliefs of a pharmacist." App.130a, 401a.

The Governor also created a new taskforce to finalize the text of the rule. The taskforce consisted of members of Planned Parenthood, the Governor's policy advisor, and three pharmacists. App.131a. Although all three pharmacists supported conscience-based referrals, the Governor and Planned Parenthood took conscience-based referrals off the table. App.132a. The taskforce then agreed that the rule should preserve referral for a variety of business, economic, and convenience reasons, but not for reasons of conscience. App.134a, 351-54a.

To guarantee final approval of the rule, Governor Gregoire personally called the Commission Chairman before a key vote and told him to "do [your] job." App.136a. She also involved Planned Parenthood in the process of interviewing candidates

for the Commission. When the Commission Chairman seemed resistant, and Planned Parenthood opposed his reappointment, the Governor refused to reappoint him. Instead, she appointed two new Commission members recommended by Planned Parenthood. App.137-38a. The new Commission Chairman stated that "I for one am never going to vote to allow religion as a valid reason for a facilitated referral." App.145a. He also stated that he would recommend prosecuting conscientious objectors "to the full extent of the law," App.186-87a, and that he viewed those who refer for reasons of conscience as "immoral" and engaging in "sex discrimination," App. 367a. He testified that the Regulations affected conscientious objectors and no others. App.140a, 144a.

On April 12, 2007, the Commission voted to approve the Governor's rule. App.138a. In the notice sent to pharmacies describing the new rule, the Commission referred only to Plan B and singled out only one prohibited reason for referral: conscientious objection. App.139a, 360a. The Commission's spokesperson testified that "the object of the rule was ending refusals for conscientious objection." App. 359a, 362a.

C. The New Regulations

The new "Delivery Rule" creates "a duty to deliver lawfully prescribed drugs or devices . . . in a timely manner," App.158a, subject to seven exemptions. The first five exemptions cover situations where (a) the prescription is erroneous, (b) there are guidelines affecting the availability of the

drug, (c) the pharmacy lacks specialized equipment or expertise needed to dispense the drug, (d) the prescription is potentially fraudulent, or (e) the drug is out of stock. A sixth exemption excuses pharmacies when a customer is unable to pay the pharmacy's "usual and customary" charge. A seventh exemption was added as a catch-all, covering any circumstances that are "substantially similar" to the first six exemptions. The district court found "abundant evidence" that the enumerated exemptions permit pharmacies to refer for a "wide variety" of common business, economic, and convenience reasons. App.175a, 135-36a, 171a, 200a-211a, 222a. And the "substantially similar" language was designed to give the Commission "wiggle room" to grant additional exemptions. App.134-36a, 212-213a, 221a, 354a.

One of the exemptions in the Delivery Rule—the out-of-stock exemption—also incorporates by reference an older "Stocking Rule," which provides that a pharmacy "must maintain at all times a representative assortment of drugs in order to meet the pharmaceutical needs of its patients." App.161a. The Stocking Rule has long given pharmacies broad discretion to decline to stock drugs for business or convenience reasons, and the out-of-stock exemption incorporates this discretion into the new Delivery Rule. App.162a. Thus, under the Delivery Rule, if a pharmacy chooses not to stock a drug for business or convenience reasons—*i.e.*, "good faith compliance

with [the Stocking Rule]"—there is no duty to deliver the drug. App.160-61a, 221-22a.[3]

D. The Regulations' Operation in Practice

In practice, the new Regulations have not changed pharmacies' traditional discretion to decline to stock or deliver drugs for reasons related to business, economics, or convenience. As the district court found, pharmacies have continued to decline to stock drugs for all of the "widespread, widely known" reasons mentioned above—such as when a drug might be unprofitable, fall outside supplier contracts, require additional equipment or training or paperwork, attract an undesirable clientele, or fall outside a chosen business niche. App.162-65a, 231a. And even when drugs are in stock, pharmacies have

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[3] The Ninth Circuit wrongly stated that Petitioners "do not challenge the Stocking Rule." App.16a, 18a n.2, 35a. But Petitioners repeatedly challenged the Stocking Rule at summary judgment, pretrial, trial, and appeal. *See*, *e.g.*, Pls.' Consolidated Resp. to State Defs.; Defs.-Intervenors' Mots. for Summ. J., 22, Apr. 26, 2010, ECF No.401. (Stocking Rule is "[a]t the center of this case"); Pls.' Trial Br., Nov. 10, 2011, ECF No.510 (pretrial); 92-100a, 162-165a (trial); Br. of Appellees, 19-21, 42-43, 73-76, 86-100, 135, Nov. 14, 2012, ECF No.62. The district court expressly ruled on it, mentioning the Stocking Rule in its ruling no less than thirty-seven times. Petitioners' Ninth Circuit brief cited it almost fifty times. Hence, the Stocking Rule was both pressed and passed upon below. The Stocking Rule is also expressly incorporated by one of the exemptions under the Delivery Rule. Thus, a challenge to the Delivery Rule necessarily requires the court to consider the Commission's interpretation and application of the Stocking Rule. App.161a.

continued to decline to deliver them for a variety of reasons—such as when they are asked to perform simple compounding, provide unit dosing, or accept an undesirable form of payment. App.166-68a. In all of these situations and more, pharmacies have continued to refer customers to other pharmacies, and none of these referrals has ever been deemed to violate the Stocking or Delivery Rules.

By contrast, the Regulations have made Petitioners' conscience-based referrals illegal. When abortion-rights activists discovered Ralph's position on Plan B, they sent coordinated patrols of test-shoppers to request Plan B and then file complaints against Ralph's. Test-shoppers also filed complaints against a nearby Walgreens, Sav-On, and Albertsons. When the other pharmacies informed the Commission that Plan B was temporarily out of stock, they were deemed to be in compliance, and the investigations were closed. Conversely, when Ralph's informed the Commission that dispensing Plan B would violate the owner's religious beliefs, they were deemed to be in "outright defiance" of the Regulations and the investigation was kept open. App.184-86a. The Chairman of the Commission testified that if Petitioners continue their practice of not stocking Plan B, they will be subject to the revocation of their pharmacy license. App.186-87a.[4]

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[4] Ralph's pharmacy remains open because the district court enjoined the Regulations and the Ninth Circuit has temporarily stayed its mandate pending this Court's review.

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Abortion-rights groups also organized a boycott and picketing of Ralph's. Picketers stood on both sides of the store entrance, yelling at customers and urging them to boycott the store. The Governor's office joined in the boycott, canceling an account with Ralph's that had been in place for sixteen years. App.185a.

Test-shoppers also targeted Petitioners Thelen and Mesler. Before adoption of the Delivery Rule, their employers allowed them to refer the rare Plan B customers to nearby pharmacies. But after the adoption of the Regulations, their employers informed them that they could no longer be accommodated. Thelen was constructively discharged, and Mesler was informed that she would have to transfer to a pharmacy in another state unless the Regulations were enjoined. As the district court found, this is the unavoidable result of the Regulations, because they force pharmacies to choose between either keeping a non-objecting pharmacist on duty at all times at a cost of tens of thousands of dollars annually, or terminating the objecting pharmacist. App.188a, 237a.

E. Trial Proceedings

On July 25, 2007, Petitioners filed suit challenging the Regulations under the Free Exercise, Equal Protection, and Due Process Clauses. The district court granted a preliminary injunction, *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245 (W.D. Wash. 2007), which the Ninth Circuit reversed, *Stormans, Inc. v. Selecky*, 586 F.3d 1109 (9th Cir. 2009) ("*Stormans I*"), App.263-332a. On

remand, Respondents agreed not to enforce the Regulations against Petitioners pending trial. Stipulation and Order, Mar. 6, 2009 (ECF No.355).

The district court then held a twelve-day bench trial, involving twenty-two witnesses and almost 800 exhibits. Much of the trial focused on the effect of the Regulations in practice. Reviewing four years of experience under the Delivery Rule, and over forty years of experience under the Stocking Rule, the court found that "the effect of the law in its real operation" was to "exempt pharmacies and pharmacists from stocking and delivering lawfully prescribed drugs for an almost unlimited variety of secular reasons, but fail to provide exemptions for reasons of conscience." App.80-81a. It found that pharmacies have continued to refer customers for "countless" business, economic, and convenience reasons, and that the State has been aware of and permitted these practices regardless of the potential effect on patient health. App.86a, 170a, 231a. Instead, "the only result of the Regulations has been to prohibit conscientious objections to Plan B." App.245a.

The district court also found that the Regulations had been selectively enforced, and that no conduct except conscience-based referrals has ever been deemed to violate either rule. The State claimed that this was because it enforces its regulations only in response to citizen complaints, and no citizens have ever complained about nonreligious referrals. But the district court found this testimony "to be implausible and not credible." App.176a. The Commission uses a "wide variety of

mechanisms" to promote compliance, including initiating its own complaints, inspecting pharmacies regularly, and test shopping pharmacies. *Id.* The court also found that relying on citizen complaints only made the selective enforcement problem worse, because the Commission was well aware that "Planned Parenthood and other pro-choice groups have conducted an active campaign to seek out pharmacies and pharmacists with religious objections to Plan B and to file complaints." App.228a. This resulted in a "severely disproportionate number of investigations directed at religious objections to Plan B." *Id.*

The court also made detailed findings on the Regulations' history and purpose. The court found that "the evidence at trial revealed no problem of access to Plan B or any other drug before, during, or after the rulemaking process." App.146a. Instead, the evidence "demonstrat[ed] that the predominant purpose of the [Regulations] was to stamp out the right to refuse" for reasons of conscience. App.57a. The Commission confirmed its purpose in public pronouncements and voluminous internal correspondence—all of which revealed that "the goal of the [Commission], the Governor, and the advocacy groups" was to "bar pharmacists and pharmacies from conscientiously objecting," while "allowing pharmacies and pharmacists to refuse to dispense for practically any other reason." App.58-59a, 172a.

Based on its findings, the district court held that the Regulations were neither "neutral" nor "generally applicable" under the Free Exercise Clause. App.248a. It also held that the Regulations

failed strict scrutiny because there was no problem of access to Plan B, and because the State had stipulated that conscience-based referral is "a time-honored pharmacy practice" that "do[es] not pose a threat to timely access" to Plan B. App.248-49a

F. The Ninth Circuit's Decision

A panel of the Ninth Circuit reversed, concluding that "the rules are neutral and generally applicable" and "rationally further the State's interest in patient safety." App.10a. The panel acknowledged that, in practice, pharmacies routinely refer patients elsewhere for a variety of business, economic, and convenience reasons. But it held that "the enumerated exemptions [in the Delivery Rule] are 'necessary reasons for failing to fill a prescription' in that they allow pharmacies to operate in the normal course of business," and were therefore legitimate. App.30a.

Regarding selective enforcement, although the panel acknowledged that the Commission had never taken action against nonreligious referrals, it held that the Commission had no "specific intent to disadvantage religious objectors." App.40a. The fact that "Ralph's has been implicated in a disproportionate percentage of investigations" was simply a function of the fact that "the Commission responds only to the complaints that it receives." App.39a.

Finally, addressing the historical background of the Regulations, the panel held that "[t]he collective will of the [Commission] cannot be known, except as

expressed in the text'" and official documents explicating the final rules. App.27a (quoting *Stormans I* at App.312a). And, "[e]ven if the Commission had drafted and adopted the rules solely in response to incidents of refusal to deliver Plan B, that fact would not *necessarily* mean that the rules were drafted with the intent of discriminating against religiously motivated conduct." App.28a n.6.

The Ninth Circuit denied rehearing en banc. App.261-62a.

REASONS FOR GRANTING THE PETITION

I. The Ninth Circuit's decision should be summarily reversed in light of *Lukumi*.

The Ninth Circuit's decision is so patently inconsistent with *Lukumi* that summary reversal is warranted. *See Am. Tradition P'ship, Inc. v. Bullock*, 132 S. Ct. 2490 (2012) (summarily reversing Montana Supreme Court's refusal to follow *Citizens United v. FEC*, 558 U.S. 310 (2010)).

In *Lukumi*, this Court struck down three ordinances banning animal sacrifice, unanimously concluding that the ordinances fell "well below the minimum standard necessary to protect First Amendment rights." 508 U.S. at 543. The ordinances were not "neutral" or "generally applicable" because they burdened "Santeria adherents but almost no others"; they "proscribe[d] more religious conduct than [wa]s necessary to achieve their stated ends"; and they exempted "[m]any types of animal deaths or kills" that undermined the government's interests

"in a similar or greater degree than Santeria sacrifice does." *Id*. at 536-38, 543.

Here, after an extensive trial, the district court found that the Regulations operate in precisely the same manner: They burden "religious objections" but no others; they prohibit conscience-based referrals even when the State has stipulated that they "pose[] no threat to timely access to Plan B"; and they are "riddled with secular exemptions that undermine their stated goal" "in a similar or greater degree" than conscience-based referrals would. App.233a, 235a, 106a, 200a.

The Ninth Circuit did not find any of these key factual findings to be clearly erroneous. Instead, it purported to distinguish *Lukumi* on four grounds, none of which are even remotely plausible. First, it said that the Regulations are neutral because they apply "to *all* objections to delivery that do not fall within an exemption." App.23a. But that is a truism: All laws apply to conduct that isn't exempt. In *Lukumi*, for example, the ordinances applied to *all* animal killing that wasn't exempt. The problem was the breadth of the exemptions, which protected "almost all killing of animals except for religious sacrifice." 508 U.S. at 536. The same problem is present here: The Regulations in practice protect all forms of referral except conscience-based referral. Indeed, it is undisputed that *no* secular referral has *ever* been found to violate the Regulations.

Second, the Ninth Circuit reasoned that the Regulations are neutral because they *might* apply to secular referrals in the future—such as refusals to

deliver "diabetic syringes, insulin, HIV-related medications, and Valium." App.23-24a. But *Lukumi* requires the court to consider "the effect of a law in its real operation"—not speculate about the future. 508 U.S. at 535. Here, it is undisputed that the Regulations have never applied to any secular conduct, and, in any event, the district court expressly found that these hypothetical future referrals are exempt. App.151-57a, 234a.

Third, the Ninth Circuit suggested that the Regulations are neutral because they "specifically *protect* religiously motivated conduct" by "allowing pharmacies to 'accommodate' individual pharmacists" who have religious objections. App.22a. But that simply disregards the district court's factual findings, which expressly stated that the Regulations do *not*, in practice, work that way; rather, "the Delivery Rule renders the pharmacist's right to conscientious objection illusory." App.55a, 180-83a. The vast majority of pharmacies have only one pharmacist on duty, which makes it impossible to accommodate individual pharmacists. That is what happened to the two individual pharmacist Petitioners, and there is no record of any individual pharmacist ever being accommodated under the Regulations. App.188a. Indeed, the Commission's own witnesses admitted that the Regulations do not accommodate objectors. App.180-83a.

Finally, the Ninth Circuit held that the fact that there are "other means that might achieve the [government's] purpose" without burdening religious exercise does not demonstrate targeting. App.26a. But *Lukumi* says just the opposite: When laws

"proscribe more religious conduct than is necessary to achieve their stated ends," that is "significant evidence" of "improper targeting." 508 U.S. at 538. Here, the State has *stipulated* that conscience-based referrals "do not pose a threat to timely access to lawfully prescribed medications"—yet it still seeks to punish them. App.249a. That is significant evidence of targeting, and the panel simply disregarded it—along with the binding stipulation—in violation of *Lukumi*. App.25-27a.; *see also Christian Legal Soc. v. Martinez*, 561 U.S. 661, 677 (2010) ("[Factual stipulations are] binding and conclusive.").

In short, the Regulations here are just as blatantly targeted at religious conduct as the ordinances unanimously struck down in *Lukumi*. The Ninth Circuit's transparent attempt to avoid applying *Lukumi*, as well as its flagrant disregard of the district court's extensive factual findings, warrant summary reversal.

II. The Ninth Circuit's decision dramatically curtails the Free Exercise Clause in conflict with six other circuits.

Alternatively, the Court should grant plenary review to address the stark conflicts created by the Ninth Circuit's decision on three critical issues of free exercise doctrine: the significance of secular exemptions, the relevance of selective enforcement, and the use of a law's history to demonstrate discriminatory intent. A conflict on any one of these issues would merit this Court's attention. A conflict on all three demands it.

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A. The Ninth Circuit's decision conflicts with the Third, Sixth, Tenth, and Eleventh Circuits and the Iowa Supreme Court on the use of exemptions to prove that a law is not generally applicable.

1. Following *Lukumi*, the Third, Sixth, Tenth, and Eleventh Circuits and the Iowa Supreme Court have held that a law is not generally applicable when it exempts nonreligious conduct that undermines the government's interests "in a similar or greater degree than [religious conduct] does." 508 U.S. at 543-44.

In *Fraternal Order of Police Newark Lodge No. 12 v. City of Newark*, 170 F.3d 359 (3d Cir. 1999), the Third Circuit considered a free-exercise challenge to a police department's grooming policy. The policy exempted beards grown for medical reasons, but not for religious reasons. Writing for the Third Circuit, then-Judge Alito held that the policy was not generally applicable, because the exemption for medical reasons involved "a value judgment that secular (*i.e.*, medical) motivations for wearing a beard are important enough to overcome [the government's] general interest in uniformity but that religious motivations are not." *Id.* at 366. And "when the government makes a value judgment in favor of secular motivations, but not religious motivations, the government's actions must survive heightened scrutiny." *Id.*; *see also Blackhawk v. Pennsylvania*, 381 F.3d 202, 211 (3d Cir. 2004) (Alito, J.) (wildlife permitting fee was not generally

applicable where it exempted zoos and circuses, but not Native Americans).

Similarly, in *Ward v. Polite*, 667 F.3d 727 (6th Cir. 2012), the Sixth Circuit considered a free-exercise challenge to a policy that limited the ability of counseling students to refer clients to other counselors. The policy "permit[ted] referrals for secular—indeed mundane—reasons," such as when a client could not pay, or wanted end-of-life counseling. *Id.* at 739. But it did not permit referrals for religious reasons. The Sixth Circuit held that this "exemption-ridden policy" was "the antithesis of a neutral and generally applicable policy and just the kind of state action that must run the gauntlet of strict scrutiny." *Id.* at 740.

In *Midrash Sephardi, Inc. v. Town of Surfside*, 366 F.3d 1214, 1234-35 (11th Cir. 2004), the Eleventh Circuit considered a zoning ordinance that limited the types of permissible uses in a business district in order to create "retail synergy." The zoning code included an exemption for nonprofit clubs and lodges, but not for houses of worship. The Eleventh Circuit held that exempting clubs and lodges, but not houses of worship, "violates the principles of neutrality and general applicability because private clubs and lodges endanger [the town's] interest in retail synergy as much or more than churches and synagogues." *Id.* at 1235.

Finally, in *Mitchell County v. Zimmerman*, 810 N.W.2d 1 (Iowa 2012), the Iowa Supreme Court considered an ordinance that protected the surface of county roads by banning vehicles with tires that had

steel protrusions. The ordinance had an exemption for school buses, tire chains, and certain pneumatic tires with ice grips or tire studs during certain months of the year. *Id.* at 5. But it did not grant an exemption to local Mennonites, who were required by their faith to use only steel wheels. *Id.* at 15-16. The Iowa Supreme Court held that the ordinance was not generally applicable, because the ordinance applied to the Mennonites but not to "various *other* sources of road damage." *Id.*

2. Under the rule adopted in these courts, this case would be straightforward. As the district court found, the Regulations "exempt pharmacies and pharmacists from stocking and delivering lawfully prescribed drugs for an almost unlimited variety of secular reasons." App.81a. For example, a pharmacy can decline to stock Clozapine (a schizophrenia drug for patients who are suicidal) because it finds it inconvenient to monitor the patient's blood work. App.164a. A pharmacy can decline to stock Lovenox (a blood thinner for patients at risk of heart attack) because it may have to order more of the drug than the patient has requested. App.172-73a. And a pharmacy can decline to stock Plan B because it has chosen a geriatric or pediatric niche. App.162a, 361a.

Even when a drug is ordinarily in stock, a pharmacy can decline to deliver it if the prescription calls for simple compounding or unit dosing, simply because the prescription would require a little more time. App.167a. A pharmacy can decline to deliver Plan B if the patient offers to pay with Medicaid. *Id.* And a pharmacy can decline to deliver Plan B if it simply ran out due to careless inventory

management. App.166a. In all of these scenarios—and many more—pharmacies routinely refer patients elsewhere. The district court provided a chart summarizing twenty-seven different types of secular referrals that are commonplace. App.200-08a. And the Ninth Circuit held that the district court's findings on this point were "not clearly erroneous." App.32a.

The district court also found, after reviewing "voluminous testimony and documentary evidence," that these secular referrals "endanger the government's interests [in ensuring timely access to medication] in a similar or greater degree than Plaintiffs religiously motivated referrals." App.200a. For example, if a pharmacy declines to stock Plan B because it chooses to focus on a pediatric niche, or if it runs out of Plan B due to careless inventory management, or if it declines to sell Plan B to a woman who offers to pay with Medicaid, it can refer the patient elsewhere, even if there are no nearby pharmacies that stock it. App.211-12a, 214a. (Indeed, if the pharmacy declines to accept Medicaid, it need not even make a referral. *Id.*) But if the same pharmacy declines to stock Plan B for religious reasons, and offers a facilitated referral to one of thirty nearby pharmacies that stock it, that is illegal. *Id.* The Commission's own witnesses acknowledged that the former refusals for business and convenience reasons are "a much more serious access issue" than the referral for reasons of conscience. App.357a, 211-12a. As the district court found, "this is a straightforward concession that the Regulations permit nonreligious referrals 'that endanger[] [the government's] interests in a similar

or greater degree' [than] Plaintiffs religiously motivated referrals." App.212a (quoting *Lukumi*, 508 U.S. at 543).

These admissions make this a far easier case than *Fraternal Order, Ward, Midrash,* or *Mitchell County*. In those cases, the laws exempted only a narrow slice of secular conduct—medical beards in *Fraternal Order*, end-of-life counseling and inability to pay in *Ward*, private clubs in *Midrash*, and school buses, tire chains, and snow tires in *Mitchell County*. All other secular conduct that might undermine the government's interests was prohibited. But here, the Regulations exempt an "almost unlimited variety" of secular conduct (App.81a, 86a)—in fact, they have never been applied against any secular conduct at all. The government's own witnesses admitted that this secular conduct poses "a much more serious access issue" than Petitioners' religious conduct would. App.211-12a, 357a. And the Commission has *stipulated* that Petitioners' conscience-based referrals "do not pose a threat to timely access to lawfully prescribed medications," "including Plan B." App.249a.

3. Although the district court relied heavily on these cases from other jurisdictions, and the parties briefed them extensively, the Ninth Circuit did not even mention them, much less attempt to distinguish them.

The Ninth Circuit offered two reasons for ignoring secular exemptions; neither can be squared with the decisions of other circuits or with *Lukumi*. First, the panel held that the exemptions for secular

referrals protect "'necessary reasons for failing to fill a prescription' in that they allow pharmacies to operate in the normal course of business." App.30a (quoting *Stormans I* at 314a). In other words, referrals for business reasons are "necessary," but referrals for religious reasons are not. This is precisely the sort of "value judgment in favor of secular motivations" that other circuits and this Court have condemned. *Fraternal Order of Police*, 170 F.3d at 366. Indeed, governments in other cases routinely argue that secular exemptions are "necessary" and religious exemptions are not. In *Fraternal Order*, for example, the government claimed that the exemption for medical beards was necessary to comply with the Americans with Disabilities Act, but a religious exemption was not. *Id.* at 365-66. In *Mitchell County*, the government claimed that the exemption for school buses was necessary "for safety reasons," but a religious exemption was not. 810 N.W.2d at 16. And in *Lukumi*, the government claimed that exemptions for hunting and pest control were "self-evident[ly]" "justified," but a religious exemption was not. 508 U.S. at 544. In each case, this value judgment triggered strict scrutiny.

Second, the Ninth Circuit held that even though secular referrals are commonplace, and even though no secular referral has ever been punished, the Commission might still prohibit those practices in the future "if complaints were filed about th[em]." App.32a. But *Lukumi* requires courts to consider "the effect of a law in its *real operation*"—not how it might operate in theory. 508 U.S. at 535 (emphasis added). Accordingly, the Court in *Lukumi* considered

the entire range of animal killing that actually occurred—not just what was "approved by express provision" in the ordinances, but also what was "not prohibited" in practice. *Id.* at 543. Similarly, in *Ward*, the Sixth Circuit rejected the government's claim that secular referrals were forbidden in theory, because "there [we]re at least two settings where" referral had been allowed in practice. 667 F.3d at 736; *see also Axson-Flynn v. Johnson*, 356 F.3d 1277, 1298-99 (10th Cir. 2004) (considering whether a theoretically neutral rule permitted exemptions in practice).

4. The Ninth Circuit's decision also conflicts with the Third, Sixth, and Tenth Circuits on the closely related doctrine of "individualized exemptions." As this Court has explained, when a law gives the government discretion to grant case-by-case exemptions based on "the reasons for the relevant conduct," strict scrutiny is required. *Lukumi*, 508 U.S. at 537 (quoting *Employment Div., Dept. of Human Resources of Ore. v. Smith*, 494 U.S. 872, 884 (1990)); *see also Sherbert v. Verner*, 374 U.S. 398 (1963). In *Blackhawk*, writing for the Third Circuit, then-Judge Alito struck down a law that permitted exemptions from a wildlife permitting fee when an exemption would be "consistent with sound game or wildlife management." 381 F.3d. at 210. In *Ward*, the Sixth Circuit struck down a rule that permitted "ad hoc" exemptions from a no-referral policy. 667 F.3d at 739-40. And in *Axson-Flynn*, the Tenth Circuit ruled against a university policy that allowed "ad hoc" exemptions from the university's curricular requirements. 356 F.3d at 1298-99. In each of these cases, the problem was that the law was "sufficiently

open-ended" that it allowed the government to grant exemptions based on an "individualized governmental assessment of the reasons for the relevant conduct." *Blackhawk*, 381 F.3d at 209 (quoting *Smith*, 494 U.S. at 884) (citing *Lukumi,* 508 U.S. at 537; *Fraternal Order,* 170 F.3d at 364-65).

The Regulations in this case are even more problematic, because they include three open-ended provisions stacked on top of each other. First, the Stocking Rule requires pharmacies to maintain a "representative assortment" of drugs. As the district court found, this provision is "extraordinarily vague and open-ended." App.221a. The Commission has never offered any guidance on the meaning of "representative assortment"; it has never deemed any pharmacy except Ralph's to be in violation of it; and its own witnesses admitted that the provision "must be interpreted on a case-by-case basis depending on the reasons for the relevant conduct." *Id*. Thus, the Commission has "broad discretion" to determine, for example, that a niche pharmacy's decision not to stock Plan B is permissible, but a religiously motivated pharmacy's decision is not. App.88a, 221-22a.

On top of that, pharmacies are exempt from delivering a drug any time they are out of stock despite "good faith" compliance with the vague "representative assortment" requirement. As the district court found, "[n]o [Commission] witness was able to give a definition of 'good faith.'" App.221a. The Commission's witnesses "consistently testified"—using the precise language of *Lukumi*, no less—that "good faith" compliance "must be assessed

on a case-by-case basis depending on the reasons for the relevant conduct." *Id.*; cf. *Lukumi*, 508 U.S. at 537 (prohibiting an "individualized governmental assessment of the reasons for the relevant conduct" (quoting *Smith,* 494 U.S. at 884)). Thus, the Commission can decide that a pharmacy that failed to order enough Plan B (as Walgreens, Sav-On, and Albertsons did) is in "good faith" compliance with the Stocking Rule, but a religiously motivated pharmacy like Ralph's is not.

Finally, the Delivery Rule includes an exemption not only for "good faith" compliance with the Stocking Rule, but also for any conduct that is "substantially similar" to other exempted conduct. Several Commission witnesses testified that this language was added precisely to give the Commission "wiggle room" to grant additional exemptions. App.134-36a, 212-213a, 221a, 354a. And as the district court found, the only way to apply this provision is to "examine the underlying reasons for the pharmacy's conduct on a case-by-case basis" to determine whether it is "substantially similar" to other exempted conduct. App.220a. Thus, the Commission has "unfettered discretion" to decide that a pharmacy's decision not to stock Plan B for business reasons is "substantially similar" to other exempted conduct, but a religious decision is not. App.88a.

Given these three open-ended provisions, the district court rightly held that the Regulations are "significantly more problematic" than the Regulations struck down in *Blackhawk* and *Axson-Flynn*. App.222a. But the Ninth Circuit ignored

these cases. It simply averred that the Regulations do not create a system of individualized exemptions because "the provisions are tied to particularized, objective criteria." App.34a. As the district court found, not only are there no "objective criteria" constraining the Commission's discretion, but "the stocking rule appears to be nothing but individualized exemptions, and the delivery rule mandates individualized exemptions on its face." App.223a, 87-88a.

The Ninth Circuit's ruling also misses the point: The legal question in the other circuits is not simply whether the law includes objective criteria, but whether those criteria allow the government to make "case-by-case inquiries" into "the reasons for the relevant conduct." *Axson-Flynn*, 356 F.3d at 1297; *Blackhawk*, 381 F.3d. at 207. That the State makes such case-by-case inquiries is undisputed here. Thus, the Ninth Circuit's decision squarely conflicts with the rulings of the Third, Sixth, and Tenth Circuits.

B. The Ninth Circuit's decision conflicts with the Third Circuit on the relevance of evidence of selective enforcement against religious conduct.

The Ninth Circuit's decision also conflicts with the Third Circuit on the question of whether even a facially neutral and generally applicable rule is subject to strict scrutiny due to selective enforcement. In *Tenafly Eruv Association, Inc. v. Borough of Tenafly*, 309 F.3d 144 (3d Cir. 2002), the court considered a city ordinance that banned the placement of any materials on public utility poles. It

was undisputed that this ordinance was neutral and generally applicable on its face. But in practice, the city had not enforced the ordinance absent a complaint. The city had done nothing to prohibit common directional signs, lost animal signs, or holiday decorations. But reacting to "vehement objections" from local residents, the city prohibited *lechis* placed by Orthodox Jews. The Third Circuit held that the government's "invocation of the often-dormant Ordinance" against religious items triggered strict scrutiny. *Id.* at 168.

Likewise, in this case, it is undisputed that the Commission has done nothing to enforce the Regulations against widespread referrals for secular reasons. No secular referral has ever been found in violation of the Regulations, even though the district court found that such referrals are well-known. App.225a, 231a. But when abortion-rights activists filed complaints against Ralph's, the Commission stated that they were in "outright defiance" of the Regulations. Indeed, even when abortion-rights activists filed complaints against pharmacies that failed to stock Plan B for *secular* reasons, the Commission deemed those pharmacies to be in compliance with the Regulations and rejected the complaints. App.184a. Based on this evidence, the district court held that Petitioners had "establish[ed] selective enforcement under *Tenafly*." App.231a.

Without ever mentioning *Tenafly*, the Ninth Circuit held that there was no selective enforcement because "[t]he Commission enforces the [Regulations] through a complaint-driven process," and the Commission has not received any complaints

about "similarly situated, secularly motivated [conduct]." App.37-38a. This holding not only ignores the district court's factual findings that this testimony was "implausible and not credible," App.176a, it also squarely conflicts with *Tenafly*, where the city also enforced its ordinance in response to "vehement objections," and there was no evidence that the city had received any complaints about similarly situated, secularly motivated conduct. 309 F.3d at 151-53. Indeed, this case is far stronger than *Tenafly*, because there is direct evidence of discriminatory intent: The Commission's Chairman vowed that he was "never going to vote to allow religion as a valid reason for facilitated referral," and said that conscientious objectors are engaged in "immoral" "sex discrimination" and should be prosecuted "to the full extent of the law," among other hostile statements. App.145a, 186-87a, App. 367a.

In any event, as the district court found, the Commission's reliance on citizen complaints "only made the selective enforcement problem worse." App.228a. It found that before adopting the Regulations, the Commission was well aware that "pro-choice groups have conducted an active campaign to [file complaints against] pharmacies and pharmacists with religious objections to Plan B," but that "[i]n the vast majority of cases, a referral for business reasons is never going to generate a complaint." App.179a. Thus, the natural result of relying on citizen complaints was "a severely disproportionate number of investigations directed at religious objections to Plan B." App.228a. From 2006-2008, Ralph's was 700 times more likely to be

investigated than any other pharmacy. App.179-80a n.174.

C. The Ninth Circuit's decision conflicts with the Seventh and Eighth Circuits on the use of a law's historical background to show a lack of neutrality.

The Ninth Circuit's decision also conflicts with the Seventh and Eighth Circuits on the question of whether courts can assess the neutrality of a law by examining its "historical background." *Lukumi*, 508 U.S. at 540. Of course, evidence of hostility in the historical background of a law is not *necessary* to establish a violation of the First Amendment. In *Lukumi* itself, nine Justices found a free exercise violation, while only Justices Kennedy and Stevens proceeded to analyze the law's historical background. *Id.* But "[p]roof of hostility or discriminatory motivation may be *sufficient* to prove that a challenged governmental action is not neutral." *Shrum v. City of Coweta*, 449 F.3d 1132, 1145 (10th Cir. 2006) (emphasis added). And considering such evidence is consistent with this Court's approach under the Establishment and Equal Protection Clauses. *See, e.g.*, *Edwards v. Aguillard*, 482 U.S. 578, 594-95 (1987); *Reno v. Bossier Parish Sch. Bd.*, 520 U.S. 471, 489 (1997).

Following Justice Kennedy's analysis in *Lukumi*, the Seventh and Eighth Circuits have expressly held that courts must consider a law's historical background in deciding whether it is neutral. *See St. John's United Church of Christ v. City of Chicago*, 502 F.3d 616, 633 (7th Cir. 2007) ("[W]e must look at

. . . the 'historical background of the decision under challenge'") (quoting *Lukumi*, 508 U.S. at 540); *CHILD, Inc. v. Min De Parle*, 212 F.3d 1084, 1090 (8th Cir. 2000) (lack of neutrality "can be evidenced by objective factors such as the law's legislative history") (citing *Lukumi,* 508 U.S. at 535, 540). Two more circuits—the First and Sixth—have also considered evidence of historical background without expressly treating Justice Kennedy's analysis of historical background as controlling. *See Wirzburger v. Galvin*, 412 F.3d 271, 281-82 (1st Cir. 2005) (considering "evidence of animus against Catholics in Massachusetts in 1855 when the [law] was passed"); *Prater v. City of Burnside*, 289 F.3d 417, 429-30 (6th Cir. 2002) (relying on historical allegations and legislative history).

By contrast, the Ninth Circuit simply pretended that the extensive record of the Regulations' historical background did not exist. It also rejected the district court's factual finding of discriminatory intent, even though it was supposed to accord that finding "great deference on appeal." *Miller-El v. Cockrell*, 537 U.S. 322, 340 (2003) (quoting *Hernandez v. New York*, 500 U.S. 352, 364 (1991)). As the district court found, the record includes "abundant" and "voluminous" evidence of discriminatory intent—including "reams of emails, memoranda, and letters between the Governor's representatives, Pharmacy [Commission] members, and advocacy groups" demonstrating that the Regulations were "aimed at Plan B and conscientious objectors from their inception." App.57a, 140a, 242a. The Governor asked her advisors to ensure that the Regulations were "clean

enough for the advocates re: conscious/moral issues." App.58a, 130a, 244a. To make sure they passed, she replaced Commission members with those recommended by Planned Parenthood. App.137-38a. The Executive Director admitted that the Commission was trying to "draft language to allow facilitating a referral for only . . . non-moral or non-religious reasons." App.59a, 131a. The Commission's own publications described "the issue" addressed by the Regulations as "emergency contraception" and "reasons of conscience." App. 139a, 369-72a. The Commission's Chairman vowed "never" to vote "to allow religion as a valid reason for a facilitated referral." App.145a, 407a. And the Commission's own witnesses admitted that "the object of the rule was ending refusals for conscientious objection." App.359a, 140a. As the district court explained: "Literally all of the evidence," except *post hoc* testimony by State witnesses, "demonstrates that the 2007 rulemaking was undertaken primarily (if not solely) to ensure that religious objectors would be required to stock and dispense Plan B." App.91a.

That is not religiously neutral under the Seventh and Eighth Circuits' approach. It is as if, in *Lukumi*, the mayor asked his advisors to make sure the ordinance was "clean enough" on "Santeria sacrifice issues"; the city attorney admitted that he was trying to "draft language to allow animal killing for only non-religious reasons"; the council chairman vowed "never to vote to allow Santeria sacrifice as a valid reason for animal killing"; and city officials admitted that "the object of the rule was ending Santeria sacrifice." The Ninth Circuit's holding that "[n]othing in the record" shows discriminatory intent

is absurd (App.28a) and plainly conflicts with rulings by other circuits.

III. This case is a clean vehicle to resolve critical questions of free exercise law and to preserve the national consensus on an issue of exceptional importance.

This case is an ideal vehicle to address these critical questions of free exercise law. The record is fully developed after a twelve-day bench trial. The parties have stipulated that facilitated referrals "do not pose a threat to timely access to lawfully prescribed medications," "includ[ing] Plan B." App.142a. And there is no evidence that any of Petitioners' customers has ever been denied timely access to any drug. App.147. This fatally undermines the State's ability to "identify an actual problem in need of solving." *Brown v. Entm't Merchs. Ass'n*, 131 S. Ct. 2729, 2738 (2011) (quotation omitted).

If the Ninth Circuit's decision stands, it will be the first time that health care professionals have been forced to participate in what they consider to be an abortion. This would dramatically shift the balance struck in *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850-51 (1992), contradict forty years of statutory conscience protections in the area of abortion and family planning, and rob Petitioners of their dignity by denying them the ability "to establish [their] religious (or nonreligious) self-definition in the political, civil, and economic life of our larger community." *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2785 (2014) (Kennedy, J., concurring).

The Ninth Circuit's decision also threatens all religious minorities. If these Regulations are neutral and generally applicable—when they are riddled with exemptions for secular conduct, when they have never been applied to anything but religious conduct, when the government has stipulated that the religious conduct is harmless, and when there is overwhelming evidence of discriminatory intent—then any law can be upheld as neutral and generally applicable. That cannot be the meaning of the Free Exercise Clause. The Ninth Circuit's decision is truly radical, grossly out of step with the jurisprudence of this Court and other circuits, and demands this Court's review.

CONCLUSION

The petition should be granted.

Respectfully submitted.

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