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# SECOND-TRIMESTER ABORTION DANGERTALK

GREER DONLEY\* & JILL WIEBER LENS\*\*

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**Abstract:** Abortion rights are more vulnerable now than they have been in decades. This Article focuses specifically on the most assailable subset of those rights: the right to a pre-viability, second-trimester abortion. Building on *Carhart v. Gonzales*, where the Supreme Court upheld a federal ban on a safe and effective second-trimester abortion procedure, states have passed new second-trimester abortion restrictions that rely heavily on the woman-protective rationale—the idea that the restrictions will benefit women. These newer second-trimester abortion restrictions include bans on the Dilation & Evacuation (D&E) procedure, bans on disability-selective abortions, and mandatory perinatal hospice and palliative care counseling in cases of life-limiting fetal conditions. This Article discusses the paternalism and traditional gender stereotypes underlying these newer abortion restrictions and uses empirical studies to discredit the woman-protective rationale justifying them. The Article also suggests a radical, new response to claims that women need protection from second-trimester abortion: the embrace of second-trimester abortion “dangertalk.” First introduced in medical literature by abortion providers, dangertalk refers to the uncomfortable truths about abortion that supporters often avoid. These topics include the nature of second-trimester abortion procedures and the emotional complexity that can especially accompany second-trimester abortion. This Article advocates for greater openness about these topics, arguing that silence only capitulates the narrative of second-trimester abortion to those opposing abortion rights. The Article envisions second-trimester abortion care that better recognizes these realities and provides women with more choices that might make second-trimester abortion easier, including alternative procedures and the option of memory-making to process difficult emotions, like grief. Finally, this Article argues that more transparency about these difficult subjects will help rebut the woman-protective rationale used to justify second-trimester abortion restrictions.

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\*\* Robert A. Leflar Professor of Law, University of Arkansas School of Law, Fayetteville. I dedicate this Article to my sweet boy in heaven, Caleb Marcus Lens.

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## INTRODUCTION

The death of Justice Ruth Bader Ginsburg and the confirmation of Justice Amy Coney Barrett renew and inflame existing fears about the future of abortion rights in the United States. Many are reasonably worried about the fate of *Roe v. Wade*,<sup>1</sup> as interpreted by *Planned Parenthood of Southeastern Pennsylvania v. Casey*,<sup>2</sup> given that the newly composed Supreme Court recently announced that it will hear a case that challenges its central holding.<sup>3</sup> The case, *Jackson Women's Health Organization v. Dobbs*, involves a ban on abortion after fifteen weeks, before the fetus is viable.<sup>4</sup> The Court granted certiorari on the very broad question of whether all pre-viability abortion bans are unconstitutional. That *Roe* and *Casey* prohibited pre-viability bans is the very reason that numerous lower federal courts have found other second-trimester abortion restrictions unconstitutional. For instance, lower courts have held unconstitutional state bans on a second-trimester abortion procedure known as Dilation and Evacuation (D&E)<sup>5</sup> and state bans on abortion due to fetal anomaly.<sup>6</sup> If the Court in *Dobbs* concludes that some pre-viability abortion bans are constitutionally permissible—as many suspect it will—the constitutionality of these other second-trimester restrictions is immediately in question.<sup>7</sup>

Numerous state laws specifically target second-trimester abortion even though it is rare in the United States—less than seven percent of abortions occur after thirteen weeks of pregnancy.<sup>8</sup> Women<sup>9</sup> need second-trimester

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<sup>1</sup> 410 U.S. 113, 164–66 (1973), *holding modified by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 845–46 (1992).

<sup>2</sup> 505 U.S. 833, 845–46 (1992).

<sup>3</sup> *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019), *cert. granted in part*, 2021 BL 181590 (U.S. May 17, 2021) (No. 19-1392).

<sup>4</sup> *Id.*

<sup>5</sup> *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 2020 WL 6551717 (6th Cir. 2020), *cert. granted in part*, 141 S. Ct. 1734 (2021); *but see* *Whole Woman's Health v. Paxton*, 2021 WL 3661318 (5th Cir. 2021) (finding Texas's ban on the D&E procedure constitutional). *See generally* Mary Ziegler, *What's Next for Abortion Law?*, BOS. REV. (Sept. 1, 2020), <http://bostonreview.net/politics-law-justice/mary-ziegler-whats-next-abortion-law> [<https://perma.cc/YE6U-LQXM>] (discussing the future of abortion laws in the United States).

<sup>6</sup> *See* *Preterm-Cleveland v. Himes*, 940 F.3d 318 (6th Cir. 2019), *vacated pending rehearing en banc*, 944 F.3d 630 (6th Cir. 2019).

<sup>7</sup> *Id.*

<sup>8</sup> CDCs Abortion Surveillance System FAQs, CDC (last updated Nov. 25, 2020), [https://www.cdc.gov/reproductivehealth/data\\_stats/abortion.htm](https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm) (citing data from 2018); *see also infra* Part I (discussing occurrence of first- and second-trimester abortions).

<sup>9</sup> Trans men also need reproductive healthcare, including abortion. Many reproductive justice scholars are moving to adopt gender neutral language when discussing reproductive health in recognition of this fact, which we support. In this particular paper, however, we have opted to continue using gendered language because so much of our argument relies on gender stereotypes that are hard to capture and discuss without a reference to gender.

abortions for a variety of reasons: a later discovery of pregnancy, changed circumstances after an initial decision to keep the pregnancy, the need to save money for the procedure, or a fetal or maternal health condition discovered during pregnancy.<sup>10</sup> Adolescents, women with less education, and Black women are more likely to need second-trimester abortions.<sup>11</sup> Despite its rarity, second-trimester abortion consumes enormous attention in the abortion debates, and public support for abortion in the second trimester drops dramatically.<sup>12</sup>

Perhaps the largest anti-abortion victory in the last twenty years is the Supreme Court's decision in *Gonzales v. Carhart*,<sup>13</sup> which affirmed a federal ban on a safe second-trimester abortion procedure known as Dilation & Extraction (D&X).<sup>14</sup> Underpinning the Court's decision was the idea that the D&X was so "gruesome" that women would suffer emotional distress and regret if they later learned the specifics of the procedure.<sup>15</sup> Importantly, this victory was not simply limited to the legal realm—the campaign also successfully reduced public support for abortion generally by inundating Americans with pictures of fetal parts and intentionally evocative descriptions of second-trimester abortion procedures.<sup>16</sup>

*Carhart* entrenched into law the idea that women need protection from abortion procedures. The woman-protective rationale remains the argument of the most sophisticated anti-abortion advocates.<sup>17</sup> It attempts to nullify *Casey*'s fundamental assumption that abortion benefits women, freeing the Court to overturn abortion precedent. The rationale is also important because of its legitimizing role—reframing abortion restrictions as protective, not

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<sup>10</sup> See *infra* Part I (discussing the reasons women obtain second-trimester abortions).

<sup>11</sup> *Id.*

<sup>12</sup> Lydia Saad, *Trimesters Still Key to U.S. Abortion Views*, GALLUP (June 13, 2018), <https://news.gallup.com/poll/235469/trimesters-key-abortion-views.aspx> [https://perma.cc/NAZ9-WACF]; David Crary & Hannah Fingerhut, AP-NORC poll: Most say restrict abortion after 1st trimester, AP News (June 25, 2021), <https://apnews.com/article/only-on-ap-us-supreme-court-abortion-religion-health-2c569aa7934233af8e00bef4520a8fa8>.

<sup>13</sup> 550 U.S. 124, 168 (2007).

<sup>14</sup> See *infra* notes 83–86 and accompanying text (providing overview of D&X procedure).

<sup>15</sup> *Carhart*, 550 U.S. at 159–60.

<sup>16</sup> See *infra* notes 87–91 and accompanying text (discussing political success among the anti-abortion activists on restricting access to D&X abortions).

<sup>17</sup> MARY ZIEGLER, ABORTION AND THE L. IN AM.: *ROE V. WADE* TO THE PRESENT 143–45 (2020).

harmful, to women.<sup>18</sup> The architects of the anti-abortion movement have always believed that they could “chang[e] hearts and minds” if they could convince the public that abortion harms women.<sup>19</sup>

This Article describes how anti-abortion activists are once again using the woman-protective rationale to justify recent second-trimester abortion restrictions—bans on the D&E procedure, bans on abortions based on fetal anomaly, and requirements to inform women of perinatal hospice and palliative care programs after the diagnosis of fetal anomaly.<sup>20</sup> Building on legal scholarship critical of the woman-protective rationale, this Article exposes the paternalism and gender stereotyping behind these more recent second-trimester abortion restrictions.<sup>21</sup> We also use studies of women’s abortion experiences to debunk claims regarding abortion restrictions as a means to best protect women’s psychological health.<sup>22</sup>

Despite the inaccuracies and sexist stereotyping inherent in the woman-protective rationale, it remains intuitive to many—especially in the context of second-trimester abortion, when the uncomfortable realities of second-trimester abortion seem to increase the alleged need to protect the woman. In *Carhart*, Justice Kennedy admitted he had no evidence to support his conclusions about women’s regret, yet he still concluded that women needed protection from a safe medical procedure.<sup>23</sup> This intuitive presumption is compounded by abortion precedent that gives state legislatures wide discretion to consider “medical uncertainty” and reach a conclusion at odds with the medical establishment.<sup>24</sup> As a result, evidence-based arguments refuting the woman-protective rationale may not be effective in court.

We thus propose a new strategy for supporting second-trimester abortion rights—a radical reconceptualization of abortion dialogue in the United States. Our proposal builds on the pioneering work of abortion providers who

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<sup>18</sup> See *infra* notes 187–270 and accompanying text (discussing the woman-protection rationale and its role in upholding laws that restrict abortion access).

<sup>19</sup> ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 145.

<sup>20</sup> See *infra* notes 187–270 and accompanying text (discussing the woman-protection rationale and bans on certain abortion procedures).

<sup>21</sup> See *infra* notes 187–270 and accompanying text (explaining the reasoning behind allowing abortion restrictions and the paternalism and gender-stereotyping inherent in the woman-protective rationale).

<sup>22</sup> See *infra* notes 271–396 and accompanying text (discussing relevant empirical studies that debunk the woman-protective rationale).

<sup>23</sup> *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007); See also Terry A. Maroney, *Emotional Common Sense as Constitutional Law*, 62 VAND. L. REV. 851, 901 (2009).

<sup>24</sup> *Id.* at 163; see also *infra* notes 187–270 and accompanying text (discussing states that have passed abortion restriction laws with the reasoning that women need protection).

introduced the concept of “dangertalk” to describe open dialogue about uncomfortable abortion truths.<sup>25</sup> Our Article introduces the concept of abortion dangertalk to legal scholarship and expands its reach. In particular, we focus on two dangertalk subjects related to second-trimester abortion. First, we discuss the unique nature of the second-trimester abortion procedure, which is “visually and viscerally different” than first-trimester abortion because it involves “removing what looks like a fully formed small baby” instead of a “microscopic fetus and gestational sac.”<sup>26</sup> Second, we note that women can experience a broad range of emotional responses to abortion, especially later abortions, including negative emotions, like grief. The abortion rights movement often avoids public discussion of these dangertalk subjects because of the fear that it could hurt the movement in litigation and the public narrative.<sup>27</sup>

We argue that avoiding these truths does not protect abortion rights. To the contrary, the silence capitulates the narrative to the anti-abortion community, which has exploited it to its own advantage. We suggest that the uncomfortable truths about second-trimester abortion, including the specifics of second-trimester abortion procedures and the complexity of women’s emotions concerning abortion, should be met head on by the broader abortion rights movement and discussed openly. Though many abortion providers deal with these topics in their daily practice, they remain hidden from the canonical pro-choice discourse. Embracing abortion dangertalk should disarm the anti-abortion, woman-protective narrative surrounding second-trimester abortion regulations—a narrative suggesting that women would not have chosen an abortion had they been better informed. We also argue that it will improve patient care. Greater openness on these topics would allow providers to more systemically offer patients options that could increase their autonomy and improve the abortion experience. Although these frank discussions come with risks, we think the benefits outweigh them.

The Article proceeds as follows. In Part I, we explore why women need second-trimester abortion, contradicting common assumptions made about women who need this care.<sup>28</sup> In Part II, we describe recent popular second-

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<sup>25</sup> See generally Lisa A. Martin et al., *Dangertalk: Voices of Abortion Providers*, 184 SOC. SCI. & MED. 75 (2017) (providing an overview of the concept of dangertalk in the healthcare field).

<sup>26</sup> Lisa H. Harris, *Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse*, 16 REPRO. HEALTH MATTERS 74, 76 (2001).

<sup>27</sup> See Martin et al., *supra* note 25, at 80 (discussing healthcare providers’ and activists’ apprehension toward dangertalk because of the potential for anti-abortion advocates to negatively scrutinize it).

<sup>28</sup> See *infra* notes 32–68 and accompanying text.

trimester abortion laws: bans the D&X and D&E procedures, bans that outlaw abortion based on certain (or all) fetal anomalies, and laws that mandate perinatal hospice and palliative care counseling.<sup>29</sup> In Part III, we undercut the state's claims that these laws benefit women and expose the paternalism and gender stereotyping behind these restrictions.<sup>30</sup> In Part IV, we argue that embracing dangertalk will both rebut the woman-protective rationale and improve abortion care.<sup>31</sup>

## I. THE NEED FOR SECOND-TRIMESTER ABORTION

A typical pregnancy lasts forty weeks and is divided into three trimesters.<sup>32</sup> Though one might assume the first week of pregnancy starts at conception, doctors typically date pregnancies to start on the first day of a woman's last menstrual period. That means women are considered two weeks pregnant at conception, and are at least four weeks pregnant when a pregnancy test can first detect the pregnancy. The first trimester lasts the first thirteen weeks of pregnancy. The second trimester extends from fourteen weeks to twenty-seven weeks of pregnancy. The third trimester extends from twenty-eight weeks until birth, which usually occurs around forty weeks.<sup>33</sup>

Although the vast majority of abortions in the country occur during the first trimester, not all do. Using the most recent data from 2018, 92.2% of abortions were performed in the first trimester, 6.9% were performed at fourteen to twenty weeks' gestation (the first half of the second trimester), and 1.0% were performed at twenty-one weeks or later (the second half of the second trimester or later).<sup>34</sup> Even though these second-trimester abortions are rare, they are villainized. In 2021, only 34% of Americans said that abortion should be legal in most or all circumstances in the second trimester, compared

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<sup>29</sup> See *infra* notes 69–186 and accompanying text.

<sup>30</sup> See *infra* notes 187–270 and accompanying text.

<sup>31</sup> See *infra* notes 271–396 and accompanying text.

<sup>32</sup> *How Your Fetus Grows During Pregnancy: Frequently Asked Questions*, AM. COLL. OBSTETRICS & GYNECOLOGISTS, <https://www.acog.org/womens-health/faqs/how-your-fetus-grows-during-pregnancy> [<https://perma.cc/6KQF-ZQVD>].

<sup>33</sup> *Id.*

<sup>34</sup> Katherine Kortsmitt et al., *Abortion Surveillance—United States, 2018*, MORBIDITY & MORTALITY WKLY. REP. SURVEILLANCE SUMMARY 6 (Nov. 27, 2020), <https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm> [<https://perma.cc/N8VS-3KNS>]; see also Rachel K. Jones & Lawrence B. Finer, *Who Has Second-Trimester Abortions in the United States?*, 85 *CONTRACEPTION* 544, 544 (2012) (noting that only 9–10% of abortions occur in the second trimester); *Later Abortion*, GUTTMACHER INST. (Nov. 2019), <https://www.guttmacher.org/evidence-you-can-use/later-abortion> [<https://perma.cc/2WMW-DQE9>] (discussing that roughly only 1% of abortions occur at or after twenty-one weeks).

to almost twice as many (61%) who said it should be legal in most or all circumstances in the first trimester.<sup>35</sup>

A variety of reasons exist why women need abortions after the first trimester.<sup>36</sup> As one might expect, women who obtain second-trimester abortions may discover their pregnancies later than women who have first-trimester abortions.<sup>37</sup> Historically, confirmation of pregnancy did not occur until “quickening”—a woman’s first feeling of fetal movement—which does not occur until at least the second trimester.<sup>38</sup> Today, however, there is a common societal view that women are “in tune” with their bodies and have control over their fertility, suggesting that women know—or at least should know—they are pregnant, even early on.<sup>39</sup> Moreover, enhanced technology surrounding pregnancy detection, such as home tests and ultrasounds, entrench the notion that women can, and should, detect their pregnancy even earlier. As a result, women who fail to discover a pregnancy until after the first trimester are often perceived as irresponsible.<sup>40</sup>

The normalization of early detection, however, is based on assumptions about early pregnancy that are not always true. It is important to note at the outset that nearly half of pregnancies in the United States—an incredibly high proportion—are unintended.<sup>41</sup> When women are not trying to get pregnant, they are often not tracking their periods, making it harder to recognize if their menstrual cycle is late.<sup>42</sup> Furthermore, many women who become pregnant may have no symptoms, experience bleeding during the pregnancy that they mistake for their period, have irregular periods, or are using birth control

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<sup>35</sup> Crary & Fingerhut, *supra* note X. This number was higher than a poll in 2018, which found that only 28% of Americans thought that abortion should be legal in the second trimester. Saad, *supra* note 12.

<sup>36</sup> See ACOG, *Second Trimester Abortion*, 121 OBSTETRICS & GYNECOLOGY 1394, 1394 (2013) (describing the various circumstances that can lead to second-trimester abortion).

<sup>37</sup> Diana G. Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, 77 CONTRACEPTION 289, 290 (2008); see also Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or after 20 Weeks?*, 45 PERSPS. SEXUAL & REPROD. HEALTH 210, 212–14 (2013) (explaining that women were also more likely to need an abortion after twenty weeks if they discovered their pregnancy late (at twelve weeks, on average)).

<sup>38</sup> Carrie Purcell et al., *Women’s Embodied Experiences of Second Trimester Medical Abortion*, 27(2) FEMINISM & PSYCH. 163, 167–68 (2017).

<sup>39</sup> *Id.* at 167.

<sup>40</sup> See *id.* at 172 (“Participants were acutely sensitive to how a later discovery of pregnancy might appear to others.”).

<sup>41</sup> See *Unintended Pregnancy in the United States*, GUTTMACHER INST. (Jan. 2019), <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states> [<https://perma.cc/P72B-W3D7>] (noting that between 2001 and 2011, almost half of pregnancies in the United States were unplanned).

<sup>42</sup> Cleveland Clinic, *Can you be Pregnant and not know it?*, (Nov. 7, 2019) <https://health.clevelandclinic.org/can-you-be-pregnant-and-not-know-it/> (advising that women track their cycles to be better aware of the possibility of pregnancy).



when the pregnancy occurs, all of which mean the woman has no reason to suspect pregnancy.<sup>43</sup> Obesity, lack of nausea and vomiting, and unawareness of last menstrual period also make it difficult to detect pregnancy and are significantly associated with delays in obtaining an abortion.<sup>44</sup> In addition, women with less education are more likely to discover a pregnancy late, likely due to a dearth of reproductive health education.<sup>45</sup> For example, in a study of European women who had abortions after sixteen weeks of pregnancy, two-thirds of the participants did not learn of their pregnancy until after twelve weeks.<sup>46</sup> “For some, this was because they were using contraception, had recently had a baby, had irregular periods, or were otherwise not expecting to be pregnant.”<sup>47</sup> As a result, a first trimester abortion was almost immediately not an option.

Once the pregnancy is discovered, women who terminate in the second trimester also frequently suffer other delays due to the lack of certainty about whether to terminate, difficulties saving money for the abortion, and long travel distances (more than fifty miles) to an abortion facility.<sup>48</sup> Women who need abortions after twenty weeks are more likely to live more than three hours from an abortion facility.<sup>49</sup> For many, the logistical burdens imposed by long-distance travel, including public transportation, childcare, and time off work, can be daunting.<sup>50</sup> Moreover, the second-trimester abortion procedure often takes two to three days, with many states also having waiting periods that add another day’s worth of travel, childcare, and expenses.<sup>51</sup> And because second-trimester abortions are complicated to perform, fewer providers offer them, making access difficult for many women.<sup>52</sup> Putting this all together, if a woman does not discover her pregnancy until months after it begins, and then needs weeks or more to decide whether she wants to terminate, save the necessary money for the procedure, or plan the logistics associated with long travel, she will inevitably need a second-trimester abortion.

Some second-trimester abortions also occur in intended pregnancies. For instance, women who make the initial choice to continue their pregnancy,

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<sup>43</sup> Purcell et al., *supra* note 38, at 167.

<sup>44</sup> Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, *supra* note 37, at 290, 292.

<sup>45</sup> Jones & Finer, *supra* note 34, at 549.

<sup>46</sup> Purcell et al., *supra* note 38, at 171.

<sup>47</sup> *Id.*

<sup>48</sup> Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, *supra* note 37, at 289–90; *Later Abortion*, *supra* note 34.

<sup>49</sup> Foster & Kimport, *Who Seeks Abortions at or after 20 Weeks?*, *supra* note 37, at 212.

<sup>50</sup> *Id.* at 212–15.

<sup>51</sup> Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 AM. J. PUB. HEALTH 1687, 1687 (2014).

<sup>52</sup> *Id.*

may decide to terminate later when faced with disruptive life events, such as ending a relationship or losing employment.<sup>53</sup> A woman may also learn of a maternal or fetal health condition that forces her to consider abortion in a pregnancy she intended. A study published in 2012 noted that only a small cohort of participants stated their pregnancies were planned, but those women were more likely to seek second-trimester abortions.<sup>54</sup> And more than half of women who had an abortion in an intended pregnancy did so after sixteen weeks.<sup>55</sup>

In the case of fetal anomaly, almost always, the fetal diagnosis will occur in the second or even the third trimester.<sup>56</sup> Though late first-trimester screening tests exist, the screening tests are not diagnostic, and require additional testing in the second trimester for confirmation.<sup>57</sup> Furthermore, many non-genetic conditions cannot be diagnosed until an anatomy scan is conducted, which does not occur until around twenty weeks.<sup>58</sup> Currently, in the United States, most women who receive a life-threatening fetal diagnosis choose to terminate. Roughly 80–90% of parents chose to terminate after learning of a fatal fetal diagnosis, and 60–75% of parents chose to terminate for other life-threatening fetal diagnoses.<sup>59</sup> Fetal anomalies, however, are relatively rare and not all women seek testing. As a result, only about 14% of women who obtained an abortion did so because of fetal health issues.<sup>60</sup>

Women may discover an issue with their own health that forces them to consider termination in the second trimester with an intended pregnancy.<sup>61</sup> For instance, she might be diagnosed with cancer, the treatment for which should not be delayed, but which could be toxic to the fetus.<sup>62</sup> A woman's water could also break early, or the placenta could partially detach prior to

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<sup>53</sup> Jones & Finer, *supra* note 34, at 549; *see also* Purcell et al., *supra* note 38, at 173 (explaining the “common experience” of a partnership ending as motivation for a woman to seek second-trimester abortion).

<sup>54</sup> Jones & Finer, *supra* note 34, at 549.

<sup>55</sup> *Id.* at 547–549.

<sup>56</sup> Greer Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, 105 MINN. L. REV. 175, 218–20 (2020).

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.* at 184–85, 188.

<sup>60</sup> Greer Donley, *Does the Constitution Protect Abortions Based on Fetal Anomaly?: Examining the Potential for Disability-Selective Abortion Bans in the Age of Prenatal Whole Genome Sequencing*, 20 MICH. J. GENDER & L. 291, 296 (2013).

<sup>61</sup> Elizabeth Czukas, *Therapeutic Termination of a Pregnancy*, VERY WELL FAMILY (Nov. 6, 2019), <https://www.verywellfamily.com/reasons-for-therapeutic-termination-2371295> [https://perma.cc/NZP4-HMGC].

<sup>62</sup> Min Hee Shim et al., *Clinical Characteristics And Outcome Of Cancer Diagnosed During Pregnancy*, 59 OBSTETRICS & GYNECOLOGY SCI. 1, 6 (2016).

viability, a time when the baby is unlikely to survive outside of the womb.<sup>63</sup> Either scenario could expose the pregnant woman to infection, hemorrhage, or other risks.<sup>64</sup> A pregnancy could also exacerbate other pre-existing health conditions that threaten a woman's health before the fetus is viable.<sup>65</sup> In these instances, a woman may be in the unexpected position of considering termination.

Age, race, and class are highly associated with a woman seeking a second-trimester abortion. Women were more likely to need a second-trimester abortion if they are adolescents, lack a high school degree, or rely on health insurance to pay for the abortion.<sup>66</sup> A 2012 study also concluded that black women, women with less education, and "those who had experienced three or more disruptive events in the last year" were more likely to have an abortion at thirteen weeks of pregnancy or later.<sup>67</sup> As a result, additional restrictions on second-trimester abortion will disproportionately affect poor women, women of color, and young women.

Despite the myriad reasons that women need second-trimester abortions, anti-abortion activists have targeted these abortions for regulation as part of their broader agenda of ending abortion. In the section below, we describe some of the most common second-trimester abortion laws that have surfaced in the last few decades.<sup>68</sup> We later link them to the larger anti-abortion strategy of defending abortion laws by claiming they are necessary to protect women.

## II. TARGETING SECOND-TRIMESTER ABORTION

Although women need and have second-trimester abortions, public acceptance of abortion drops significantly after the first trimester. More than sixty percent of Americans support abortion in most or all cases in the first trimester, but only thirty-four percent felt the same in the second trimester.<sup>69</sup>

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<sup>63</sup> See Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 217–18 (discussing the time of viability as beginning around twenty-four weeks of pregnancy).

<sup>64</sup> *Id.* at 186.

<sup>65</sup> *Abortion Can Be Medically Necessary*, ACOG (Sept. 25, 2019), <https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary> [<https://perma.cc/79AY-ERX4>].

<sup>66</sup> Jones & Finer, *supra* note 34, at 546.

<sup>67</sup> *Id.* at 544. The study defined disruptive life events as "falling behind on rent or mortgage, unemployment of a month or more, separating from a partner, having a baby, moving two or more times, having a serious medical problem, having a friend or family member with a serious medical problem, death of a close friend, being the victim of robbery or a burglary or having a partner incarcerated." *Id.* at 546.

<sup>68</sup> See *infra* notes 69–186 and accompanying text (discussing recent restrictions on abortion access).

<sup>69</sup> Cray & Fingerhut, *supra* note 12.

All abortion restrictions, from waiting periods to mandatory counseling, affect second-trimester abortion, but a woman’s ability to obtain an abortion in the second trimester is specifically limited in a variety of ways. Under both *Roe* and *Casey*, the state can legally prohibit abortion after viability—the point at which the fetus could likely survive outside of the womb.<sup>70</sup> Because fetuses grow at slightly different rates, the determination of viability requires a case-by-case analysis of each fetus, but usually occurs around twenty-four weeks of pregnancy.<sup>71</sup> Thus, states are free to prohibit late second-trimester abortion, and the vast majority prohibit abortion at this point or earlier. Twenty states ban abortion at “viability,” and four states ban abortion at twenty-four weeks.<sup>72</sup> Many other states ban abortion earlier in the second trimester—arguably before viability. For example, seventeen states currently ban abortion at twenty-two weeks and one state has an active twenty-week ban.<sup>73</sup> Since May of 2019, after Justice Kennedy retired, conservative states have tried to ban abortion even earlier in the pregnancy, from conception to eighteen weeks. Some lower courts have held that laws banning abortion between fifteen and twenty-two weeks are unconstitutional, but not all.<sup>74</sup>

In May 2021, the Supreme Court granted certiorari in a case involving Mississippi’s fifteen-week abortion ban, agreeing to hear argument on “whether all pre-viability prohibitions on elective abortions are unconstitutional.”<sup>75</sup> This question involves a direct challenge to the central holding from *Roe* and *Casey*—that the state cannot prohibit any woman from obtaining an abortion before viability.<sup>76</sup> *Dobbs* foreshadows a Supreme Court willing to dive into the abortion controversy and reshape abortion rights jurisprudence.

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<sup>70</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *Roe v. Wade*, 410 U.S. 113, 163–64, (1973), *holding modified by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

<sup>71</sup> Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 217–18.

<sup>72</sup> *Id.*

<sup>73</sup> *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST. (Jan. 1, 2020), <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions> [<https://perma.cc/34AX-AAJV>].

<sup>74</sup> See Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 221 (discussing examples of some states, such as Arizona, North Carolina and Utah, that attempted to ban abortion early in the second trimester).

<sup>75</sup> *Jackson Women’s Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019), *cert. granted in part*, 2021 BL 181590 (U.S. May 17, 2021) (No. 19-1392).

<sup>76</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878–79 (1992). All of the lower courts who have considered the issue have held these pre-viability abortion laws unconstitutional. *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020); *SisterSong Women of Color Reprod. Justice Collective v. Kemp*, 472 F.Supp.3d 1297, 1302 (N.D. Ga. 2020); *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc., v. Parson*, 389 F. Supp. 3d 631, 630 (W.D. Mo. 2019); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019).

And if the Court holds, as is expected, that pre-viability abortion restrictions can be constitutional, the contours of that holding will likely be fleshed out most immediately in cases involving the second-trimester abortion law restrictions discussed in this Article. In particular, recent *en banc* circuit decisions upholding Texas’s D&E abortion ban and Ohio’s Down Syndrome abortion ban—both of which created a circuit split—are perfectly teed up for the Supreme Court to consider next term.<sup>77</sup>

This Article focuses on restrictions based on “how” the doctor would perform the second-trimester abortion and “why” the woman sought the second-trimester abortion. More specifically, we focus on laws that ban the Dilation and Evacuation (D&E) and Dilation and Extraction (D&X) surgical procedures and abortion restrictions related to fetal anomaly. These restrictions are part of the long-term, anti-abortion strategy of slowly chipping away at abortion rights over time. By drawing attention to more controversial abortions, the hope is to degrade support for abortion rights generally. Courts analyze the constitutionality of all abortion laws, included the ones we highlight below, under the undue burden test from *Casey*, which asks whether the law places “a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.”<sup>78</sup> The Sections to follow in this Part discuss restrictions on various abortion procedures, how they fit into the anti-abortion strategy, and the status of litigation concerning them. Section A provides an overview of restrictions on D&X procedures.<sup>79</sup> Section B describes similar efforts related to the D&E procedure.<sup>80</sup> Section C discusses disability-selective abortion bans.<sup>81</sup> Last, Section D explores mandates on counseling for women after receiving a fetal diagnosis.<sup>82</sup>

### A. D&X Bans

One of the most successful anti-abortion campaigns over the past quarter century was the movement to ban a second-trimester abortion procedure called D&X.<sup>83</sup> This procedure allowed physicians to remove the fetus whole, making fewer passes through a woman’s cervix with instruments that could potentially damage the uterus, and therefore reduce risks. To allow the fetus

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<sup>77</sup> *Whole Woman’s Health v. Paxton*, Case 2021 WL 3661318 (5th Cir. 2021); 994 F.3d 512, 535 (6th Cir. 2021).

<sup>78</sup> *Casey*, 505 U.S. at 878.

<sup>79</sup> See *infra* notes 83–104 and accompanying text.

<sup>80</sup> See *infra* notes 105–131 and accompanying text.

<sup>81</sup> See *infra* notes 132–157 and accompanying text.

<sup>82</sup> See *infra* notes 158–186 and accompanying text.

<sup>83</sup> See ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 152 (describing the D&X campaign as a “political godsend” for leading anti-abortion groups).

to be removed whole, the D&X involves partially delivering the fetus in a breech (feet first) position, and emptying the contents of the skull, so that it can collapse and safely pass through the cervix.<sup>84</sup> Typically, the fetus would die during the procedure, but fetal demise could also be initiated beforehand with either an injection or by cutting the umbilical cord.<sup>85</sup> The D&X procedure was used not only in abortion, but also for miscarriage or stillbirth management in the second or third trimester.<sup>86</sup> The only difference in these situations is that the fetus would have died on its own before the D&X began.

Anti-abortion activists dubbed this procedure “partial birth abortion”—a non-medical term that stuck and even made it into subsequent legislation.<sup>87</sup> This term had a large impact in framing the debate—it allowed opponents of the D&X procedure to make comparisons to infanticide and “draw upon the powerful mental images and emotions evoked by birth.”<sup>88</sup> The term incorrectly suggested that D&X procedures were performed on healthy, full-term babies, when in reality, the vast majority of D&X abortions occurred before viability.<sup>89</sup> In large part because of this framing, not only did the anti-abortion movement succeed in gaining a nationwide D&X ban, which was upheld by the Supreme Court, but it also dramatically influenced public opinion.<sup>90</sup> Within a few years, Americans supporting legal abortions “under all circumstances” fell by nearly a third, from about thirty-four percent to only twenty-two percent.<sup>91</sup>

The abortion rights community did not initially anticipate the controversy surrounding the D&X procedure because it was a new and rarely used procedure.<sup>92</sup> But once state and federal bans were enacted, the predominant

<sup>84</sup> *Id.* at 150, 152; Rigel C. Oliveri, *Crossing the Line: The Political and Moral Battle over Late-Term Abortion*, 10 YALE J. L. & FEMINISM 397, 403 (1998).

<sup>85</sup> Soc’y of Fam. Planning, *Induction Of Fetal Demise Before Abortion*, 81 CONTRACEPTION 462, 463 (2010).

<sup>86</sup> See Gabriela Weigel et al., *Understanding Pregnancy Loss in the Context of Abortion Restrictions and Fetal Harm Laws*, KAISER FAM. FOUND. (Dec. 4, 2019), <https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/> [<https://perma.cc/57R6-7YHF>] (“D&X can be used in abortion but also in stillbirth management if the intact stillborn is desired by the family for personal reasons (religious, burial ceremony, etc.) or medical reasons to assess cause of death.”). In the United States, pregnancy loss before twenty weeks is called miscarriage, and loss after twenty weeks is called stillbirth. *About Stillbirth*, STAR LEGACY FOUND., <https://starlegacyfoundation.org/about-stillbirth/> [<https://perma.cc/47QU-JT3Y>].

<sup>87</sup> Oliveri, *supra* note 84, at 406–07; SHELDON EKLAND-OLSON, WHO LIVES, WHO DIES, WHO DECIDES? 181 (2018).

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Gonzales v. Carhart*, 550 U.S. 124 (2007).

<sup>91</sup> See ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 156 (discussing the ruling’s effect on public opinion).

<sup>92</sup> *Id.* at 152.

strategy to oppose them was to focus on their lack of a health exception.<sup>93</sup> It became a tactical decision to focus entirely on a small subset of women who had a D&X abortion: women who terminated after learning of a severe fetal diagnosis.<sup>94</sup> There were some advantages to focusing on these cases—the women were relatable to those in positions of power as they were often white, educated, married, already mothers, and carrying wanted pregnancies.<sup>95</sup> This strategy was effective early on in the debates, and even led to President Clinton vetoing two bills because they lacked a health exception. But the strategy later backfired when the public learned that the majority of D&X abortions occurred outside of this context—meaning most women who received a D&X were not doing so because of a fetal anomaly. Critics have also suggested that this tactic of focusing on fetal anomaly abortions reinforced notions of the “good” abortion and villainized women who obtained a D&X due to other reasons.<sup>96</sup>

Soon after President George W. Bush was inaugurated, he signed into law the federal “Partial-Birth Abortion Act,” which lacked a health exception.<sup>97</sup> Abortion rights activists were optimistic that the Supreme Court would invalidate the law—after all, the Court had recently invalidated a nearly identical state law in 2000, albeit by a 5–4 margin.<sup>98</sup> But by the time the federal law reached the Supreme Court in 2007, President Bush had nominated two new members to the Court, including, most importantly, the replacement of Justice O’Connor with Justice Alito. The anti-abortion community had recently started incorporating arguments that women who had abortions regretted their choice, including amicus briefs from regretful women, which became a part of the legal strategy defending the D&X ban.<sup>99</sup> In *Gonzales v. Carhart*, the Court upheld the federal ban, distinguishing its previous decision on narrow grounds with a 5–4 majority that included Justice Alito.<sup>100</sup>

The federal D&X ban is still on the books today, and many states also have passed their own D&X bans, using similar language.<sup>101</sup> Notably, the

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<sup>93</sup> Oliveri, *supra* note 84, at 413.

<sup>94</sup> *Id.* at 414; ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 161.

<sup>95</sup> Oliveri, *supra* note 84, at 420, 430.

<sup>96</sup> *Id.* at 424, 430.

<sup>97</sup> 18 U.S.C. § 1531.

<sup>98</sup> Stenberg v. Carhart, 530 U.S. 914, 922 (2000).

<sup>99</sup> ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 173–75.

<sup>100</sup> *Gonzales v. Carhart*, 550 U.S. 124, 133 (2007); see ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 177 (discussing addition of Justice Alito to the Supreme Court and its effect on anti-abortion case rulings).

<sup>101</sup> *Bans on Specific Abortion Methods Used After the First Trimester*, GUTTMACHER INST. (July 1, 2020), <https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester> [https://perma.cc/4YF6-TWVH].

federal ban only applies when the D&X is performed on a viable fetus.<sup>102</sup> As a result, providers could continue to perform D&X abortions if they induced fetal demise beforehand, although the law caused a chilling effect that makes any D&X procedure essentially non-existent.<sup>103</sup> The D&X ban still left women with the ability to obtain abortions, just with a procedure other than the D&X. Not all anti-abortion activists were happy with this litigation strategy, which devoted enormous resources to passing and defending a law that did not prevent any abortions.<sup>104</sup> The campaign was nevertheless successful at shifting the abortion debate to the right by focusing public attention on the uncomfortable details of an abortion procedure.

### B. D&E Bans

Given the success of D&X bans, anti-abortion legislatures have recently passed state laws that ban the most common type of abortion procedure in the second trimester: D&E. Unlike a D&X procedure, a D&E abortion does not remove the fetus whole, but instead requires the provider to make multiple passes into the uterus with instruments to remove the fetus in parts.<sup>105</sup> The woman's cervix is typically dilated over the course of hours or days before the procedure.<sup>106</sup> The D&E is also used for management of second-trimester miscarriage and some early stillbirths.<sup>107</sup> Like the federal D&X ban, state D&E bans usually apply only to D&Es performed without fetal demise beforehand.

Eleven states have tried to ban D&E abortions, but the ban is only active in two jurisdictions: Mississippi and West Virginia.<sup>108</sup> Litigation is ongoing in many more states. It is clear that anti-abortion groups are pursuing the same strategy that was effective in banning the D&X. "Taking a page out of the playbook of the successful 'partial birth' campaign, anti-abortion oppo-

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<sup>102</sup> 18 U.S.C. § 1531.

<sup>103</sup> EKLAND-OLSON, *supra* note 87, at 199.

<sup>104</sup> ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 175 (explaining anti-abortion activists' frustration with "incremental restrictions").

<sup>105</sup> Oliveri, *supra* note 84, at 445.

<sup>106</sup> *Id.*

<sup>107</sup> See Am. Coll. of Obstetricians and Gynecologists & Soc'y for Maternal-Fetal Med., *Obstetric Care Consensus: Mgmt. of Stillbirth*, 135:3 AM. J. OBSTETRICS & GYNECOLOGY e110, e122–23 (2020) (explaining that D&E is available for stillbirth in the second trimester and may be safer than induction of labor, which often also still requires a D&E to remove the placenta). *But see About Stillbirth*, *supra* note 86 (listing a D&E as a common procedure after miscarriage, but not stillbirth).

<sup>108</sup> *Bans on Specific Abortion Methods Used After the First Trimester*, *supra* note 101.



nents have given a grotesque-sounding nonmedical name to” the D&E: dismemberment abortions.”<sup>109</sup> Though only 6.9% of U.S. abortions occur after the first trimester, roughly 95% of them are completed with a D&E.<sup>110</sup> If this method were banned, abortion providers would be left with only two remaining options for second trimester abortion: abortion through labor and delivery (induction abortion) or inducing fetal demise before a D&E or D&X.<sup>111</sup>

The first option, induction abortion, is neither popular nor widely available.<sup>112</sup> As the name suggests, induction abortion requires a woman to labor and give birth. It typically takes days of induced labor before the fetus will be delivered, and in one-third of cases, the woman will still need surgery to remove the placenta.<sup>113</sup> As a result, induction abortions are more time-consuming, invasive, painful, and expensive than D&E abortions.<sup>114</sup> But perhaps most importantly, they are also more dangerous: 30–43% of women who had induction abortions experienced complications, compared to only 5–10% of women who had D&Es.<sup>115</sup> Induction abortions are also less accessible because only a handful of clinics offer them; otherwise, women they must be performed in a hospital.<sup>116</sup> Eleven states go so far as to ban abortions in public hospitals.<sup>117</sup> And even in states where hospital abortions are allowed, most do not provide abortions—either for practical considerations or moral objections—and the cost can be prohibitive for most women.<sup>118</sup>

<sup>109</sup> DAVID S. COHEN & CAROLE JOFFE, *OBSTACLE COURSE 201* (2020); see also Megan K. Donovan, *D&E Abortion Bans: The Implications of Banning the Most Common Second-Trimester Procedure*, 20 GUTTMACHER POL’Y R. 35, 36 (2017), [https://www.guttmacher.org/sites/default/files/article\\_files/gpr2003517.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr2003517.pdf) [<https://perma.cc/G9AA-YV8Y>] (discussing potential effects of banning D&E abortion procedures).

<sup>110</sup> Kortsmitt et al., *supra* note X; Donovan, *supra* note 109, at 35.

<sup>111</sup> *Id.* at 37.

<sup>112</sup> *Id.* The women who choose it are typically carrying wanted pregnancies and wanting the opportunity to meet their baby and say goodbye. *Id.* If a woman desires a fetal autopsy, she must also undergo induction abortion. *Id.*

<sup>113</sup> Kate E. Pettit et al., *Improved Safety of Second Trimester Dilation and Evacuation Versus Induction of Labor in the Management of Fetal Demise or Termination*, AM. J. OBSTETRICS & GYNECOLOGISTS, <https://www.ajog.org/action/showPdf?pii=S0002-9378%2816%2931180-2> [<https://perma.cc/G54G-BD4S>].

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*; see also Soc’y of Fam. Planning, *Labor Induction Abortion in the Second Trimester*, 84 CONTRACEPTION 4, 6 (2011) (discussing higher complication rates in induction procedures versus D&E procedures).

<sup>116</sup> COHEN & JOFFE, *supra* note 109, at 209–11; Soc’y of Fam. Planning, *Labor Induction Abortion in the Second Trimester*, *supra* note 115, at 7.

<sup>117</sup> COHEN & JOFFE, *supra* note 109, at 209.

<sup>118</sup> See Varvara B. Zeldovich et al., *Abortion Policies in U.S. Teaching Hospitals*, 135 OBSTETRICS & GYNECOLOGY 1296, 1299 (2020) (describing differing policies surrounding hospital abortions in teaching hospitals across the United States).

The other option requires a provider to induce fetal demise prior to the abortion. Fetal demise can be initiated by injecting the fetus with a medication that stops its heart (either through the woman's abdomen or cervix) or by tying the umbilical cord, thus cutting off the fetus's oxygen source, before the D&E.<sup>119</sup> The former adds an unnecessary procedure that creates additional patient risks, including infection, cardiac arrest, and hemorrhage in the woman.<sup>120</sup> This procedure also increases the cost, time, and pain associated with the abortion.<sup>121</sup> Though the latter can often be completed at the beginning of the abortion procedure, making it a cost-free and less invasive alternative to initiate fetal demise, it is not always technically possible because fetal position can make it impossible for the physician to reach the umbilical cord.<sup>122</sup>

The Supreme Court will likely determine the constitutionality of a D&E ban in the near future.<sup>123</sup> Abortion rights activists have argued that these laws must be unconstitutional because they ban the procedure used for 95% of second-trimester abortions—in their view, effectively banning pre-viability, second-trimester abortions altogether in express contravention to *Roe* and *Casey*.<sup>124</sup> There is support for this argument in the reasoning of the *Carhart* opinion, where the Court held that states may ban the D&X precisely because

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<sup>119</sup> Soc'y of Fam. Planning, *Induction Of Fetal Demise Before Abortion*, *supra* note 85, at 465–66.

<sup>120</sup> Donovan, *supra* note 109, at 37; *see also* W. Ala. Women's Ctr. v. Williamson, 900 F.3d 1310, 1324 (11th Cir. 2018) (noting the risks associated with the procedures used to cause fetal demise); Blair McNamara et al., *A Qualitative Study of Digoxin Injection Before Dilation and Evacuation*, 97 *CONTRACEPTION* 515, 515 (2018) (describing the increased risks of the use of digoxin before a D&E, including nausea and vomiting, increased risk of hospital admission between the injection and the D&E, and the increased risk of extramural delivery (delivery that occurs outside of a facility intended for childbirth)).

<sup>121</sup> *Williamson*, 900 F.3d at 1327; Kristina Tocce et al., *Umbilical Cord Transection to Induce Fetal Demise Prior to Second-Trimester D&E Abortion*, 88 *CONTRACEPTION* 712, 712 (2013).

<sup>122</sup> Soc'y of Fam. Planning, *Induction Of Fetal Demise Before Abortion*, *supra* note 85, at 466.

<sup>123</sup> *See* EMW Women's Surgical Ctr., P.S.C. v. Friedlander, 2020 WL 6551717 (6th Cir. 2020), *cert. granted in part*, 141 S. Ct. 1734 (2021) (holding that a ban on the D&E abortion procedure is unconstitutional); *see also* Whole Woman's Health v. Paxton, 2021 WL 3661318 (5th Cir. 2021) (finding Texas's ban on the D&E procedure constitutional); Ziegler, *What's Next for Abortion Law?*, *supra* note 5 (discussing anti-abortion activists strategies to "unravel" abortion laws in the United States and what the future may hold for abortion rights).

<sup>124</sup> *See* W. Ala. Women's Ctr. v. Miller, 299 F. Supp. 3d 1244, 1286 (M.D. Ala. 2017) (recounting the abortion clinic's argument that banning the D&E procedure effectively denies the right to pre-viability abortions in the second trimester); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846 (1992) ("Before viability, the State's interests are not strong enough to support a prohibition of abortion . . ."); *see also* *Roe v. Wade*, 410 U.S. 113, 163 (1973) ("With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability.").

women would still have access to second-trimester, pre-viability abortions using a D&E.<sup>125</sup>

States have responded that this extra requirement does not actually ban these abortions, as it only requires the additional step of inducing fetal demise. Therefore, it is no different than laws that mandate waiting periods after consent or an ultrasound prior to an abortion.<sup>126</sup> Under this argument, the same reasoning from *Carhart* applies—women are not prevented from obtaining a pre-viability, second-trimester abortion if they can either have an induction abortion or a D&E with fetal demise. Thus far, courts have not accepted that argument. Instead courts have held that “fetal demise methods—their attendant risks; their technical difficulty; their untested nature; the time and cost associated with performing them; the lack of training opportunities; and the inability to recruit experienced practitioners to perform them” create an undue burden, and are therefore unconstitutional.<sup>127</sup> And abortion providers are quick to note that these laws create a slippery slope to more impactful abortion regulations in the future, like bans on drugs that induce fetal death, which would then force women into induction abortions.<sup>128</sup>

In late summer 2021, the Fifth Circuit, sitting *en banc*, found Texas’s D&E ban constitutional.<sup>129</sup> This decision creates a circuit split with the Sixth Circuit’s prior finding that Kentucky’s D&E ban was unconstitutional,<sup>130</sup> inviting Supreme Court’s intervention. Also, if the Court opens the door to pre-viability abortion bans in *Dobbs*, the energy behind D&E bans will only grow.<sup>131</sup>

### C. Disability-Selective Abortion Bans

Anti-abortion state legislatures are also targeting the reasons women may choose second-trimester abortions. Over the past decade, sixteen states have passed laws aimed at banning abortions that are based on the race, sex,

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<sup>125</sup> *Gonzales v. Carhart*, 550 U.S. 124, 164 (2007) (“Alternatives are available to the prohibited procedure. As we have noted, the Act does not proscribe D&E.”).

<sup>126</sup> *Id.*; COHEN & JOFFE, *supra* note 109, at 202.

<sup>127</sup> *W. Ala. Women’s Ctr. v. Williamson*, 900 F.3d 1310, 1327 (11th Cir. 2018) (noting similar holdings from all other courts to consider the issue).

<sup>128</sup> COHEN & JOFFE, *supra* note 109, at 202.

<sup>129</sup> *Whole Woman’s Health v. Paxton*, Case 2021 WL 3661318 (5th Cir. 2021).

<sup>130</sup> Though the Supreme Court recently granted cert in part, the Court will only consider a non-merits-based question related to who can defend the state law. *EMW Women’s Surgical Ctr., P.S.C. v. Friedlander*, 2020 WL 6551717 (6th Cir. 2020), *cert. granted in part*, 141 S. Ct. 1734 (2021).

<sup>131</sup> *Jackson Women’s Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019), *cert. granted in part*, 2021 BL 181590 (U.S. May 17, 2021) (No. 19-1392).

or disability of the fetus.<sup>132</sup> These laws have been referred to as “reasons-based abortion bans” as they ban all abortions that are performed for a particular reason.<sup>133</sup> The most successful of the reasons-based abortion bans have been those that are based on a fetal disability. Because fetal anomalies are almost always diagnosed after the first trimester, these bans almost exclusively impact second-trimester abortion care.<sup>134</sup> These laws can have intuitive appeal as anti-discrimination laws, and some notable judges and justices—including Judge Easterbrook, Justice Barrett, and Justice Thomas—have expressed support for them on that basis.<sup>135</sup> Given the complex history between the abortion rights and disability rights communities, abortion rights advocates are in a difficult position as they consider how to best object to abortion bans based on the disability of the fetus.<sup>136</sup>

A range of fetal diagnoses may prompt a woman to consider termination. Many disability-restrictive abortion bans focus on Trisomy 21 (colloquially known as Down Syndrome) or include a range of anomalies, but often excluding those identified as fatal.<sup>137</sup> But the oldest of these laws—from North Dakota—is very broad and could be interpreted to include all fetal anomalies,

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<sup>132</sup> See *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST. (June 28, 2021), <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly> [<https://perma.cc/AXX8-969Z>] (providing an overview of state abortion bans that restrict “specific pregnancy conditions and populations”).

<sup>133</sup> Greer Donley, *Does the Constitution Protect Abortions Based on Fetal Anomaly?: Examining the Potential for Disability-Selective Abortion Bans in the Age of Prenatal Whole Genome Sequencing*, 20 MICH. J. GENDER & L., 291, 326–27 (2013) (discussing whether the state or federal government has the authority to ban abortions due to the fetus’s genetic abnormality); Carole J. Petersen, *Reproductive Autonomy and Laws Prohibiting “Discriminatory” Abortions: Constitutional and Ethical Challenges*, 96 U. DET. MERCY L. REV. 605, 618–19 (2019) (discussing the ethical and constitutional considerations regarding state laws that ban abortion because of “sex, race, or disability of the fetus”); Marc Spindelmann, *On the Constitutionality of Ohio’s Down Syndrome Abortion Ban*, 79 OHIO STATE L.J. 19, 32–33 (2018) (examining a state’s ban on abortion due to the fetus’s Down Syndrome diagnosis).

<sup>134</sup> Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 218.

<sup>135</sup> See e.g., *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1792 (2019) (Thomas, J., concurring) (discussing that “[i]n other contexts, the Court has been zealous in vindicating the rights of people even potentially subjected to race, sex, and disability discrimination”); *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r of Ind. State Dep’t of Health*, 917 F.3d 532, 536 (7th Cir. 2018) (Easterbrook, J., dissenting) (stating that “[u]sing abortion to promote eugenic goals is morally and prudentially debatable on grounds different from those that underlay the statutes *Casey* considered”).

<sup>136</sup> Mary Ziegler, *The Disability Politics of Abortion*, 2017 UTAH L. REV. 587, 626–27 (2017).

<sup>137</sup> See Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 181–91, 222–26 (providing overview of disability-selective abortions bands and describing fetal anomalies as ranging from minor disability to fatal conditions).

including the most fatal conditions.<sup>138</sup> These very serious anomalies can be both genetic (for instance, Trisomy 13 or 18) or structural (for instance, anencephaly or bilateral renal agenesis), though many more exists that are also (slightly less) life-threatening.<sup>139</sup> These conditions almost always result in stillbirth or infant mortality, and no child with them has survived to adulthood.

Abortion bans specifically aimed at fetal anomaly are not the only way in which states ban these abortions. As week-based bans apply earlier and lack an exception for abortions based on fetal anomaly, they in effect also ban these abortions. Almost all fetal anomalies are diagnosed in the second trimester.<sup>140</sup> Though women are often screened for certain genetic conditions—such as Trisomy 13, 18, and 21—late in their first trimester, those tests are not diagnostic, and the results from the diagnostic test will almost always be received after fourteen weeks. Non-genetic fetal anomalies are typically not diagnosed until the anatomy ultrasound around twenty weeks.

Current week-based bans already make it difficult—if not impossible—for some women to obtain an abortion after learning of a fetal anomaly. And as state legislatures have tried to move the week-based bans earlier, they have explicitly found it acceptable that the ban prevents women from terminating even in the face of a life-limiting fetal anomaly.<sup>141</sup> For example, in Missouri, anti-abortion advocates have specifically defended the lack of an exception for life-limiting fetal conditions in its eight-week ban.<sup>142</sup> Arkansas's ban also lacks such an exception, with one state legislator noting that the woman

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<sup>138</sup> 14 N.D. CENT. CODE ANN. § 14-02.1-04.1(1) (West 2013); *see also* Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 183 (discussing the most severe types of fetal anomalies, often called "fatal" or "lethal" and labeled as "being incompatible with life").

<sup>139</sup> Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 181–91.

<sup>140</sup> *Id.* at 217–19.

<sup>141</sup> *Id.*

<sup>142</sup> *See* MO. REV. STAT. § 188.056 (West 2019) (preliminarily enjoined by *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc., v. Parson*, 389 F. Supp. 3d 631, 630 (W.D. Mo. 2019)).

should continue the pregnancy to enable organ donation—despite its impossibility after stillbirth.<sup>143</sup> No court has explicitly considered the constitutionality of a timing-based ban that did not create an exception for fetal anomalies.<sup>144</sup>

Before 2021, all courts to consider disability-selective abortion laws held them unconstitutional under *Casey*,<sup>145</sup> which held that a state cannot outright prevent any woman from obtaining a pre-viability abortion.<sup>146</sup> The courts reasoned that disability-selective abortion bans would, by definition, prevent some women from receiving a pre-viability abortion—those terminating on the basis of a prenatal diagnosis.<sup>147</sup> But the tide is changing. In 2019, the Supreme Court denied certiorari on a Seventh Circuit case, which invalidated, as unconstitutional, a law in Indiana that banned abortions based on fetal diagnoses, such as Down Syndrome and other disabilities, but excluded “lethal fetal anomal[ies].”<sup>148</sup> The Court specifically noted that it was following tradition by not granting petitions for those that introduce legal

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<sup>143</sup> Rachel Herzog, *House Oks Abortion Ban*, ARK. DEM. GAZETTE (Mar. 6. 2021), <https://www.eldoradonews.com/news/2021/mar/06/house-oks-abortion-ban/> [<https://perma.cc/6V4V-2MKZ>]; see also *infra* notes 239–240 and accompanying text (discussing some states’ invocation of the woman-protective rationale in prohibiting abortions based on fatal fetal prenatal diagnoses).

<sup>144</sup> Though the issue was raised before the Ninth Circuit, the court did not address it; instead, it held the abortion ban unconstitutional because it banned pre-viability abortions. *Isaacson v. Horne*, 716 F.3d 1213, 1231 (9th Cir. 2013); see also *Little Rock Fam. Planning Servs. v. Rutledge*, 2019 WL 3323731 (E.D. Ark. 2019) (enjoining enforcement of Arkansas’s eight-week abortion ban). For additional background on the issue and arguments raised before the Ninth Circuit, see Brief of Andrew M. Tobin, Speaker of the Ariz. House of Representatives and Steve Pierce, President of the Ariz. Senate Supporting Appellees and Affirmance, *Isaacson v. Horne*, 2012 WL 4086817 (9th Cir. 2012) (No. 12-16670) and Brief for Amici Curiae Am. Coll. of Obstetricians and Gynecologists and Am. Congress of Obstetricians and Gynecologists in Support of Plaintiffs-Appellants and Reversal, *Isaacson v. Horne*, 2012 WL 4086817 (9th Cir. 2012) (No. 12-16670). For an analysis of why an exception for fetal anomaly might be constitutionally required even if *Roe* and *Casey* are limited or overturned, see Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note X.

<sup>145</sup> See *Preterm-Cleveland v. Himes*, 294 F. Supp. 3d 746, 755 (S.D. Ohio 2018) (“The State cannot dictate what factors a woman is permitted to consider in making her choice. The State’s attempt to carve out exceptions to a categorical right [to pre-viability abortions] where none exist fails as a matter of law.”); see also *Little Rock Family Planning Servs. v. Rutledge*, 398 F. Supp. 3d 330, 384 (E.D. Ark. July 23, 2019) (“[T]he State may not prohibit a woman from exercising that right solely upon the basis on which a woman makes her decision.”); *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Parson*, 389 F. Supp. 3d 631, 635 (W.D. Mo. 2019) (noting that the State cannot prohibit a woman’s right to obtain an abortion prior to viability).

<sup>146</sup> See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (“Before viability, the State’s interests are not strong enough to support a prohibition of abortion . . .”).

<sup>147</sup> See cases discussed *supra* note 146.

<sup>148</sup> IND. CODE ANN. § 16-34-4-1 (West 2021).

questions that other lower courts have not yet considered.<sup>149</sup> Some lower courts have interpreted the Supreme Court's language as inviting a circuit split to consider the issue more fully,<sup>150</sup> especially in light of Justice Thomas's fiery dissent in which he expressed his view that the law may be constitutional.<sup>151</sup> In *Box v. Planned Parenthood of Indiana and Kentucky, Inc.*, he reasoned that the law could be necessary to prevent disability discrimination.<sup>152</sup> Judges Barrett and Easterbrook, who heard the case before the Seventh Circuit in 2018, espoused similar views in their dissent.<sup>153</sup>

In April 2021, in *Preterm-Cleveland v. McCloud*, the Sixth Circuit, sitting *en banc*, held Ohio's Down Syndrome abortion ban—prohibiting a doctor who has actual knowledge that a woman's reason for obtaining an abortion is due to a fetal Down Syndrome diagnosis—constitutional.<sup>154</sup> It reasoned, oddly, that the law would not actually ban these abortions because women are not required to tell their doctors about their motivation for the abortion, nor should doctors assume that a diagnosed fetal anomaly *is* the reason for an abortion.<sup>155</sup> Commentators have suggested that this opinion reinterprets the Ohio law as a “don't ask, don't tell” policy for abortion care.<sup>156</sup> This opinion created the invited circuit split, teeing the case up for the Supreme Court review, but also neutered the law by making it practically unenforceable. Regardless of the Sixth Circuit's specific reasoning though, if the

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<sup>149</sup> *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1783 (2019).

<sup>150</sup> See *Reprod. Health Servs. of Planned Parenthood of St. Louis Region*, 389 F. Supp. 3d at 636 (“While it can be speculated that the Supreme Court's language in *Box* implicitly invited appellate judges to review the merits of prohibitions of discriminatory abortions, any such invitation was not addressed to district judges.”).

<sup>151</sup> See *Box*, 139 S. Ct. at 1783–93 (Thomas J., concurring).

<sup>152</sup> See *id.* at 1792 (“Enshrining a constitutional right to an abortion based solely on the race, sex, or disability of an unborn child, as Planned Parenthood advocates, would constitutionalize the views of the 20th-century eugenics movement.”).

<sup>153</sup> See 917 F.3d 532, 536 (Easterbrook J., dissenting) (describing the Indiana law at issue—which attempted to make illegal abortions performed for reasons, such as sex, race, or disability—as a “eugenics statute”).

<sup>154</sup> 994 F.3d 512, 535 (6th Cir. 2021). The Sixth Circuit held that the Ohio law was not a ban on abortions based on Down Syndrome. *Id.* Shortly before this decision, the Sixth Circuit panel had also allowed Tennessee's law banning abortions on the basis of Down Syndrome to go into effect pending the appeal of a district court's preliminary injunction preventing enforcement. *Memphis Ctr. For Reprod. Health v. Slatery*, No. 20-5969, 2020 U.S. App. LEXIS 36780 (6th Cir. Nov. 20, 2020).

<sup>155</sup> *Id.*

<sup>156</sup> Debra Cassens Weiss, *Full 6th Circuit Upholds 'Don't Ask, Don't Tell' Law Punishing Docs Who Perform Down Syndrome Abortions*, ABA J. (Apr. 13, 2021), <https://www.abajournal.com/news/article/full-6th-circuit-upholds-dont-ask-dont-tell-law-punishing-docs-who-knowingly-perform-down-syndrome-abortions> [https://perma.cc/7DTS-JN6Q].

Court finds in *Dobbs* that some pre-viability abortion bans are constitutional, disability selective abortion bans will also receive greater focus.<sup>157</sup>

#### *D. Mandatory Counseling After Fetal Diagnosis*

Congress and the states have also passed laws mandating that healthcare providers give pregnant patients information on fetal diagnoses. Some of these laws are seemingly unrelated to abortion, mandating disclosure of information at the time of diagnosis. One example is the Prenatally and Postnatally Diagnosed Conditions Act, passed with bipartisan support and which President Bush signed in 2008.<sup>158</sup> One purpose of the law is to disclose the latest information on the potential health effects associated with a diagnosis, including the range of “physical, developmental, educational, and psychosocial outcomes.”<sup>159</sup> Numerous states representing both political leanings have also passed similar laws in order to help parents make informed decisions.<sup>160</sup> Though these laws are far from perfect, they can help ensure that parents have access to the best possible information on the fetal diagnosis. Importantly, they are not tied to abortion regulations in any discernable way and do not encourage any outcome.

Other state laws, however, do not mandate disclosure until the woman, having already decided to terminate, appears at the clinic desiring an abortion—tying the provision of information to abortion access. For instance, Wisconsin law mandates that if the unborn child has been diagnosed with a disability, the woman must be provided printed materials with information on “community-based services,” financial assistance programs, and support groups for parents of children with disabilities, in addition to information on adoption of children with special needs.<sup>161</sup> Unlike mandated disclosure at the time of diagnosis, these laws make disclosure and receipt of this information prerequisites to obtaining an abortion. The disclosure will occur when the woman—who has already decided to terminate—visits the clinic to obtain an abortion.<sup>162</sup>

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<sup>157</sup> *Jackson Women’s Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019), cert. granted in part, 2021 BL 181590 (U.S. May 17, 2021) (No. 19-1392).

<sup>158</sup> Prenatally and Postnatally Diagnosed Conditions Awareness Act, Pub. L. No. 110–374, 122 Stat. 4051 (codified at 42 U.S.C. § 280g–8).

<sup>159</sup> *Id.* at § 2(1)–(3) (emphasis added).

<sup>160</sup> See Bret D. Asbury, *Fostering Informed Choice: Alleviating the Trauma of Genetic Abortions*, 25 CORNELL J. L. & PUB. POL’Y 293, 315–16 (2015).

<sup>161</sup> WIS. STAT. ANN. § 253.10(3)(c)(2)(e) (West 2021); see also ARIZ. REV. STAT. § 36-2158(A)(2)(a)–(c) (2021).

<sup>162</sup> See Cohen & Jofee, *supra* note X, at 30 (describing studies demonstrating that most women are certain of their abortion decision by the time they arrive at an abortion or family planning clinic).



An increasingly popular example of tying the provision of information to abortion access is state laws mandating disclosure to a woman about perinatal hospice and palliative care (PHPC) “as an alternative to abortion” before she can obtain an abortion.<sup>163</sup> PHPC is an emerging area of medical care for women and parents who choose to continue their pregnancies after a life-limiting fetal diagnosis.<sup>164</sup> The palliative care part of the model starts at the time of the fetal diagnosis, providing families with traditional maternal-fetal care, but also “physical, psychological, spiritual, or existential” care as culturally appropriate.<sup>165</sup> The hospice part of care is medical care focused on comfort if the baby survives birth and the family chooses comfort care.<sup>166</sup> Currently, most women learn of the possibility of PHPC from their obstetrician or maternal fetal specialist, genetic counselor, or nurse.<sup>167</sup>

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<sup>163</sup> ARIZ. REV. STAT. ANN. § 36-2158(A)(1)(a); ARK. CODE ANN. § 20-16-2304 (2021); IND. CODE ANN. § 16-34-2-1.1(5)(a)–(b) (West 2021); KAN. STAT. ANN. § 65-6709(a)(6) (2021); MINN. STAT. ANN. § 145.4242 (West 2021); MISS. CODE ANN. § 41-41-141(2) (2021); OKLA. STAT. ANN. tit. 63, § 1-746.2 (West 2021); WIS. STAT. ANN. § 253.10(3)(c)(2). Two state laws also mandate PHPC disclosure, but are not tied to abortion access. *See* IND. CODE ANN. § 16-25-4.5-6 (requiring that provider notify patient about PHPC following fetal diagnosis); NEB. REV. STAT. § 71-5003 (2021) (noting discretionary disclosure after diagnosis). In Indiana, a patient is informed of PHPC both at the time of diagnosis and at the abortion clinic. IND. CODE ANN. § 16-25-4.5-6. For a detailed description of these statutes, see Ashley Flakus, *Choosing Wisely: Envisioning Perinatal Hospice Notification Laws that Inform and Empower*, 98 WASH. U. L. REV. 587 (2020). Most of these statutes require disclosure of information on PHPC in case of a “lethal fetal condition.” *See e.g.*, ARIZ. REV. STAT. ANN. § 36-2158(A)(1)(a), (G)(1) (mandating provision of information on PHPC when woman seeks abortion due to a “lethal fetal condition” meaning “fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth”); ARK. CODE ANN. § 20-16-2304 (same); IND. CODE ANN. § 16-25-4.5-2 (same). *But see* KAN. STAT. ANN. § 65-6709(a)(6), (m)(2) (mandating PHPC disclosure for “medically challenging pregnancies” defined as diagnosis of “(A) a severe anomaly; or (B) an illness, disease or defect which is invariably fatal”); OKLA. STAT. ANN. tit. 63, § 1-746.1 (defining “fetal anomaly incompatible with life” as “profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth”). We will, however, continue to use the PHPC researcher preferred term of life-limiting fetal conditions.

<sup>164</sup> This care is commonly referred to as “perinatal hospice.” We, however, are using an acronym to differentiate the two types of care and help cure the “common misconception” that perinatal hospice and palliative care are the same. Erin M. Denney-Koelsch & Denise Côté-Arsenault, *Introduction to Perinatal Palliative Care*, in PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE 5 (Erin M. Denney-Koelsch & Denise Côté-Arsenault eds., 2020). In fact, in the case of stillbirth, the woman will only use the palliative care part of PHPC.

<sup>165</sup> *Id.*; Charlotte Wool et al., *Provision of Services in Perinatal Palliative Care: A Multi-center Survey in the United States*, 19:3 J. PALLIATIVE MED. 279, 280 (2016).

<sup>166</sup> Erin M. Denney-Koelsch & Denise Côté-Arsenault, *Introduction to Perinatal Palliative Care*, in PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE 5 (Erin M. Denney-Koelsch & Denise Côté-Arsenault eds., 2020).

<sup>167</sup> *Id.* at 281 (describing that, in a survey, 97% of women were directly referred by their obstetrician or maternal fetal medicine provider, 73% learned from genetic counselor, 60% learned from a nurse, another 60% learned from a nurse, 60% learned from a social worker,

Despite its growth, accessibility to PHPC is not as broad as state statutes suggest.<sup>168</sup> Kansas has a PHPC notification law,<sup>169</sup> but has only three facilities, all of which are located around Kansas City in the eastern-most side of the state.<sup>170</sup> Mississippi’s PHPC notification statute mandates that providers inform women of the availability of PHPC, yet only one program exists in Mississippi.<sup>171</sup> Cost issues may also affect access.<sup>172</sup> Insurance companies generally cover the costs of pregnancy and childbirth using a single global fee, and PHPC may not be included in that global fee.<sup>173</sup> This includes Medicaid, which covers almost half of all pregnancies each year in the United States.<sup>174</sup> Many families may be unable to pay for the additional care on their own.<sup>175</sup> Researchers also note that significant barriers to PHPC care exist for poor women and women of color.<sup>176</sup>

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61% learned from the internet, and 39% learned from “other”). Similarly, a perinatal hospice and palliative care coordinator based in Kansas estimated that 98% of their referrals came from obstetricians. Telephone Interview with Patti Lewis, Founder of Alexandra’s House (June 4, 2020).

<sup>168</sup> Am. Coll. of Obstetricians & Gynecologists, *Perinatal Palliative Care*, 134(3) OBSTETRICS & GYNECOLOGY e84, e87 (2019) (describing that use of perinatal palliative care is low due to the “availability of programs, patient access issues, and physician education and training barriers”).

<sup>169</sup> KAN. STAT. ANN. § 65–6709(a)(6).

<sup>170</sup> *If You Are Pregnant Directory of Available Services*, Bureau of Family Health, KAN. DEP’T OF HEALTH & ENV’T (2018), [http://www.womansrighttoknow.org/download/Directory\\_of\\_Services\\_English.pdf](http://www.womansrighttoknow.org/download/Directory_of_Services_English.pdf) [https://perma.cc/JYK2-DB7D]. One Kansas PHPC center is actually located in Kansas City, Missouri. *Id.*

<sup>171</sup> *Perinatal Hospice & Palliative Care Programs and Support*, PERINATAL HOSPICE & PALLIATIVE CARE, <https://www.perinatalhospice.org/list-of-programs> [https://perma.cc/3S4X-LGBP].

<sup>172</sup> Little is known about the cost of PHPC. The Perinatal Hospice and Palliative Care website claims that PHPC is not expensive, but mentions that only one insurance plan specifically covers it. *Frequently Asked Questions*, PERINATAL HOSPICE & PALLIATIVE CARE, <https://www.perinatalhospice.org/faqs> [https://perma.cc/8Q7J-XUVY]. It also explains that PHPC is no more expensive than abortion, and “[e]ven if perinatal hospice were to cost more, many parents say the value of treating their child with dignity, and the healing peace that comes from protecting and caring for their baby as long as he or she is able to live, cannot be measured in dollars and cents.” *Id.*

<sup>173</sup> Stefanie J. Hollenbach et al., *Obstetric Mgmt. in Life-Limiting Fetal Conditions*, in PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE, *supra* note 164, at 82.

<sup>174</sup> See KATHY GIFFORD ET AL., THE HENRY J. KAISER FAM. FOUND., MEDICAID COVERAGE OF PREGNANCY AND PERINATAL BENEFITS: RESULTS FROM A STATE SURVEY 3, 15 (2017), <http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-and-Perinatal-Benefits> [https://perma.cc/N2XB-VKTW] (“Maternity care is typically reimbursed with a global fee that covers all care for pregnant women through the postpartum period.”).

<sup>175</sup> Hollenbach et al., *supra* note 173, at 82.

<sup>176</sup> Natalia Henner et al., *Considerations in Unique Populations in Perinatal Palliative Care: From Culture, Race, Infertility, and Beyond*, in PERINATAL PALLIATIVE CARE: A CLINI-

PHPC lacked political origins, but the antiabortion-movement has strategically adopted it as a “political tool.”<sup>177</sup> For example, a prominent anti-abortion group, the Americans United for Life, created the Perinatal Hospice Information Act Model Legislation & Policy Guide.<sup>178</sup> The guide explains that it is imperative that parents are informed of “more compassionate” options besides abortion.<sup>179</sup> Again, UAL’s model legislation and all but one of these laws currently in place mandate notification for women seeking to terminate at the abortion clinic but not at diagnosis.<sup>180</sup> Using abortion as a trigger for disclosure shows this is a tool for dissuasion, rather than a law seeking to help all women who receive a life-limiting fetal diagnosis.<sup>181</sup>

To date, there have been no challenges to the constitutionality of mandatory information about disabilities PHPC counseling. Any challenge would not likely be successful given the Court’s history of affirming statutes purportedly aimed at ensuring informed consent, even when the law expresses the state’s preference for childbirth over abortion.<sup>182</sup> In the context of PHPC, however, the “informed consent” laws express the state’s preference for still-

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CAL GUIDE, *supra* note 164, at 361; *see also* Jill Wieber Lens, *Miscarriage, Stillbirth & Reprod. Just.*, 98 WASH. U. L. REV. 1, 38–39 (2021) (describing how the effectiveness of mental and emotional healthcare after stillbirth differs depending on the mother’s race).

<sup>177</sup> Danielle Paquette, *Perinatal hospice care prepares parents for the end, at life’s beginning*, WASH. POST (Apr. 16, 2016); Stassa Edwards, *Perinatal Hospice Care Has Increasingly Become an Alternative to Abortion*, JEZEBEL (Apr. 19, 2016), <https://jezebel.com/perinatal-hospice-care-has-increasingly-become-an-alter-1771783259> [https://perma.cc/2HLR-JUF7]. PHPC also appears to fall on the anti-abortion side of the abortion debate because the vast majority of women who choose to continue the pregnancy after receiving a life-threatening fetal diagnosis are religious. Jennifer Guon et al., *Our Children Are Not a Diagnosis: The Experience of Parents Who Continue Their Pregnancy After a Prenatal Diagnosis of Trisomy 13 or 18*, 164 AM. J. MED. GENETICS 308, 310–11 (2013). PHPC, however, does not include religious care but does include spiritual care. Maurice Hopkins, *Spiritual Care in the Perinatal Period*, in PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE, *supra* note 164, at 234 (explaining the differences between religion and spirituality).

<sup>178</sup> *Perinatal Hospice Information Act*, AMS. UNITED FOR LIFE, <https://aul.org/what-we-do/legislation/> [https://perma.cc/YG44-NYTG].

<sup>179</sup> *Id.* Arkansas’s PHPC law is identical to the model AUL legislation. ARK. CODE ANN. § 20–16–2304.

<sup>180</sup> *See supra* note 168.

<sup>181</sup> *See* Flakus, *supra* note 163, at 594 (discussing how such laws can dissuade women from obtaining an abortion).

<sup>182</sup> *See e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (discussing that information may be required to be disclosed to the patient, so long as the information is “truthful and not misleading”).

birth or infant mortality over termination. Any anti-abortion success in decreasing abortion rates, however, only means an increase in stillbirth and infant mortality rates.<sup>183</sup>

It is far from clear that disclosure laws will persuade women to continue a pregnancy. In the context of a fetal diagnosis, most of a woman's decision-making will occur in discussions with her doctors. By the time she has scheduled an appointment for an abortion, she has already made her decision and additional counseling on disabilities or PHPC is probably not going to make a large impact.<sup>184</sup> Plus, many life-threatening fetal diagnoses are made at the threshold of viability, after which state laws often prohibit abortion. Therefore, even if she was interested in PHPC, she'd have very little (if any) time to learn more before losing her ability to legally terminate in her state. Disclosure of information on disabilities and PHPC at the abortion clinic will likely not change the woman's mind, but it may very well increase her emotional distress—causing increased “guilt for going through with a decision that now feels framed by the state as the ‘wrong’ choice to make.”<sup>185</sup> The timing changes the disclosure “from an empowering piece of knowledge helping in *making* a decision to a last-ditch effort to dissuade her from the choice she has *already* made.”<sup>186</sup>

### III. REFUTING THE STATE'S CLAIMED NEED TO PROTECT WOMEN FROM SECOND-TRIMESTER ABORTION

It is clear that the anti-abortion movement has targeted second-trimester abortion as part of its stepping-stone campaign to end all abortion. State leg-

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<sup>183</sup> The availability of abortion after a lethal fetal diagnosis is inextricably linked to stillbirth and infant mortality rates. When abortion is available, stillbirths due to “congenital abnormalities account for less than 10% all stillbirths after 22 weeks of gestation, with a median of 7.4% and a median rate of 0.4 per 1000 births . . . . Conversely with good diagnostics and where termination of pregnancy is illegal, a higher proportion of congenital abnormalities is reported (e.g., 21% in Ireland).” Joy E. Lawn et al., *Stillbirths: Rates, Risk Factors, and Acceleration Towards 2030*, 387 LANCET 587, 597 (2016); see also LINDA L. LAYNE, *MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA* 12 (2003) (explaining that the “fetal death rate due to lethal abnormalities declined by almost half between the 1970's and 1980's” because of abortion). Similarly, Canada's infant mortality rates had remained stagnant between 1991 and 1995 but then dramatically declined in 1996, with one study suggesting that the reason was increased prenatal diagnosis of abnormalities and terminations. Shiliang Liu et al., *Relationship of Prenatal Diagnosis and Pregnancy Termination to Overall Infant Mortality in Canada*, 287(12) JAMA 1561, 1563 (2002).

<sup>184</sup> See Flakus, *supra* note 163, at 595 (discussing that by the time a woman goes to a clinic to obtain an abortion, “they are certain of their decision”).

<sup>185</sup> *Id.* (discussing the “serious emotional ramifications” that can occur in trying to persuade a woman to reconsider her decision to terminate a pregnancy).

<sup>186</sup> *Id.*

islatures claim numerous justifications for the second-trimester abortion restrictions discussed above. One justification common to all of them is the woman-protective rationale—the idea that abortion hurts women, and women thus need protection from it.<sup>187</sup> Professor Mary Ziegler highlighted that the weaponization of this rationale is the strategy of “abortion’s most sophisticated opponents.”<sup>188</sup> Claiming that abortion actually harms women attempts to combat abortion rights activists’ greatest argument—that abortion is necessary for women to achieve equality and control their destiny, the same argument the Court relied on in *Casey*.<sup>189</sup>

The woman-protective rationale first surfaced in *Casey* to affirm an informed consent provision that was purportedly necessary to prevent the psychological consequences of a not-fully-informed decision to abort.<sup>190</sup> Building on *Casey*, the rationale took center stage four years later in *Carhart*, when the Court highlighted the need to prevent women from experiencing psychological distress when they later learn of the specifics of the Dilation & Extraction (D&X) procedure—a distress unsupported by actual evidence.<sup>191</sup> Since *Carhart*, states have attempted to rely on the woman-protective rationale to justify numerous abortion restrictions, including requiring abortion providers to have hospital admitting privileges nearby as a quality metric, although with mixed results.<sup>192</sup> This strategy is continuing today in *Dobbs*,

<sup>187</sup> Most of these laws are also justified on the grounds that they are necessary to protect the fetus from either a “gruesome” death or from discrimination. These justifications are outside the scope of our paper.

<sup>188</sup> Mary Ziegler, *The Heartbeat Bills Were Never the Real Threat to Abortion*, N.Y. TIMES (Mar. 3, 2020), <https://www.nytimes.com/2020/03/03/opinion/abortion-supreme-court.html> [https://perma.cc/8P3H-PYPE].

<sup>189</sup> ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 145.

<sup>190</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (explaining that an informed consent provision helps “reduc[e] the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed”).

<sup>191</sup> See Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 837 (2007) (describing *Carhart* as “the first time [the Court adopted] a woman-protective justification for restricting access to abortion”).

<sup>192</sup> The woman-protective rationale was successful at convincing many lower courts that targeted restrictions on abortion provider (TRAP) laws—like the requirement that physicians have hospital admitting privileges—were constitutional. This line of reasoning was ultimately unsuccessful at convincing the Supreme Court in 2016, in *Whole Woman’s Health v. Hellerstedt*. 136 S. Ct. 2292, 2300 (2016). In 2020, in *June Med. Servs. L.L.C. v. Russo*, however, a majority of the Supreme Court stated that they would have held differently had the issue been one of first impression, and Justice Roberts only concurred to uphold *Whole Woman’s Health* based on precedent. 140 S. Ct. 2103, 2133–2142 (2020) (Roberts, J., concurring). Since then, the Court has only become more conservative with Justice Barrett and certainly, if *Whole Woman’s Health* were heard today, the Court would have decided differently.

where Mississippi justifies its fifteen week ban by arguing, in part, that abortions have substantial health and emotional risks associated with them, which only increase as the pregnancy progresses.<sup>193</sup> These risks, according to the state include “depression; anxiety; substance abuse; and other emotional or psychological problems.”<sup>194</sup>

Notably, the woman-protective rationale entered the Court’s abortion jurisprudence long before *Whole Woman’s Health v. Hellerstedt*,<sup>195</sup> a case that Justice Roberts believes altered the *Casey* undue burden test by requiring the state to prove that the benefits of an abortion regulation outweigh its costs.<sup>196</sup> Under the balancing test from *Whole Woman’s Health*, if a state abortion law had no benefits, then it would create an undue burden because the burdens would almost always outweigh the nonexistent benefits. In his concurrence in *June Medical Services, L.L.C. v. Russo*, Justice Roberts explained that *Casey* does not require a balancing of the benefits and burdens of an abortion restriction, but only an analysis of the burdens.<sup>197</sup> At least theoretically, under the Chief Justice’s view, an abortion law does not need to benefit women to be constitutional so long as it is not unduly burdensome. But despite the Chief Justice’s restatement, it is clear that the Court relied on an abortion law’s benefits in *Carhart* (long before *Whole Woman’s Health*). Even if the Chief Justice doesn’t think a law’s benefits must outweigh its burdens, the woman-protective rationale can be used to justify the state’s interest in the law, and to otherwise serve a legitimizing function. The rationale provides cover against the critique that the Court is prioritizing the fetus over the woman or ignoring women’s interests entirely. The rationale enables the Court to claim, even if just in dicta, that the restriction benefits both the woman and the fetus. One scholar has posited that the rationale might even be raised more often and with less support if the law’s benefits are less integral to the analysis and thus scrutinized less.<sup>198</sup> And of course, the rationale—to the extent it is persuasive—also affects public opinion.

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<sup>193</sup> Petition for Writ of Certiorari at 8, *Dobbs v. Jackson Women’s Health Organization*, 945 F.3d 265 (5th Cir. 2019) (No. 19-1392).

<sup>194</sup> *Id.*

<sup>195</sup> 136 S. Ct. 2292 (2016).

<sup>196</sup> *June Med. Servs.*, 140 S. Ct. at 2136 (Roberts, J., concurring). Justice Roberts voted with the majority, holding that Louisiana’s law in *June Medical* was unconstitutional, but he made clear that he would sympathetically review novel abortion restrictions. *Id.* at 2133.

<sup>197</sup> *Id.* The Fifth Circuit claimed to be following Justice Roberts’s *June Medical* opinion in upholding Texas’s D&E ban and the Fifth Circuit still discussed the woman protective rationale in evaluating the state’s interest. 10-11, 15.

<sup>198</sup> See Reva B. Siegal, *Why Restrict Abortion? Expanding the Frame on June Medical*, 2020 SUP. CT. REV. 1, 46 (forthcoming 2021) (“we can see that conservative judges attacking balancing [from *Whole Woman’s Health*] are embracing standards that will legitimate the woman-protective health justifications of TRAP laws and weaken the restrictions that *Casey* imposes on them.”)

This Part builds on existing legal scholarship that criticizes the paternalism and gender stereotypes underpinning the woman-protective rationale generally,<sup>199</sup> focusing on the special arguments made in the second trimester. Section A exposes the paternalism and gender stereotypes behind D&X and Dilation and Evacuation (D&E) bans, and Section B focuses on restrictions regarding abortions due to fetal anomalies.<sup>200</sup> Both Sections also present empirical evidence demonstrating that the laws will only harm women's health.<sup>201</sup>

### A. Protection from "Gruesomeness"

In *Carhart*, the Court relied heavily on the woman-protective rationale in holding Congress's ban on the D&X second-trimester abortion procedure constitutional. First, without citing any evidence, Justice Kennedy concluded that some women eventually regret their decision to abort.<sup>202</sup> Then, he noted that the regret would be even stronger for women who later learn the specifics of the D&X procedure she received:

While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow. In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails . . . . It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did

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<sup>199</sup> See e.g., Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 224 (2009) (describing that the current state of the law does not take into consideration that women are fully capable enough to make the decision to have an abortion); see also EKLAND-OLSON, *supra* note 87, at 198–99 (discussing Justice Kennedy's remarks in *Carhart*); Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1615 (2008) (noting that the Court in *Carhart* "portrays women as unusually fragile and unable to make informed choices about" obtaining an abortion); Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1688 (2008) (discussing how anti-abortion activists portray women as "too weak or confused" to make the decision to have an abortion and that law's need to protect them); Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 ILL. L. REV. 991, 993 (2007) (explaining that the anti-abortion movement now seeks to "protect[] women's health and choices as mothers").

<sup>200</sup> See *infra* notes 202–230 and accompanying text.

<sup>201</sup> See *infra* notes 232–270 and accompanying text.

<sup>202</sup> *Gonzales v. Carhart*, 500 U.S. 124, 159–60 (2007).

not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.<sup>203</sup>

Thus, the state's interest in protecting the woman's psychological well-being served as a basis for constitutionally depriving her of a safe and available second-trimester medical procedure.

*Carhart* created the blueprint for the recent en banc Fifth Circuit decision finding Texas's D&E ban constitutional.<sup>204</sup> The Fifth Circuit quoted this exact language from *Carhart* about a woman's later realization and explained the same was true with Texas's law—women were not being told that “the fetus's body parts—arms, legs, ribs, skull, and everything—will be ripped apart and pulled out piece by piece.”<sup>205</sup> The Fifth Circuit also more generally invoked the woman-protective rationale, recounting the State's evidence that “women seeking abortions benefit physically and psychologically when fetal death occurs before dismemberment” as fetal demise “can help with emotional difficulties for the patient.”<sup>206</sup> Thus, depriving women of the option of a D&E without fetal demise beforehand is actually in their best interest.

Other states have also argued this same analogy between Congress's D&X ban and their own D&E bans. Arkansas first described the “chillingly barbaric” nature of the procedure,<sup>207</sup> and argued that a woman would feel psychological distress when she later learned the specifics.<sup>208</sup> These statements are supported by women claiming as amici that they would not have consented to the abortion if they had known the details. Just as Texas did, Arkansas also argued that fetal demise beforehand psychologically benefits “an overwhelming majority of patients” because it may alleviate the difficult emotions the procedure can evoke.<sup>209</sup> Indiana similarly argued that its D&E ban “protects women's mental health by ensuring that women seeking abortion do not have a D&E only later to discover the brutal and inhumane way in which the fetus was killed.”<sup>210</sup> Indiana also added that the protection was

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<sup>203</sup> *Id.* (internal citations omitted). Justice Kennedy overlooks the real reason that doctors may not disclose the specifics of an abortion procedure, mainly because informed consent law does not require it. *See infra* notes 333–335 and accompanying text (explaining that a provider is not required to explain the details of an abortion procedure to a woman).

<sup>204</sup> *Whole Woman's Health v. Paxton*, 2021 WL 3661318 (5th Cir. 2021).

<sup>205</sup> *Id.* at \*8.

<sup>206</sup> *Id.* at \*7.

<sup>207</sup> Brief of Appellants at 31–32, *Hopkins v. Jegley*, No.17–2879, (8th Cir. Dec. 1, 2017).

<sup>208</sup> *See id.* at 6 (noting that one woman lamented that none of her medical providers explained the procedure—“that the limbs of my baby would be ripped apart and torn out” or “the emotional and psychological” cost of enduring the procedure).

<sup>209</sup> Brief of Appellants, *Jegley*, *supra* note **Error! Bookmark not defined.**, at 34.

<sup>210</sup> *See* Def.'s Mem. In Opp. To Plf.'s Mot. For Prelim. Inj., *Bernard v. Individual Members of Ind. Med. Licensing Bd.* at 14, No. 1:19-cv-1660-SEB-DML (S.D. Ind. May 17,



especially necessary because women seeking second-trimester abortion are especially susceptible to experiencing a “wide range of adverse psychological reactions” after an abortion.<sup>211</sup>

These arguments are laden with gender stereotypes—that women *should* be horrified of the D&X and D&E procedures.<sup>212</sup> And thus, any woman who did consent to these procedures—as Reva Siegal explained in other abortion contexts—must have been “mistaken or misled or coerced or pressured into decisions they do not want to make and should not make because abortion violates women’s nature as mothers.”<sup>213</sup> Further, the state reinforces yet another prominent gender stereotype of the emotional pregnant woman, incompetent to make medical decisions, when it suggests that women are best protected by banning the procedure, instead of informing them about what the procedure entails beforehand. Justice Ginsburg and legal scholars have noted this paternalism in the D&X context.<sup>214</sup> For instance, a legal scholar has explained that outside of the abortion context, the law does not interfere with non-pregnant, mentally competent adults making critical decisions related to their healthcare that they may regret afterwards. Yet when it comes to a pregnant woman making the decision to obtain an abortion, the law suggests that “someone other than the patient knows better what life choices will lead to

2019) (arguing that the ban “protects women’s mental health by ensuring that women seeking abortion do not have a D&E only later to discover the brutal and inhumane way in which the fetus was killed”); *see also* Resp. in Opp. to Plf.’s Mot. for Prelim. Inj. or TRO., Little Rock Family Planning Servs. v. Rutledge at 46, 397 F. Supp. 3d 1213 (E.D. Ark. 2019) No. 4:19-cv-00449-KGB, 2019 WL 7563579 (arguing that D&E abortions lead “real Arkansas women suffer profound grief and sorrow caused by their decision to have a dismemberment abortion of a quickened, unborn child”); Def. Brinkman’s Resp. in Opp. to Mot. for TRO and/or Prelim. Inj. at 12, EMW Women’s Surgical Ctr., P.S.C. v. Meier, No. 3:18-cv-00224-JHM-DW (W.D. Ky. May 8, 2018) (“Indeed, any abortion has the potential to result in grief or anguish for the mother who has chosen to abort her child.”).

<sup>211</sup> Def.’s Mem. In Opp. To Plf.’s Motion For Prelim. Inj., *supra* note 210, at 14.

<sup>212</sup> *See* Maroney, *supra* note X, at 900.

<sup>213</sup> Siegel, *The New Politics Of Abortion*, *supra* note 199, at 1013; *see also* Siegel, *Dignity and the Politics of Protection*, *supra* note 199, at 1792 (“The new gender paternalism is in fact the old gender paternalism: laws . . . for the claimed purpose of protecting women from coercion and/or freeing them to be mothers.”).

<sup>214</sup> *See* Gonzales v. Carhart, 500 U.S. 124, 184 (2007) (Ginsberg, J., dissenting) (“The solution the Court approves, then, is *not* to require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks . . . . Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety.”); *see also* EKLAND-OLSON, *supra* note 87, at 198 (“In a textbook example of paternalism, [the Court] wanted to protect her, even if her own values and assessment of the situation differed from theirs.”); CAROL SANGER, ABOUT ABORTION 132 (2017) (“The Court decided it was better for everyone to ban the whole thing rather than to force a confrontation through disclosure ahead of time.”); Dresser, *supra* note 199, at 1615 (“Abortion disclosure laws separate women deciding about abortion from people deciding about other kinds of medical interventions.”).

mentally healthy consequences,” and therefore she must be protected from herself.<sup>215</sup>

Actual evidence, however, shows the opposite—that D&Xs and D&Es can be psychologically beneficial for women.<sup>216</sup> This is especially true when a D&X is requested in the context of fetal anomaly. As one scholar has noted, Justice Kennedy ignored evidence that some women preferred the D&X to *avoid regret* by saying goodbye to a wanted pregnancy: “This is precisely because the intact process produces what Justice Kennedy found an unthinkable preference: an entire fetal body . . . .”<sup>217</sup> For these women, they found it vitally important to be able to “see[], hold[], and bid[] goodbye to their baby” after the abortion.<sup>218</sup>

[A]fter the [D&X], if the family desires, the hospital staff will prepare the baby to look as “untraumatized” as possible. They have little gowns that they dress the fetus in. They wrap it very gently in a blanket. They sometimes have a little bonnet that they put over the head. . . . And then they present this to the patient and generally her husband as well. And the patients are sometimes satisfied with that, and sometimes they completely undress the fetus, and look at it, and touch it, and cry, and say goodbye.”<sup>219</sup>

This described practice is called “memory-making.” Giving women this option is part of the standard of care after stillbirth, and also common in perinatal hospice and palliative care (PHPC).<sup>220</sup> Extensive and almost undisputed empirical evidence of women after stillbirth shows that this time with the baby psychologically benefits the mother.<sup>221</sup> There is no reason to think the same benefits wouldn’t inure in the abortion context when a woman chooses memory-making. The D&X gave women the ability to hold their child intact without requiring them to give birth with an induction abortion.<sup>222</sup> Thus, the D&X was a cheaper, less risky, and less invasive procedure that

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<sup>215</sup> Manian, *supra* note 199, at 259.

<sup>216</sup> See Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 225–31 (discussing D&X and D&E procedures and their mental and emotional effects on women).

<sup>217</sup> SANGER, *supra* note 214, at 151.

<sup>218</sup> *Id.*

<sup>219</sup> Joint Appendix at 43–44, *Gonzales v. Carhart*, 500 U.S. 124 (2007) (No. 05–380), 2006 WL 1440830.

<sup>220</sup> See *infra* notes 362–364 and accompanying text (discussing providers offering the option of memory-making).

<sup>221</sup> See *infra* notes 362–364 and accompanying text (discussing the potential benefits of memory-making).

<sup>222</sup> COHEN & JOFFE, *supra* note 109, at 209–11.

still allowed this type of memory-making.<sup>223</sup> Admittedly, far from all women who have D&Xs would desire memory-making, but as explored below, some find it beneficial and have fewer negative emotions if allowed to receive it.

Even though these bans theoretically allow D&E and D&X procedures to continue if fetal demise is initiated beforehand, studies show that fetal demise before a D&E can actually increase psychological difficulty for some women.<sup>224</sup> Though some women reported feeling that their abortion was more acceptable with fetal demise, others specifically expressed emotional difficulty when fetal demise was induced a day or more in advance of the procedure, as is common, because they were troubled by the idea of carrying a dead fetus. For the women who had started to feel fetal movement, the immediate cessation of movement could be jarring. Notably, some of the women who were ultimately reassured by the fetal demise were still troubled with the decreased fetal movement and carrying of a dead fetus. Women experiencing pregnancy loss echo these sentiments, describing having lost their agency in becoming “the passive vessel of a corpse. One woman described feeling like a ‘human coffin,’ another like ‘a living tomb.’”<sup>225</sup> Thus, there is not one-size-fits-all approach that justifies requiring all women who need second-trimester abortions to first instigate fetal demise. It is a helpful resource for many women, but a distressing one for others, and women should be able to choose if it would be beneficial to them.

Similarly, the possibility of induction abortion— as an alternative to fetal demise, still permissible under the statute—would also not protect women’s interests. Studies demonstrate that women prefer D&Es and D&Xs over induction abortion because induction abortion is almost identical to childbirth.<sup>226</sup> In a European study, some women who had induction abortions resented health professionals treating them in the same way that women in childbirth are treated and reported that delivering the fetus was traumatic and painful. One woman was especially distressed at the idea of the abortion occurring while lying back in a bed, just like childbirth. The authors explained that the similarities to childbirth detracted from the idea of second-trimester abortion as a necessary healthcare procedure.<sup>227</sup> The women who had a D&E

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<sup>223</sup> Though some memory making is available with a D&E, only the D&X allows women to hold an intact baby.

<sup>224</sup> See generally McNamara et al., *supra* note 120, 516–18 (describing the “varied understanding” of fetal demise among women and evaluating women’s experience with this procedure).

<sup>225</sup> LAYNE, MOTHERHOOD LOST, *supra* note X, at 86.

<sup>226</sup> See generally Purcell et. al., *supra* note 38, at 174–76 (recounting women’s experiences of second-trimester abortion by labor induction and its parallels to childbirth). The study describes that one group of women had an abortion by labor induction, which was called a “medication” abortion. *Id.* at 165. The other group had a D&E with fetal demise beforehand. *Id.*

<sup>227</sup> *Id.* at 180.

told very different stories, with much less emphasis on the specifics of the procedure itself.<sup>228</sup>

The similarities between induction abortions and childbirth are likely not lost on the anti-abortion movement. An induction equates abortion to childbirth—a defining experience of motherhood for many women.<sup>229</sup> Requiring birth would condition abortion on a woman’s willingness to confront her fetus and agree to deliver a child to force its death. The point is to make abortion distressing and painful, to shame them into continuing the pregnancy, to force them to choose between giving birth to a live child or a dead one. “Legislators have decided that some experience of one’s infant, if only childbirth itself, is necessary to grasp the profound nature of what is at stake in the decision to separate from one’s baby.”<sup>230</sup> Requiring fetal demise before a surgical abortion or requiring abortion via labor induction creates a medical experience similar to a woman whose pregnancy ends naturally before birth, in either late miscarriage or early stillbirth. Perhaps state legislators are hoping these similarities will “correct” women to act more like mothers.<sup>231</sup>

### B. Good Mothers and Children with Disabilities

The woman-protective rationale is also front and center in state defenses of disability-selective abortion bans and PHPC counseling laws. First, with respect to disability-selective abortion bans, states claim that a ban is needed to protect women who “feel ‘bullied’ into aborting their unborn child”<sup>232</sup> because doctors allegedly pressure or mislead women into abortions after prenatal diagnosis.<sup>233</sup> States claim that physicians “provide biased information”

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<sup>228</sup> *Id.* at 176 (“The accounts of women who had undergone surgical procedures thus appeared to be more distanced from the corporeality of the procedure....”).

<sup>229</sup> *SEE SANGER, supra* note 214, at 122 (describing state attempts to force women to feel like mothers before abortion).

<sup>230</sup> *Id.* Another way legislators can force women to confront their fetus is through mandatory ultrasound laws. *See Note, J. Aidan Lang, The Right to Remain Silent: Abortion and Compelled Physician Speech*, 62 B.C. L. REV. 2091, 2091–95 (2021) (discussing state laws that require informed consent and ultrasound prior to an abortion—including a mandate that physicians point out the fetus’s features to a patient as they conduct an ultrasound, which can be distressing for a woman who has chosen to terminate a pregnancy due to fetal abnormalities).

<sup>231</sup> Women who experience pregnancy loss are often pegged against those experiencing abortion, but the reality is that these two groups have a lot in common. We explore this issue in depth in a forthcoming paper.

<sup>232</sup> Def.’s Mem. in Supp. of Mot. to Dismiss, *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. State Dep’t of Health* at 15, No. 1:16–CV–763–TWP–DML (S.D. Ind. Oct. 26, 2016).

<sup>233</sup> Def Rsp. to Plf.’s Mot. for Summary Judgment, *EMW Women’s Surgical Ctr., P.S.C. v. Beshear* at 17, No. 3:19–cv–00178–DJH (W.D. Ky. Aug. 2, 2019).

and commit “overt or subtle bias or coercion.”<sup>234</sup> Not only do women (supposedly) need protection from bullying doctors, they also need it from themselves—their decision to abort, according to the state, will deny them the joy and psychological benefit of raising a child with special needs.<sup>235</sup> Essentially, the state thinks that parents will make decisions based on ableist stereotypes and should be prevented from doing so.

Sixth Circuit judges recently relied on both of these paternalistic ideas in upholding Ohio’s ban on abortions based on a fetal Down Syndrome diagnosis.<sup>236</sup> Specifically, the Sixth Circuit, in *Preterm-Cleveland v. McCloud*, explained the asserted state interest to protect “families from coercive healthcare practices” demonstrated by uncited “[e]mpirical reports” from parents that “doctors explicitly encouraged abortion or emphasized the challenges or raising children with Down syndrome.”<sup>237</sup> Judge Bush’s concurring opinion also suggested that this law will be good for parents and families because their child will make them happy: “79% of parents of children with Down Syndrome felt that ‘their outlook on life was more positive because of their child’ and 88% of people whose siblings have Down Syndrome felt that they were better people for their sibling’s presence in their life.”<sup>238</sup>

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<sup>234</sup> Brief of Defendants-Appellants, *Preterm-Cleveland v. Himes* at 18, 20, No. 18–3329 (6th Cir. June 22, 2018); *see also* Resp. in Opp. To Plf.’s Mot. for TRO/Prelim. Inj., *Memphis Ctr. for Reprod. Health v. Slatery* at 16, No. 3:20-cv-00501 (M.D. Tenn. July 6, 2020) (arguing that “medical professionals often pressure expectant mothers who receive a Down syndrome diagnosis to have an abortion and fail to provide them with accurate information about the child’s prognosis.”).

<sup>235</sup> Def. Resp. to Plf.’s Mot. for Summary Judgment, *supra* note 233, at 23; *see also* Brief of Appellants, *Reprod. Health Servs. of Planned Parenthood of the St. Louis Region et al., v. Parson et al.* at 19–21, Nos. 19–2882, 19–3134 (8th Cir. Nov. 14, 2019) (explaining that parents are happy with their decision to have their child with Down Syndrome and that the child brings joy to their families).

<sup>236</sup> *See Preterm-Cleveland v. McCloud*, 994 F.3d 512, 581–82 (6th Cir. 2021) (discussing the need for women to be protected from “coercive abortions”). Notably, The Sixth Circuit interpreted the ban as not a total ban because a pregnant patient could still receive an abortion if they did not reveal the basis. *Id.* at 522.

<sup>237</sup> *Id.* at 518. Logically, one would presume that this alleged pressure is exerted before a woman makes her decision, that is before she enters the abortion clinic. The state law, however, would affect only the doctor performing the abortion at the clinic.

<sup>238</sup> *Id.* at 549–50 (Bush, J., concurring). He also echoed and cited to Seventh Circuit Judge Marion’s partial concurring opinion, which concluded that Indiana’s Down Syndrome ban was constitutional because parents of children with Down Syndrome “are quite happy and lead fulfilling lives” and because children with Down syndrome are a joy to be around. *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r of Ind. State Dep’t of Health*, 888 F.3d 300, 316 (7th Cir. 2018), *reh’g en banc granted, judgment vacated*, 727 F. App’x 208 (7th Cir. 2018), *vacated*, 917 F.3d 532 (7th Cir. 2018), and *opinion reinstated*, 917 F.3d 532 (7th Cir. 2018), and *cert. granted in part, judgment rev’d in part sub nom.* *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780 (2019).

States also use the woman-protective rationale to justify restrictions on abortion in the case of life-threatening or fatal conditions. States claim, “the grieving process is actually better for the woman by actually going ahead and giving birth,”<sup>239</sup> and that women will experience “more despair and depression” if they terminate than if the child is stillborn or dies in hospice.<sup>240</sup> PHPC laws similarly note the purported psychological benefit of continuing a pregnancy after a fatal prenatal diagnosis. Arkansas’s “Women’s Right to Know” PHPC law expressly states that termination can cause women to experience more serious long-term mental health issues, whereas continuing the pregnancy with PHPC allows families to be “emotionally and spiritually prepared for the death of their child.”<sup>241</sup> A required brochure produced by the Indiana Department of Health<sup>242</sup> provides similar advice and also suggests that abortion can delay and complicate the healing process.<sup>243</sup> Whereas, “mothers who chose to carry their baby to term recover to baseline mental health more quickly than those who aborted due to fetal anomaly” accentuating that PHPC is psychologically safe for women.<sup>244</sup>

The idea that women are bullied into terminating after a prenatal diagnosis relies on the sexist stereotype of the incompetent or vulnerable pregnant woman overly susceptible to suggestion or persuasion, as does the state’s solution to ban these abortions.<sup>245</sup> First and foremost, it is important to note that studies contradict states’ claims that women are pressured into abortion after

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<sup>239</sup> Eric Adler, “I Would Have Delivered a Dead Baby.” *Missouri Law Denies Abortion for Fatal Disorders*, KAN. CITY STAR (Aug. 5, 2019), <https://www.kansascity.com/news/politics-government/article231942993.html> [https://perma.cc/28FF-9DTF].

<sup>240</sup> Arya Sundaram, *Texas Senate Removes Exception That Allows Abortion After 20 weeks if the Pregnancy is Unviable*, TEX. TRIBUNE (May 7, 2019), <https://www.texastribune.org/2019/05/07/texas-abortion-law-allowing-procedures-after-20-weeks-removed-senate/> [https://perma.cc/GY69-MADE].

<sup>241</sup> ARK. CODE ANN. § 20-16-2302(a)(4)–(5) (2021).

<sup>242</sup> *Perinatal Hospice*, IND. STATE DEP’T OF HEALTH, <https://www.in.gov/isdh/files/Perinatal%20Hospice%20Brochure.pdf> [https://perma.cc/NZH2-M5BG]. The brochure also warns of physical risks of terminating and claims childbirth has no increased risk. *Id.* But increased physical risks do exist in stillbirth. See Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. 666, 670–72 (2020) (discussing research showing that women face more life-threatening complications in stillbirth than in live childbirth); see also Elizabeth Wall-Wieler et al., *Severe Maternal Morbidity Among Stillbirth and Live Birth Deliveries in California*, 134(2) OBSTETRICS & GYNECOLOGY 310, 312 (2019) (explaining that the chances of life-threatening complications for the woman are nearly five times greater in a stillbirth than a live birth).

<sup>243</sup> *Perinatal Hospice*, *supra* note 242.

<sup>244</sup> *Id.*

<sup>245</sup> Siegal, *Why Restrict Abortion?*, *supra* note X, at 20 (“In addition to arguing that access to abortion threatened women’s health, Reardon also argued that access to abortion threatened women’s freedom. Women were coerced into abortions that traumatized them.”).

a prenatal diagnosis.<sup>246</sup> And this makes sense—what would motivate a woman’s doctor to encourage abortion? What stake would they have in that outcome? But even if it were true, the obvious solution would be to mandate neutral counseling that occurs at the time of diagnosis, not at the time of abortion. In fact, the federal Prenatally and Postnatally Diagnosed Conditions Awareness Act already attempts to provide additional resources to parents facing a prenatal diagnosis that are neutral and unbiased.<sup>247</sup> Instead, the state argues that women must be deprived of abortion as an option, suggesting that pregnant women cannot be trusted to make the right choice for themselves and their families *even with* accurate and unbiased information.

Similarly, the need to protect women from abortion after a prenatal diagnosis is also based on stereotypical, gendered notions of motherhood. The notion that motherhood is a gift regardless of a child’s disability relies solely on traditional gender stereotypes about “good” mothers, playing on the shame some women may already feel by considering abortion.<sup>248</sup> According to the archetype, a good mother would never choose to end her child’s life. She would embrace any disabilities affecting her fetus and selflessly give herself over as a caretaker regardless of the sacrifices that are entailed.<sup>249</sup> If her fetus suffered a life-threatening diagnosis, a good mother would want to savor the limited time she had left with her baby before he or she died—she would seek PHPC to ease her fears and experience the “life and death” of her child in a secure, supportive setting with her family.<sup>250</sup> These stereotypes, however, are not based on a woman’s actual experiences. Women who terminate after learning of a fetal anomaly often report doing so out of the love they have for their child and not wanting to watch their child suffer in this world.<sup>251</sup> Many

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<sup>246</sup> See e.g., Marijke J. Korenromp et al., *Maternal Decision to Terminate Pregnancy After Diagnosis of Down Syndrome*, 19 AM. J. OBSTETRICS AND GYNECOLOGY 149.e1, 149.e4 (2007) (explaining that only one woman in the entire study reported feeling pressure from her health care provider to terminate her pregnancy).

<sup>247</sup> Prenatally and Postnatally Diagnosed Conditions Awareness Act, Pub. L. No. 110–374, 122 Stat. 4051 (codified at 42 U.S.C. § 280g–8).

<sup>248</sup> See Nao Araki, *The Experiences of Pregnant Women Diagnosed with a Fetal Abnormality*, 24:2 J. JAPAN ACAD. MIDWIFERY 358, 361 (2010) (discussing the pressure a mother can feel in trying to be a “good mother”).

<sup>249</sup> See *id.* (discussing the isolation and uncertainty that women may experience in taking care of their child). Anti-abortion activists similarly attempted to shame women terminating due to fetal anomaly within the debate over D&X abortions before *Carhart*, describing even fatal anomalies “as inconveniences which callous parents used to justify abortion, but that loving parents should confront and overcome.” Oliveri, *supra* note 84, at 409–10.

<sup>250</sup> See MISS. CODE. ANN. § 41-41-141(2) (explaining why some women would choose PHPC).

<sup>251</sup> See Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 208–09, 226–28 (recounting a woman’s story of choosing to obtain an abortion and discussing the motivation behind decisions to terminate in the case of severe fetal anomaly).

women also terminate because they think it is in the best interest of their living children, who they also feel bound to protect.<sup>252</sup>

We do not challenge the fact that many parents who have children with disabilities love them unconditionally and are eternally grateful for their existence. But this is a self-selecting group of parents who had the option of terminating and chose to continue the pregnancy. It is inappropriate to extrapolate this positive experience onto parents who would have otherwise terminated. We also note that it is not surprising that women express joy in having a child. There is enormous pressure to publicly express gratitude for a child, even when one's feelings are more conflicted: the duty to embrace motherhood means that "regret over motherhood becomes inappropriate once a child is born."<sup>253</sup> These social pressures are so strong that it is difficult to evaluate the reliability of any study regarding the decision to have the child.<sup>254</sup> That is not to say that it is better for women to terminate in the face of a prenatal diagnosis—it's not. For any given family, the "best" decision will be different.

Further, studies show that women who choose to terminate a pregnancy after a prenatal diagnosis do not regret their decision, nor do women who continue the pregnancy.<sup>255</sup> Relatedly, for decades, tort law has recognized the reasonableness of a woman's choice to terminate a pregnancy due to a fetal diagnosis.<sup>256</sup> Specifically, a wrongful birth claim allows a woman to sue for

<sup>252</sup> Jamie R. Abrams, *The Polarization of Reproductive and Parental Decision-Making*, 44 FLA. ST. U. L. REV. 1281, 1309–10 (2017).

<sup>253</sup> Katrien Schaubroeck & Kristien Hens, *Parental Choices and the Prospect of Regret: An Alternative Account*, 25(5) INT'L J. PHIL. STUD. 586, 590 (2017).

<sup>254</sup> *Id.* at 589.

<sup>255</sup> See e.g., Korenromp et al., *supra* note 246, at 149.e3 (explaining that only 6% of women in a survey expressed regret over terminating, 75% of whom felt regret "occasionally" and 25% of whom felt regret "strongly"); Stina Lou et al., *Termination of Pregnancy Following a Prenatal Diagnosis of Down Syndrome: A Qualitative Study of the Decision-Making Process of Pregnant Couples*, 97 ACTA OBSTETRICS GYNECOLOGY SCANDANAVIA 1228, 1234 (2018) (discussing that couples did not regret their decision to terminate a pregnancy).

<sup>256</sup> See Jeffrey R. Botkin, *Prenatal Diagnosis and the Selection of Children*, 30 FLA. ST. U. L. REV. 265, 276 (2003) ("The single largest number of wrongful birth cases have been brought for failure to provide information about the risk of Down syndrome to women of 'advanced maternal age.'"); see e.g., *Wilkie v. Aslam*, No. BPG-08-1425, 2009 WL 3487903, at \*1 (D. Md. 2009) (discussing the issue of whether a physician was negligent in not informing a parent of the increased risk that her child would be born with Down Syndrome and whether the diagnosis was the proximate cause of needing to provide post-majority care); *Fruiterman v. Granata*, 668 S.E.2d 127, 129 (Va. 2008) (reversing a wrongful birth suit for lack of demonstrating proximate causation); see also Daniel W. Whitney & Kenneth N. Rosenbaum, *Recovery of Damages for Wrongful Birth*, 32 J. LEGAL MED. 167, 170–71 (explaining that wrongful birth cases are brought when children have severe birth defects versus "minor genetic defect[s]" and classifying down syndrome as a severe birth defect). That a wrongful birth claim has existed for decades, however, does not mean it is uncontroversial. See generally Lydia X. Z. Brown *Legal Ableism, Interrupted: Developing Tort Law & Policy Alternatives*



damages based on the lost ability to terminate her pregnancy due to medical malpractice in failing to diagnose or disclose birth defects. Courts have specifically rejected the idea of reducing a mother's damages for wrongful birth because of the joy she also may experience in raising her child—her joy does not justify depriving her of the ability to make an informed decision whether to terminate.<sup>257</sup> These studies and this history show that a woman is not better off psychologically or otherwise if forced to continue a pregnancy after a prenatal diagnosis. It is an immensely personal choice, and women are generally content with their choice either way.

Similarly, little to no evidence actually supports the state's argument that women are better off continuing a pregnancy even when the fetus is not expected to survive. In fact, actual PHPC research contradicts state's claims that PHPC is psychologically superior for women than terminating.<sup>258</sup> To the contrary, these researchers expressly conclude that women who choose to terminate and who choose to continue their pregnancy express a “*similar* rate of regret.”<sup>259</sup> A literature review in 2011 similarly concluded that women who choose to terminate later in the pregnancy due to fetal anomaly experience “no worse” mental health effects than women who continue their pregnancy and give birth to a baby with fatal or serious health conditions, or endure stillbirth or later miscarriage.<sup>260</sup> These researchers understand the reality that most women will suffer psychological distress regardless of their choice due to the inevitability of their child's death.

Admittedly, at least one study exists concluding that women who chose to continue their pregnancy reported less despair and depression than women

to *Wrongful Birth & Wrongful Life Claims*, 38(2) *DISABILITY STUD. Q.* (2018) (providing an overview of the history of wrongful birth claims).

<sup>257</sup> *Lodato ex rel. Lodato v. Kappy*, 803 A.2d 160, 165–66 (N.J. Sup. Ct. 2002).

<sup>258</sup> Denney-Koelsch & Côté-Arsenault, *supra* note 164, at 8.

<sup>259</sup> *Id.* (emphasis added); see also Marijke J. Korenromp et. al., *Adjustment to Termination of Pregnancy for Fetal Anomaly: A Longitudinal Study in Women at 4, 8, and 16 Months*, 201 *AM. J. OBSTETRICS & GYNECOLOGY* 160.e1, 160.e4 (2009) (discussing that “[i]n spite of the large and long-lasting psychological consequences of [termination] for fetal anomaly, < 3% of women at each occasion mentioned feelings of strong regret, “[t]here was clear improvement over time for all the women for all outcome measures” and “the majority of women adapted well to their loss.”).

<sup>260</sup> Julia A. Steinberg, *Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—A Critical Review of Research*, 21:3S *WOMEN'S HEALTH ISSUES* S44, S47 (2011). The study also pointed out that “factors associated with having later abortions may also put women at risk of psychological problems after later abortions” instead of the later abortion itself. They include the “reasons for the delay” in obtaining an abortion, “level of wantedness of the pregnancy, experiences of adverse life circumstances, mental health, demographic and economic factors, type of procedure, experiences of fetal movement, and stigma.” *Id.* at S45.

who chose to terminate their pregnancies after a lethal fatal diagnosis of anencephaly.<sup>261</sup> Numerous problems exist with the study, including its failure to account for the woman's mental health prior to the fetal diagnosis.<sup>262</sup> It also suggests that society more readily acknowledges and accepts stillbirth and infant death,<sup>263</sup> which runs contrary to other substantial research describing the isolation women feel after stillbirth and infant death.<sup>264</sup> The study also inaccurately implies that memory-making is available only after pregnancy continuation and not after abortion.<sup>265</sup> But perhaps the largest problem with the use of this study to regulate abortion is the fact that the study's findings depend on the woman's choice—that these women were offered and declined termination. One cannot extrapolate from them that women who are forced to continue pregnancies would fare as well psychologically as women who actively chose to continue the pregnancy. In fact, one could assume that given the traumatic nature of the circumstance, removing a woman's limited autonomy would only deepen her agony.

We want to conclude with a note about truly supported decision-making. It is certainly true that many parents are overwhelmed and scared when first learning of a prenatal diagnosis; they may not know what to expect in raising a child with special needs and may even default to ableist assumptions. That is why it is so important that they receive neutral and accurate information on the particular fetal anomaly at the time of diagnosis. In an ideal world, expectant parents would be connected to—and have time to connect with—parents who made either choice, to understand the reality of both experiences.

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<sup>261</sup> See Heidi Cope et al., *Pregnancy Continuation and Organization Religious Activity Following Prenatal Diagnosis of a Lethal Fetal Defect are Associated with Improved Psychological Outcome*, 35(8) *PRENATAL DIAGNOSIS* 761 (2015) (explaining that “[p]regnancy continuation was [] associated with less psychiatric distress, . . . less despair, avoidance and depression,” and that women who terminated were more likely to feel guilt).

<sup>262</sup> See Steinberg, *supra* note 260, at S45 (explaining that it is “important to consider how prior mental health [is] controlled for in analyses, because it is a strong predictive factor of mental health postpregnancy”).

<sup>263</sup> Cope et al., *supra* note 261, at 767.

<sup>264</sup> See Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents' and Physicians' Experiences of Stillbirth—A Qualitative Analysis*, 12 *BMC PREGNANCY & CHILDBIRTH* 1, 13 (describing that parents feel isolated due to “the awkwardness and discomfort felt by others when parents of a stillborn try to discuss their experience, or when they try to normalize it by mentioning their stillborn child alongside their live children as part of their family”); see also Samantha Murphy & Joanne Cacciatore, *The Psychological, Social, and Economic Impact of Stillbirth on Families*, 22 *SEMINARS IN FETAL & NEONATAL MED.* 129, 131 (2017) (“[S]tillbirth is a loss often unacknowledged and invalidated by society.”).

<sup>265</sup> See Cope et al., *supra* note 261, at 767 (“Continuing the pregnancy also allows more opportunities to find meaning and for memory making, such as opportunities to hold and care for the baby, take photographs, create other keepsakes and perhaps participate in research, tissue or organ donation, all of which can contribute positively to the grieving process.”).

Similarly, in case of a life-limiting fetal condition, the obstetrician or maternal fetal specialist should continue to provide information on, and referral to PHPC at the time of the prenatal diagnosis, long before the woman enters the abortion clinic.<sup>266</sup> Women should have access to this care regardless of their geography or economic means. For a woman to make a “fully informed decision” about whether to terminate or continue a pregnancy, she needs the most complete and accurate picture that can be provided at the relevant time.<sup>267</sup> Abortion laws only convolute this process—they force women to make rushed decisions and heavily burden one choice over the other. They do not protect women; they coerce and shame them.

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Part III demonstrates how the woman-protective rationales underlying these second-trimester abortion restrictions are paternalistic, dependent on gender stereotypes, and factually dubious or incorrect. Unfortunately, this defensive approach has not been sufficient to persuade courts to reject the woman-protective rationale underlying these second-trimester abortion restrictions. In *Carhart*, for instance, the Court’s analysis was based not on science, but the Justices’ intuition.<sup>268</sup> The Court even ignored some of the countervailing evidence presented above that the D&X helped some women avoid regret by saying goodbye. “[T]he great error of the *Carhart* majority’s invocation of emotional common sense” was to “privilege the individual Justices’ own emotional . . . reaction to the intact D&E method,” “ignore[] other permissible meaning structures” and “force[] a false consensus.”<sup>269</sup> Instead, the *Carhart* opinion actually permits the state to reach its own scientific conclusions, even if they are contradicted by the medical establishment.<sup>270</sup>

As a result, Part IV recommends a new approach to dismantling the woman-protective rationale underlying second-trimester abortion restrictions. It suggests that the abortion rights movement can fight back against

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<sup>266</sup> See *supra* note 167 and accompanying text (discussing when women are informed about PHPC).

<sup>267</sup> See ACOG Committee Opinion No. 786, *Perinatal Palliative Care*, 134 OBSTETRICS & GYNECOLOGY e84, e88 (2019) (explaining that “tenets of informed consent require that patients be presented with this full array of reasonable and ethically acceptable options” after a lethal fetal diagnosis, including abortion and perinatal palliative care).

<sup>268</sup> See Maroney, *supra* note X, at 901 (describing that Justice Kennedy thought the D&X procedure “morally (not just physically) disgusting”); see also Courtney Megan Cahill, *Abortion and Disgust*, 48 HARV. C.R.-C.L. L. REV. 409, 419–20 (describing Justice Kennedy’s focus on disgust in *Carhart*).

<sup>269</sup> Maroney, *supra* note X, at 901.

<sup>270</sup> The Court gave “legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.” *Gonzales v. Carhart*, 500 U.S. 124, 163 (2007).

many of the woman-protective claims with radical transparency about second-trimester abortion—transparency that will also improve patient care. Not only does this approach help combat the woman-protective rationale in litigation, but it might also help the abortion rights movement better frame public discussions regarding second-trimester abortion. If the Supreme Court rules in *Dobbs* that pre-viability abortion bans can be constitutional, the abortion rights movement will need new strategies to defend abortion rights across the country.

#### IV. EMBRACING ABORTION “DANGERTALK” TO REBUT THE WOMAN-PROTECTIVE RATIONALE

Despite its paternalism and inaccuracies, the woman-protective rationale has been a successful narrative in justifying abortion regulations, especially in the second trimester.<sup>271</sup> The success of the federal Partial Birth Abortion Act, and the Court’s affirmation of it in *Carhart*, should be an ominous warning about how the Court would consider these other second-trimester abortion laws with similar justifications, especially as the Supreme Court has become more conservative and hostile towards abortion rights in recent years.

We argue in this Part that the silence in canonical abortion rights discourse about the uncomfortable aspects of second-trimester abortion has given the woman-protective rationale more legitimacy and threatened abortion rights in the long term. We suggest that the abortion rights movement should more openly discuss the complicated aspects of second-trimester abortion—what emerging researchers and abortion providers have called abortion “dangertalk.”<sup>272</sup> The authors—mostly abortion providers—who coined the term used it to refer to aspects of abortion they see every day, but the abortion rights movement considers too taboo to discuss openly. Specifically, the article described that providers “wrestl[e] with views of abortion as killing, concerns (despite evidence against) about abortion causing fetal pain, causing patients pain, and the gruesomeness of dealing with fetal parts.”<sup>273</sup>

Abortion providers rarely feel free to discuss dangertalk topics openly or publicly. Rather, there is an assumption that if providers share their unfiltered abortion experiences, this will somehow threaten the success of the pro-choice movement. In particular, fear exists that some of these topics will only

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<sup>271</sup> See *id.* at 159 (discussing that women need protection from a choice that may come to regret).

<sup>272</sup> Martin et. al, *supra* note 25, at 80.

<sup>273</sup> *Id.*

perpetuate current anti-abortion messaging.<sup>274</sup> The providers asked a provocative and radical question in their article: “What would happen if, rather than shying away from the difficult, messy parts of abortion, the movement embraced them?”<sup>275</sup> After all, “[f]or these providers, struggling emotionally with aspects of the work wasn’t troubling, it was how they knew they were still thoughtful and engaged with the work.” Perhaps the same honesty would resonate with the public, many of whom likely struggle with some of these same concerns, even those who support abortion rights. Although their original article was written to better support abortion providers, the authors also suggested that dangertalk could be a potent tool to rejuvenate the abortion rights movement.<sup>276</sup>

Our Article sets out to do just that. We borrow the concept of dangertalk and build on it. We explain how an embrace of dangertalk topics in the context of second-trimester abortion could improve both patient care and rebut the woman-protective rationale. In Section A of this Part, we focus on two areas: the nature of second-trimester abortion procedures and the complex emotions second-trimester abortion can evoke for some patients.<sup>277</sup> Instead of openly confronting these topics in the public domain, national pro-choice messaging typically avoids them and pivots to comfortable talking points related to a woman’s autonomy. But this silence has allowed the anti-abortion movement to control and monopolize the narrative surrounding these abortions, while also suggesting that pro-choice leaders are dishonest and evasive. It also perpetuates abortion stigma by suggesting that women who terminate with a Dilation and Evacuation (D&E) or after a prenatal diagnosis *should* be silent. Ignoring these topics, in our opinion, is harming efforts to secure abortion rights. In Section B of this Part, we further argue that greater openness about the nature of second-trimester abortion procedures and the range of possible emotional responses following abortion will create the opportunity for more patient choice.<sup>278</sup> We recognize the risks and challenges associated with this openness, but aim to start the conversation of how embracing these taboo topics can actually strengthen abortion rights. Put simply, the abortion rights movement can best protect women by embracing radical transparency and increased choice in second-trimester abortion care.

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<sup>274</sup> *Id.*

<sup>275</sup> *Id.*

<sup>276</sup> *Id.*

<sup>277</sup> See *infra* notes 279–**Error! Bookmark not defined.** and accompanying text.

<sup>278</sup> See *infra* notes **Error! Bookmark not defined.**–396 and accompanying text

### A. *The Harm of Avoiding the Uncomfortable Truths*

Second-trimester abortion care involves uncomfortable realities that many in the abortion rights movement would rather not discuss. This Article focuses on two in particular: First, second-trimester abortion procedures involve the removal of a fetus in parts. Second, abortion generally—and especially in the second trimester—can cause complicated emotions, including grief. This Part also describes the harms of avoiding these uncomfortable realities.

In 2008, Lisa Harris, an abortion provider and professor at the University of Michigan medical school, wrote an article entitled “Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse”—a precursor to the dangertalk paper, which she also helped author.<sup>279</sup> In it, she described the “violence in abortion, especially in second trimester procedures,” where the fetus is removed in parts.<sup>280</sup> She speaks openly about the reality of a D&E procedure—including the simultaneous awe and disregard she has for the fetal parts after the procedure ends. She notes that “there can be legitimate feelings that first and second trimester abortions are qualitatively and emotionally different” because “[r]emoving a microscopic fetus and gestational sac is visually and viscerally different from removing what looks like a fully formed but small baby.”<sup>281</sup>

Harris turns a critical eye on the movement she supports and notes that “[t]he pro-choice movement has not owned or owned up to the reality of the fetus, or the reality of fetal parts.” Instead, “the violence and, frankly, the gruesomeness of abortion is owned only by those who would like to see abortion (at any time in pregnancy) disappear, by those who stand outside clinics and in front of sports arenas holding placards with pictures of fetal parts and partially dismembered fetal bodies.”<sup>282</sup> Harris has noted that the traditional abortion-rights response to images of fetal parts on signs outside of abortion clinics is dismissal—that the pictures are not real or that the falsely portray what abortions look like.<sup>283</sup> It is true that those images do not represent first-trimester abortions, which are the vast majority of abortions, but to the medical team performing second-trimester abortions, those poster images

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<sup>279</sup> Harris, *supra* note 26, at 74.

<sup>280</sup> *Id.* at 76.

<sup>281</sup> *Id.*

<sup>282</sup> *Id.*; see also Lena R. Hann & Andrea Becker, *The Option to Look: Patient-centered pregnancy Tissue Viewing at Independent Abortion Clinics in the United States*, 28(1) SEXUAL & REPROD. HEALTH MATTERS 500, 501 (2020) (“Most people can only learn about what aborted fetal tissue looks like through anti-abortion imagery and misinformation.”)

<sup>283</sup> Harris, *supra* note 26, at 77; see also ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 161 (explaining the strategic decision to not focus on the specifics of the D&X procedure).

may realistically look like the images they see during and after the procedure.<sup>284</sup>

So how does Harris reconcile her abortion practice with the nature of the procedure? At least some of it has to do with her belief—shared by many abortion rights supporters—that “*declining* a woman’s request for abortion [is] also . . . an act of unspeakable violence.”<sup>285</sup> It is violent to require a woman to endure the significant risks and burdens of pregnancy and childbirth against her will, and for a child she does not want.<sup>286</sup> The irony is that many people are disgusted when they hear the specifics of any invasive medical procedure, including childbirth, which can be quite gruesome.<sup>287</sup> Furthermore, the landmark Turnaway study has shown that women denied an abortion not only experience the physical trauma of birth, but also the long-term negative effects on their mental and physical health, financial stability, and life satisfaction.<sup>288</sup> Thus, there is no easy way out. Both giving and declining a second-trimester abortion involves violence—the question is upon whom will the violence be administered, the fetus or the woman?

We will pause here to note that the question of violence is likely iterative of concerns regarding the moral value of the pregnancy. No one would discuss the surgical removal of an organ or tumor in terms of violence, no matter how “gruesomely” it was removed. Yet for many people, even those who support abortion rights, a fetus is categorically different than an organ or tumor because it is a potential life.<sup>289</sup> And therefore, the way the abortion occurs matters to these individuals, who might be uncomfortable with the idea of removing a live fetus in parts, even if the fetus cannot feel pain until much later in the pregnancy. Of course, this position is far from universal, and we do not want to implicitly endorse any perspective on this matter by adopting the term “violence” to describe an abortion procedure. Instead, we discuss the nature of second-trimester abortion procedures without relying on any descriptive, evocative terms.

<sup>284</sup> Harris, *supra* note 26, at 77.

<sup>285</sup> *Id.*

<sup>286</sup> *Id.*; Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 730–34 (2018) (describing the unwanted, forced and in some situations, unconsented-to, surgeries that women are experiencing in childbirth, such as cesareans, episiotomies, labor induction, and delivery using vacuums and forceps);

<sup>287</sup> See Maroney, *supra* note 268, at 900.

<sup>288</sup> DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING—OR BEING DENIED—AN ABORTION* (2020); Donley et al., *The Legal and Medical Necessity of Abortion Care Amid the COVID-19 Pandemic*, 28 J.L. & Biosciences 1,11 (2020).

<sup>289</sup> See Maroney, *supra* note 268, at 901 (“The disgusting aspect of this procedure is regarded as noteworthy only because it involves destruction of a semi-developed fetus, and this regard reflects a moral valuation—reliant on the belief system revealed above—of the status and worth of that fetus.”).

The second uncomfortable truth is the possible emotional complexity of abortion for some women, a complexity more likely to present in second-trimester abortion.<sup>290</sup> Two dominant narratives exist regarding a woman's emotional experience with abortion. The anti-abortion side claims that women feel regret, and the abortion rights side claims that women feel relief.<sup>291</sup> These narratives are then used to portray these women either as victims who feel regret or as autonomous beings who feel relief.<sup>292</sup> Although this is starting to change, canonical abortion rights discourse fails to recognize possibility of other emotions, much less the possibility of multiple emotions at once.<sup>293</sup>

Though studies consistently demonstrate that the vast majority of women who terminate a pregnancy feel relief, this finding is also reductive.<sup>294</sup> The relief a women may feel after an abortion does not negate other painful emotions that may also exist. "Emotional responses to abortion are complex, and it is natural to be simultaneously satisfied with a particular decision and experience both painful and positive feelings."<sup>295</sup> One study found that even though relief was the most common emotional response to abortion, thirty percent of women felt some (or all) negative emotions after their abortion.<sup>296</sup> Emotional complexity is even more likely in the second trimester with 57% of women in one study reporting both positive and negative emotions, and grief being the most commonly reported emotion, reported by 67% of women.<sup>297</sup> Though grief was more common in women terminating intended

<sup>290</sup> Andrea Becker & Lena R. Hann, "It Makes it More Real," Examining Ambiguous Fetal Meanings in Abortion Care, 272 *Social Science & Medicine* 1, 2 (2021) (describing grief after abortion as a "thing we cannot say" in abortion rights discourse).

<sup>291</sup> Jody Lynee Madeira, *Aborted Emotions: Regret, Relationality, and Regulation*, 21 *MICH. J. GENDER & L.* 1, 4–5 (2014).

<sup>292</sup> *Id.* at 4; see Tracy A. Weitz et al., *You Say "Regret" and I Say "Relief": A Need to Break the Polemic About Abortion*, 78 *CONTRACEPTION* 87, 87 (2008) (describing the "relief/regret polemic").

<sup>293</sup> Corinne H. Rocca et al., *Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States*, 45 *PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH* 122, 123 (2013) ("In the United States, where abortion is particularly politicized, debates over its emotional effects have often focused on regret versus relief, while more complex emotional experiences have received less consideration. With a few exceptions, studies have not quantitatively assessed the extent to which negative emotions—including regret—are accompanied by positive ones.").

<sup>294</sup> Weitz et al., *supra* note 292, at 87; Corinne H. Rocca et al., *Emotions And Decision Rightness Over Five Years Following An Abortion: An Examination Of Decision Difficulty And Abortion Stigma*, 248 *SOC. SCI. & MED.* 1, 4 (2020).

<sup>295</sup> Madeira, *supra* note 291, at 12; see also Weitz et al., *supra* note 292, at 88 (explaining that emotions after abortion can range "from sadness to elation and everything in between, and even many emotions simultaneously").

<sup>296</sup> Rocca et al., *Emotions and Decision Rightness*, *supra* note 287 at 4.

<sup>297</sup> Inga-Maj Andersson, et al., *Experiences, Feelings and Thoughts of Women Undergoing Second Trimester Medical Termination of Pregnancy*, 9 *PLoSOne* 1, 9 (2014). Another



pregnancies, the same study noted that a majority of women terminating unintended pregnancies in the second trimester also felt grief.<sup>298</sup> Women needing second-trimester abortion are also more likely to feel anxiety about fetal pain; shame, stigma, and embarrassment due to the timing of the abortion; and confusion and wariness due to lack of familiarity with the actual mechanics of second-trimester abortion.<sup>299</sup> The emphasis on relief ignores those other possibly painful feelings and alienates women who have them.<sup>300</sup>

One specific emotion abortion rights advocates have been careful to avoid is the idea of “post-abortion grief.”<sup>301</sup> The fear is that acknowledging abortion grief might be improperly equated with abortion regret. But “loss and regret are two different things.”<sup>302</sup> It is entirely possible, and may even be common, for a woman to feel that she made the best decision for herself, yet still experience sadness or grief. One legal scholar has noted that “the possibility of loss . . . does not trigger a moral or a legal claim against abortion—[i]nstead it seeks to open a wider space in which to discuss how women may experience aspects of abortion.”<sup>303</sup> Acknowledging complex emotional responses is “not a prediction or endorsement; it is simply recognition.”<sup>304</sup> “Even from a pro-choice point of view, we should understand what it is like for a woman to choose abortion and what it is like for her to hold to that choice with an image of her fetus in her mind’s eye.”<sup>305</sup> This sentiment is only more powerful in the context of second trimester abortion when the fetus’s presence may be physically visible outside her body and she may have felt it move inside her body.

Acknowledging and supporting women through these complex emotions, is not irreconcilable with the decision to terminate. Studies demonstrate that women believe that abortion was the right choice regardless of complex

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study noted that “[s]maller proportions of women in the first-trimester group than of those in the near-limit group expressed regret (33% vs. 41%) and sadness (61% vs. 68%)” after their abortion, even though over 90% of women in both groups felt relief. Rocca et al., *Women’s Emotions*, *supra* note X, at 124.

<sup>298</sup> Andersson, et al., *supra* note X, at 17. Professor Madeira uses the phrase “consented but unwanted abortion” to help explain that a woman’s emotional experience with abortion is complicated. Madeira, *supra* note 291, at 51. These are women who consent to the abortion, but “might choose differently if circumstances were other than what they are—if they had a healthy fetus, more economic resources, greater flexibility with employment or education, or stronger social supports to make parenthood a workable option.” *Id.* at 52.

<sup>299</sup> Andersson, et al., *supra* note X, at 10-13. See also Purcell et al., *supra* note X at 178-79 (explaining that women can find second-trimester abortion “a largely unknown, unexpected, and challenging process”).

<sup>300</sup> Weitz et al., *supra* note 292, at 88.

<sup>301</sup> Madeira, *supra* note 291, at 22.

<sup>302</sup> SANGER, ABOUT ABORTION, *supra* note 214, at 133.

<sup>303</sup> *Id.* at 134.

<sup>304</sup> *Id.* at 133.

<sup>305</sup> *Id.* at 135.

or negative emotions.<sup>306</sup> Indeed, 84% of women whose primary emotional response to abortion was negative, felt that abortion was the correct choice one week later.<sup>307</sup> Even among women who reported feeling regret, 89% of them thought they had made the right choice one week later.<sup>308</sup> “Despite the common framing of emotional outcomes as either relief or regret, nine in [ten] women in the near-limit group who reported regret also reported relief.”<sup>309</sup> This demonstrates that the public framing of post-abortion emotions is inconsistent with many women’s lived experiences.

The national abortion rights messaging avoids both of these uncomfortable truths for the same reason—the risk of ceding ground to the anti-abortion movement.<sup>310</sup> They may also be worried that transparency about the nature of second-trimester abortion procedures could harm the women seeking the abortion, who remain steadfast in their choice, but feel more distressed or guilty about the procedure. Similarly, the pro-choice movement is worried that discussing potential feelings of loss after an abortion may sound dangerously close to regret.<sup>311</sup> Any acknowledgement of complex emotions including possible grief or loss, would “be celebrated” by the anti-abortion side “as an authentic moment of true confession” that the abortion was a mistake.<sup>312</sup> As a result, pro-choice activists have strategically avoided discussing the emotional complexity of abortion as a potential strategy.<sup>313</sup> Even worse, “[i]n pro-choice scripts, a woman who does feel regret or remorse seems at best confused and non-autonomous and at worst a traitor to women’s rights or feminism.”<sup>314</sup> Little room for nuance exists in canonical pro-choice discourse.

The studied silence approach was famously unsuccessful in *Carhart*. The abortion rights movement made serious errors in defending the Dilation and Extraction (D&X) abortion procedure.<sup>315</sup> When confronted with arguments about the “gruesomeness” of the procedure, abortion rights activists

<sup>306</sup> Andersson, et al., *supra* note X, at 20; Rocca et al., *Emotions And Decision Rightness*, *supra* note 287 at 4.

<sup>307</sup> Rocca et al., *Women’s Emotions*, *supra* note X, at 127.

<sup>308</sup> *Id.*

<sup>309</sup> *Id.*

<sup>310</sup> Purcell et. al., *supra* note 38, at 166.

<sup>311</sup> SANGER, ABOUT ABORTION, *supra* note 214, at 133.

<sup>312</sup> *Id.*; *see also* Weitz et al., *supra* note 292, at 87 (describing the difficult balance of honestly discussing a woman’s emotional needs regarding abortion “without ceding ground to those who use these needs to develop regulations that will make abortion illegal and/or less available”).

<sup>313</sup> SANGER, ABOUT ABORTION, *supra* note 214, at 133.

<sup>314</sup> Madeira, *supra* note 291, at 39.

<sup>315</sup> *See* Jeanie Ludlow, *Sometimes It’s a Child and a Choice: Toward an Embodied Abortion Praxis*, 20:1 NAT’L WOMEN’S STUDIES ASSOC. J. 26, 38-39 (2008). (describing the pro-choice failed defenses that the procedure was rare and only in cases where the woman’s health

ignored the particulars of the procedure and attempted to re-focus the discussion exclusively on “politically correct” stories—the stories of women who had a D&X after learning of fetal anomaly in a wanted pregnancy.<sup>316</sup> But this was misleading, as the majority of women who had a D&X did so without fetal anomaly, making the movement look dishonest and untrustworthy, while at the same time perpetuating the dichotomy of the “good” and “bad” abortion. The silent approach also capitulated the narrative to anti-abortion activists—who take advantage of it—inundating Americans with the uncontradicted narrative that the procedure itself was inhumane.<sup>317</sup> The anti-abortion strategy has long focused on the nature of second-trimester abortion procedures, ensuring that the public is well aware of the pictures of fetuses and fetal parts.<sup>318</sup> They set the stage, painting the picture of exactly how “gruesome” the procedure is. The lack of a response makes abortion rights activists look like they are hiding something.<sup>319</sup>

This silence trap is also the paradigmatic way that stigma operates: “[s]tigma keeps people silent about their personal experiences, and silence feeds public complacency with political attacks and destructive myths.”<sup>320</sup> Thus, later abortions, and abortions on the basis of fetal anomaly, become

or the fetus’s health were at issue); *see also* ZIEGLER, ABORTION AND THE L. IN AM., *supra* note **Error! Bookmark not defined.**, at 160 (describing the “public relations nightmare” that occurred when an abortion rights advocate admitted that thousands of D&X abortions were performed, instead of the hundreds he had initially estimated); Madeira, *supra* note 291, at 24 (“After the Partial Birth Abortion Act’s passage . . . advocates first claimed the technique was ‘used rarely and largely in cases of fetal anomaly or death’ instead of educating why the procedure was safer than others, resulting in a ‘loss of credibility’ and a loss of opportunity for public education.”).

<sup>316</sup> *See supra* note 315 and accompanying text (discussing the approach abortion rights activists took).

<sup>317</sup> *See* Ludlow, *supra* note **Error! Bookmark not defined.**, at 41 (describing the pro-choice response to the “gruesomeness” of the D&X as “disappointingly weak”).

<sup>318</sup> Ludlow, *supra* note **Error! Bookmark not defined.**, at 37.

<sup>319</sup> *Id.* at 38–39. Other misinformation that the silence surrounding the specifics of abortion procedures can perpetuate was the Center for Medical Progress’s release of heavily edited videos purporting to show that abortion clinics were selling fetal tissue and “baby parts.” Planned Parenthood later sued the Center and was awarded over \$2 million in compensatory and punitive damages and injunctive relief. *See generally* Planned Parenthood Fed’n of Am., Inc., v. Ctr. for Med. Progress, No. 16–cv–00236–WHO, 2020 WL 2065700 (9th Cir. Apr. 29, 2020) (holding that Planned Parenthood was entitled to relief due to trespass, fraudulent misrepresentations, fraud, and violation of numerous recording laws). The National Abortion Federation has also obtained injunctive relief against the Center for Medical Progress. *Nat’l Abortion Fed’n v. Ctr. for Med. Progress*, 685 Fed. App’x. 623 (9th Cir. 2017) These lies would be less possible if clinics were more transparent as to their operations—including when and why aborted fetal tissue is donated and the important, life-saving research that it enables.

<sup>320</sup> #Goodbye Stigma, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/planned-parenthood-pacific-southwest/campaigns/good-bye-stigma> [https://perma.cc/DP6T-MKCJ].

shameful because they aren't often discussed.<sup>321</sup> Greater openness can help the movement destigmatize this care. We acknowledge the valid fears that the public would be disturbed by the specifics of second-trimester abortion procedures and would not understand memory-making.<sup>322</sup> But silence has not kept these uncomfortable truths hidden.

Perhaps transparency could do better. After all, with the exception of absolutists on both sides of the spectrum, most people's views on abortion are nuanced.<sup>323</sup> And acknowledging and recognizing the complexity of abortion might humanize the issues. Admittedly, pithy messages—like “my body, my choice”—are easier to communicate and comprehend. Transparency about second-trimester abortion procedures and the emotional complexity surrounding these procedures does not translate into an easily digestible message. But one can see threads of our proposal in newer campaigns like, “Shout Your Abortion,” where women are attempting to de-stigmatize abortion care generally.<sup>324</sup> These women are telling their stories with the nuance that is often ignored in public messaging. This nuance is vitally important and far superior to the stigmatizing silence that capitulates the narrative to the anti-abortion community.<sup>325</sup>

### *B. Improving Abortion Care by Increasing Choice*

Thus far, we have endorsed a new strategy that more openly confronts the nature of second-trimester abortion procedures and the emotional complexity that second-trimester abortion can evoke for some women. In this section, we argue that this greater openness on the uncomfortable truths of

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<sup>321</sup> Later abortions have always been the subject of abortion stigma. *See generally* Norris et al., *supra* note **Error! Bookmark not defined.** (discussing the stigma associated with abortion). Historically, however, abortions based on fetal anomaly were considered some of the least stigmatized abortions. Ziegler, *The Disability Politics of Abortion*, *supra* note X, at 626–27. But as the national conversation related to disability discrimination has shifted over time, that assumption is changing.

<sup>322</sup> *See* Hann & Becker, *supra* note 282, at 505 (explaining that even some staff at a clinic do not understand “why a patient would request to view tissue”); *see also* Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 18 NEV. L. J. 955, 965–66 (2019) (explaining that the public does not understand why a woman would want to hold her stillborn child).

<sup>323</sup> For instance, as noted above, most Americans support abortion in some, but not all, circumstances. Only 8% support abortion in all cases throughout pregnancy, and only sixteen percent are opposed to it in all cases throughout pregnancy. Crary & Fingerhut, *supra* note 12. Eighty percent fall in the middle.

<sup>324</sup> *Shout Your Abortion*, SHOUTYOURABORTION.COM, <https://shoutyourabortion.com/> [<https://perma.cc/69EG-WCQE>].

<sup>325</sup> And some pithiness may still be possible. Professor Madeira recently applauded Planned Parenthood's 2014 “Not in Her Shoes” campaign, which attempts to move beyond the simplistic labels “pro-choice” and “pro-life”—for its effort to move away from the easy, traditional narratives. Madeira, *supra* note 291, at 22–23.

second-trimester abortion could more effectively rebut the woman-protective rationale and improve patient care. We imagine a consent-based framework in which women who receive second-trimester abortions are given the option to learn more about the specifics of the D&E abortion procedure, alternative procedures, and the option of memory making. We then describe how this patient-centered transparency—and the choices that come with it—will do more to rebut the woman-protective rationale than simply refuting the underlying premises.

Though we are advocating for more patient choice, it is worth noting at the outset that disclosures in the context of abortion care have a long and frustrating history. Abortion has been singled out for special treatment time and time again.<sup>326</sup> Unlike other medical procedures, where doctors are trusted to obtain consent before providing the care and policed after-the-fact by tort law, state laws often mandate particular disclosures before abortion and require waiting periods thereafter. Those mandated disclosures often encourage childbirth over abortion or flat out lie: providers might have to disclose, incorrectly, that fetuses feel pain, that personhood starts at conception, or that abortion is psychologically harmful, hurts future fertility, or could cause breast cancer.<sup>327</sup> Some might worry that suggesting additional disclosures is tone deaf to this reality and would only increase the burden on abortion providers.

We argue below, however, that more information on abortion procedures and more resources to help patients process complex emotions could on the whole be very helpful for second-trimester patients. Nevertheless, this does not mean that every patient needs to receive the same information. Outside of legally mandate disclosures, the abortion counseling community already operates on the presumption that “abortion care is not a one-size-fits-all proposition” and that patients need to be met where they are.<sup>328</sup> Patients are provided the counseling that *they* need. If a woman has already reflected on the decision, is certain of her choice, and not experiencing complex emotions about it, she should not be forced to sit through additional, unnecessary disclosures that may make her feel like she *should* feel more complicated.

It can be a challenge to identify the patients that need extra counseling and resources. Fortunately, some providers have started using tools to help them. Some, for instance, use an intake form that asks patients about their level of certainty about the abortion and their beliefs about the pregnancy, including whether they view the fetus as a child.<sup>329</sup> Patients who indicate

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<sup>326</sup> Cohen & Jofee, *supra* note X, at 157.

<sup>327</sup> *Id.* at 149-50.

<sup>328</sup> *Id.* at 146.

<sup>329</sup> *Id.* at 169.

more uncertainty or moral ambiguity about the abortion will receive more in-depth counseling. This patient-controlled approach squares nicely with our proposal. In our view, every second-trimester abortion patient should have the opportunity to learn more about the D&E procedure, possible alternatives, and resources to help them process complex emotions. But only if they want or need it. Therefore, when we explain below how dangertalk subjects should be incorporated into patient care, we are doing so with the endorsement of models that allow women to opt out if they do not want to know more. And because the second-trimester abortion patient population is so small, it should not be overly burdensome to provide.

In Subsection 1, we discuss how transparency beyond informed consent with regard to abortion procedures can promote greater patient autonomy and patient choice in second-trimester abortion care.<sup>330</sup> In Subsection 2, we discuss how abortion providers can help patients process complex emotions through memory making.<sup>331</sup>

### 1. Transparency Beyond Informed Consent

In *Carhart*, Justice Kennedy suggested that because the decision to terminate is “so fraught with emotional consequence,” some providers may not wish to provide patients with details of the procedures, and instead, only disclose what is required, such as potential risks of the procedure.<sup>332</sup> As *Carhart* implies, informed consent law does not require transparency about the particulars of a procedure.<sup>333</sup> Before a patient has their appendix removed, for instance, physicians are not required to explain the exact details of how the appendix will be removed.<sup>334</sup> Similarly, informed consent law does not require a doctor to disclose the specifics of an abortion procedure. Instead, it simply requires that doctors explain the risks, benefits, and alternatives to the procedure, which abortion providers do as a matter of course before every abortion.<sup>335</sup>

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<sup>330</sup> See *infra* notes 332–**Error! Bookmark not defined.** and accompanying text.

<sup>331</sup> See *infra* notes 355–396 and accompanying text.

<sup>332</sup> *Carhart v. Gonzales*, 500 U.S. 124, 159 (2007).

<sup>333</sup> See DAN B. DOBBS ET AL., *HORNBOOK ON TORTS* § 21.9, at 513 (2d ed. 2016) (“[T]he materiality rule does not require detailed disclosure of methods unless they are unusual or affect the risks.”); see also *Masquat v. Magurie*, 638 P.2d 1105, 1105 (Okla. 1981) (ruling that disclosure of the different methods of performing a tubal ligation was not required).

<sup>334</sup> DOBBS ET AL., *supra* note X, at 513.

<sup>335</sup> *Id.* Some states mandate that a “description of the proposed abortion method” be disclosed beforehand as part of informed consent statutes. See e.g., ARK. CODE ANN. § 20-16-1703(b)(1)(B)(i) (West 2021); KAN. STAT. ANN. 65-6709(a)(2); LA. REV. STAT. § 1061.17(B)(3)(b)(i) (West 2020).

Even if not required, however, explaining the details of the abortion procedure has real benefits. First, it fights against the critique that abortion providers are hiding important facts from women. With transparency that exceeds legal requirements, the state can no longer claim the need to protect women from the regret they will feel once they learn of the “gruesomeness” of the D&E procedure.<sup>336</sup> If it is “precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State,” then giving women this information will remove the state’s woman-protective interest. It would also rebut the argument that women need to be protected from doctors because providers are misleading and hiding information from their patients. We suspect this above-and-beyond transparency will be more effective than calling out the sexist stereotypes that suggest women need protection.

Moreover, the anti-abortion movement has been able to find women to testify in amicus briefs that no one disclosed the nature of the D&E before the abortion, and that once they learned of the specifics, they regretted their decision—the same type of stories offered during the D&X litigation.<sup>337</sup> These stories create misleading facts that harm abortion rights in both litigation and the public image. If doctors routinely disclosed the particulars of the D&E procedure, these briefs would be more difficult to support.<sup>338</sup> Though abortion providers do not need to dwell on the details of the procedure, women should have the opportunity to learn that their fetus will be removed in parts and that, though there is no evidence to suggest a fetus can feel pain before twenty-nine weeks, the fetus will die during the course of the procedure unless fetal demise is induced beforehand.<sup>339</sup>

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<sup>336</sup> Def.’s Mem. In Opp. To Plf.’s Motion For Prelim. Injun., *Bernard v. Individual Members of Indiana Med. Licensing Bd.*, at 14, No. 1:19-cv-1660-SEB-DML (S.D. Ind. May 17, 2019) (citations omitted).

<sup>337</sup> See generally Brief of Sandra Cano, the Former “Mary Doe” of *Doe v. Bolton*, and 180 Women Injured by Abortion as Amici Curiae in Support of Petitioner, *Gonzales v. Carhart*, No. 05-380, 2006 WL 1436684, at \*17 (U.S. 2006) (discussing receiving over 3,500 pages of testimony from women describing their post-abortion experiences).

<sup>338</sup> If every second trimester abortion patient were given this information, it would theoretically be impossible to find women to sign onto similar briefs absent perjury. However, patient memories regarding informed consent are far from perfect, and perjury might be more common for abortion rights litigation where individuals feel like their false testimony could “save unborn lives.”

<sup>339</sup> See Soc’y of Fam. Planning, *Induction Of Fetal Demise Before Abortion*, *supra* note 85, at 464 (“A multidisciplinary review of the medical evidence concluded that a fetus cannot experience pain until 29 weeks of gestation at the earliest, when thalamocortical connections are first present.”).

Transparency also promotes patient autonomy. Only when providers disclose comprehensive information can a woman “act[] with true procreative liberty” and autonomy.<sup>340</sup> Once the disclosure is made about the nature of the procedure, women who have genuine concerns may decide not to terminate. For instance, some women might feel a connection to their fetus that could make them more concerned about how a termination occurs. “It is disingenuous to argue that removing a fetus is no different from removing a fibroid”—at least for some women.<sup>341</sup> If this information could change some women’s minds about whether to receive the abortion or what kind of abortion they desire, it should be provided. No abortion provider wants women to have abortions they don’t want.<sup>342</sup> Though we think very few women would reach this conclusion, they should have the information that would allow them to.

This transparency also opens the possibility of greater choice in second-trimester abortion care. In particular, women should be presented with the various types of second-trimester abortion so that they can choose between them. Giving patients more choices over the procedure would more clearly mirror first-trimester abortion practice, where options for both medication abortion or surgical abortion exist.<sup>343</sup> Currently, in second-trimester abortion care, women are typically only given the option of a D&E.<sup>344</sup> We believe women should have the option of learning about alternatives, including induction abortion and the possibility of inducing fetal demise before either a D&E or D&X. An induction abortion or D&X might be particularly helpful or appealing for women terminating a wanted pregnancy or those who have emotionally connected with their fetus. These women are more likely to experience grief and desire closure. For some women, induction abortion could also ease the stigma associated with abortion by creating an experience that mimics and even looks like stillbirth.<sup>345</sup>

But even women who do not feel an emotional connection to their fetus might still be anxious about the nature of the procedure. Qualitative research demonstrates that some women are more comfortable to know that their fetus

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<sup>340</sup> Seema Mohapatra, *Law in the Time of Zika: Disability Rights and Reproductive Justice Collide*, 84 BROOK. L. REV. 325, 352 (2019).

<sup>341</sup> Harris, *supra* note 26, at 75.

<sup>342</sup> Cohen & Joffe, *supra* note X, at 149.

<sup>343</sup> See generally Wendy Simonds et al., *Abortion, Revised: Participants in the U.S. Clinical Trials Evaluate Mifepristone*, 46:10 SOC. SCI. MED. 1313 (1998) (describing a woman’s choices and experiences regarding different first-trimester abortion methods).

<sup>344</sup> See generally Donovan, *supra* note 109 (discussing the implications of banning D&E abortion procedures on second-trimester abortions).

<sup>345</sup> Stillbirth, however, can also create its own stigma with some characteristics similar to abortion stigma. See Pollock, *supra* note **Error! Bookmark not defined.**, at 166 (discussing stigma associated with abortion and stillbirth).



had died before a D&E began, while other women find it disturbing to carry a dead fetus before an abortion.<sup>346</sup> Given these varied preferences, the best solution is to give women the option of fetal demise before an abortion, if she desires. Providing this additional option would rebut the argument presented in the states' briefs that women prefer fetal demise even though it is typically not performed, and it should therefore be mandated.<sup>347</sup> If a patient chooses fetal demise, the provider could also discuss the possibility of a D&X, which would become legal.

Of course, women should also be told of the costs and risks associated with these alternative procedures. With respect to fetal demise before a D&X or D&E, women should first be told unequivocally that no evidence exists that a fetus can feel pain in the second trimester—which might relieve any discomfort women have at the idea of a D&E or D&X without fetal demise.<sup>348</sup> If the woman still desires fetal demise, she should be told that the primary method for inducing demise involves injecting a life-ending medication into the fetus's heart, and that this procedure involves extra risks and discomfort, increased costs, and a longer abortion experience.<sup>349</sup> The other method of fetal demise does not create additional risks and burdens, but is also less reliable and might not work in an individual case.

As to induction abortion, it can be prohibitively expensive given that it often requires days of inpatient care at a hospital.<sup>350</sup> Many women may not be able to afford this unless their insurance will cover the cost—an unlikely scenario.<sup>351</sup> And even if a woman could afford the extremely high out-of-pocket cost, most hospitals do not offer it.<sup>352</sup> Induction abortion is also a longer, riskier, and potentially more painful procedure that can take days and still require surgical removal of the placenta.<sup>353</sup> As a result, this will not be the ideal method for the vast majority of second-trimester abortions, unless there is an indication for fetal autopsy or a strong desire to meet and hold the child. This explains why only 2% of second trimester abortions are done by

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<sup>346</sup> McNamara et al., *supra* note 120, at 517.

<sup>347</sup> Soc'y of Fam. Planning, *Induction Of Fetal Demise Before Abortion*, *supra* note 85, at 465–66.

<sup>348</sup> *See id.* (noting that by best estimates, fetal pain starts around twenty-nine weeks).

<sup>349</sup> *Id.*; Donley, *Parental Autonomy over Prenatal End-of-Life Decisions*, *supra* note 56, at 232–33.

<sup>350</sup> Donovan, *supra* note 109, at 37.

<sup>351</sup> Adam Sonfield, *Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better U.S. Health Coverage*, GUTTMACHER INST. (June 6, 2018), <https://www.guttmacher.org/gpr/2018/06/restrictions-private-insurance-coverage-abortion-danger-abortion-access-and-better-us> [https://perma.cc/EQ3C-ZFT8].

<sup>352</sup> For instance, many states have prohibited public hospitals from offering abortion services. *See e.g.*, COHEN & JOFFE, *supra* note 109, at 209.

<sup>353</sup> Donovan, *supra* note 109, at 37.

induction, but it is the primary method for second and third trimester abortions after twenty weeks in the case of fetal anomaly.<sup>354</sup>

It is worth noting that a particular abortion provider might not be able to provide all these alternative procedures. Clinics—where 95% of abortions take place—do not typically offer induction abortions. Individual providers also may not be trained on how to induce fetal demise, or only have training on one method for inducing fetal demise. As a result, they may not be able to provide the options women seek. And if the provider can induce fetal demise, she might still not know how to perform a D&X, if requested. Many women will likely not be able to afford options that cost additional money, even if they want to. We recognize that in this context, describing to women options that do not practically exist may not provide any benefits. We nevertheless paint this picture of an ideal world of second-trimester abortion care, where women are given meaningful choice, even if we are not there yet. Regardless of whether the physician can offer additional choices for women, we still believe that, in the interest of transparency and empowered decision-making, women should have the choice to learn more about the nature of the abortion procedure and alternatives. And providers can always refer the patient to other providers, even out of state providers, who offer more choices if the patient desires it.

## 2. Recognizing Emotional Complexity through Optional Memory-Making

The canonical pro-choice script is that women feel relief after abortion, which empirically, is the most common and lasting emotional response to abortion.<sup>355</sup> But focusing on relief as the only emotional response to abortion does not further the “overall goal” of supporting a woman’s mental and physical health.<sup>356</sup> To best help and empower women, researchers emphasize the need to broaden the discussion of emotional experience—to “not be afraid to acknowledge the full range of feelings women have about abortion.”<sup>357</sup> Insisting on relief alienates the almost thirty percent of women who experience more complex emotions, including grief or loss.<sup>358</sup> Instead, we must have more open and flexible dialogue so that women feel comfortable being honest about their feelings towards abortion.<sup>359</sup> “Greater visibility has the potential to improve understandings of the ways in which women’s experiences are

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<sup>354</sup> Soc’y of Family Planning, *Clinical Guidelines, Labor Induction Abortion in the Second Trimester*, 84 *CONTRACEPTION* 4, 4 (2011).

<sup>355</sup> Rocca et al., *Emotions And Decision Rightness*, *supra* note 355, at 4.

<sup>356</sup> Weitz et al., *supra* note 292, at 88.

<sup>357</sup> *Id.*

<sup>358</sup> Rocca et al., *Emotions And Decision Rightness*, *supra* note 355, at 4.

<sup>359</sup> Madeira, *supra* note 291, at 13.

framed and constrained by the dominant narratives of pregnancy and abortion.”<sup>360</sup> Of course, we are not suggesting that grief or loss are pervasive or proper responses to abortion—far from it—rather, we are suggesting that grief or loss are reasonable responses that can be better supported.

By recognizing this reality, we can also improve patient care. At the outset, simply recognizing the possibility of these emotions and holding space for women who experience them could help women feel less confused and isolated when they occur. Many of the best abortion providers—particularly those with a second-trimester abortion practice—already do this.<sup>361</sup> But more concretely, abortion providers can also offer patients the option of memory-making to support those who are experiencing loss or grief process their emotions. The idea of memory-making comes from modern medical treatment for parents after stillbirth; it simply gives parents the opportunity to make memories with the child.<sup>362</sup> Those opportunities can include viewing, holding, or spending time with their child, taking pictures, or obtaining mementos, like footprints. It can be as extensive or as minimal as the woman desires, and can include spiritual or ceremonial acts like prayer, pseudo-baptism, or cremation /burial. Empirical research of parents who have experienced stillbirth confirms the benefits of memory-making for processing grief.<sup>363</sup> Memory-making is also standard within PHPC for parents continuing a pregnancy where the baby is not expected to survive long past birth.<sup>364</sup>

Numerous anti-abortion state legislatures acknowledge the psychological benefits of memory-making. It is one purported reason for why they ban

<sup>360</sup> Purcell et. al., *supra* note 38, at 166.

<sup>361</sup> See Cohen & Joffe, *supra* note X, at 164-70 (describing the experience of providers praying with patients and helping them work through their feelings).

<sup>362</sup> See *Position Statement: Bereaved Parents Holding Their Baby*, PREGNANCY LOSS & INFANT DEATH ALLIANCE (2008; revised 2016), [http://childrensroom.org/wp-content/uploads/2008/08/plida\\_statement\\_holding\\_baby\\_final.pdf](http://childrensroom.org/wp-content/uploads/2008/08/plida_statement_holding_baby_final.pdf) [<https://perma.cc/C7EV-GQR3>] (“The modern standard of care is to offer grieving parents repeated and extended opportunities to have close contact with their baby.”); see also Kelley & Trinidad, *supra* note 264, at 11 (describing standardized procedure in the UK to offer “photographs and footprints, and strongly encourag[e] parents to hold their stillborn infant” and describing the importance of clinician empathy); Lens, *Tort Law’s Devaluation of Stillbirth*, *supra* note **Error! Bookmark not defined.**, at 966–67 (describing changes in medical care after stillbirth).

<sup>363</sup> See Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 AM. J. ORTHOPSYCHIATRY 420, 426 (1982) (describing that research shows “almost unanimous agreement that seeing and holding the infant is helpful in successful grief resolution”); see also Lens, *Tort Law’s Devaluation of Stillbirth*, *supra* note **Error! Bookmark not defined.**, at 966–67 (describing changes in medical care after stillbirth).

<sup>364</sup> PHPC researchers explain that giving parents the opportunity to spend time with their child and providing “[t]angible keepsakes promote healthy grieving and . . . helps parents to weave the baby’s story into the fabric of their lives.” Amy Kuebelbeck & Erin M. Denney-Koelsch, *supra* note 164, at 70 (internal citations omitted).

abortion in the context of fetal anomalies or encourage PHPC for women after a life-threatening fetal diagnosis. The fact that the traditional abortion rights narrative has ignored the complex emotions women can experience after abortion plays into the state's argument. Simply put, the state's justification that women are better off continuing a pregnancy after a life-threatening fetal diagnosis assumes that women can only experience memory-making if they continue the pregnancy after the diagnosis. This is incorrect. Memory-making is also possible with abortion and would benefit many women who choose abortion in the second trimester. In fact, PHPC researchers advocate for memory-making in abortion care:

[t]hose who terminate a desired pregnancy for a [life-limiting fetal diagnosis] often experience intense grief that may have some similarities to those who carry to term. Some desire memory-making rituals similar to those who carry to term. Whatever the reasons, these families deserve compassionate care throughout their experience, opportunities for memory-making, and expert bereavement support.<sup>365</sup>

Some abortion providers already offer this optional care to varying extents.<sup>366</sup> For decades, some abortion clinics and hospitals that provide abortion have given women the opportunity to create footprints or see their fetal tissue after abortion, including holding an intact fetus if desired.<sup>367</sup> Some providers also connect a woman to a bereavement doula, who specializes in helping women create memories, often free of charge.<sup>368</sup> A 2020 study on patient viewing of fetal tissue post-abortion specifically noted a possible connection

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<sup>365</sup> *Id.* at 64; see also Hann & Becker, *supra* note 282, at 508 (summarizing providers' explanations that "abortions for anomalies require the most empathy and care, and often include additional services like ink hand and footprints, or memorial certificates"); See Carol Joffe, *Working with Dr. Tiller: Staff Recollections Of Women's Health Care Services of Wichita*, 43 *Perspectives on Sexual & Reproductive Health* 199, 199-204 (2011) (describing an abortion practice that asked patients "whether they wished to see and hold their baby after delivery and whether they wanted pictures, blankets and footprints as keepsakes. They were also asked to contemplate whether they wanted a baptism or other religious ceremony, and whether they wished to have their baby's ashes shipped to them after cremation at WHCS.").

<sup>366</sup> Ludlow, *supra* note **Error! Bookmark not defined.**, at 45.

<sup>367</sup> Hann & Becker, *supra* note 282, at 501.

<sup>368</sup> Though some bereavement doulas will only work with clients facing stillbirth or late miscarriage, many will also assist women who are terminating due to a health diagnosis. *E.g.*, *Life-Limiting Diagnosis*, PITTSBURGH BEREAVEMENT DOULAS, <https://pittsburghbereavement-doulas.com/life-limiting-diagnosis/> [https://perma.cc/6YTY-WK7V].

between viewing of fetal tissue after abortion and memory-making after stillbirth and miscarriage.<sup>369</sup> Though memory making in the context of abortion makes many abortion rights supporters uncomfortable, women should be able to benefit from memory-making regardless of whether their pregnancy ends naturally or by choice.<sup>370</sup> And integrating memory-making into abortion care undercuts any state's claim that PHPC is psychologically superior to abortion for women after a life-threatening fetal diagnosis because women can access the benefit without the corresponding restrictions.

The availability of some memory-making opportunities depends on the type of abortion procedure—meaning that state restrictions on types of procedures not only restrict a woman's choices, but also her opportunities to make memories. This is despite the state's acknowledgment of the benefits of memory-making within PHPC. An induction abortion, for instance, allows a woman to hold her baby without any physical impairments.<sup>371</sup> A D&X abortion allows similar opportunities without the extra time, expense, or need for inpatient care, including holding the baby, albeit with some trauma to the fetus's head. Holding the baby is often not possible after a D&E because the fetus is not intact, but other memories are possible. Women can, for instance, create mementoes from the heartbeat sound, have special ultrasound pictures taken, have footprints and handprints made, name the child, or have the remains cremated or buried.<sup>372</sup> These opportunities for memory-making exist regardless of the type of abortion procedure.<sup>373</sup> It is also possible that a D&E would allow for the viewing of fetal tissue with proper counseling on what to expect.

Most women having a second-trimester abortion, however, are not ending a wanted pregnancy. As a result, they may be less likely to desire memory-making. This Article still advocates, however, for giving all women the

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<sup>369</sup> Hann & Becker, *supra* note 282, at 500–01 (explaining fetal tissue viewing after abortion and noting that patients “are allowed and sometimes even encouraged to memorialize the fetus” after stillbirth and miscarriage).

<sup>370</sup> Ludlow, *supra* note X, at 28, 46. This avoidance is no different from the reproductive rights' avoidance of miscarriage and stillbirth given that any acknowledgement of a woman's feelings of loss supposedly evidences fetal personhood. Lens, *Miscarriage, Stillbirth & Reprod. Just.*, *supra* note 165, at 4.

<sup>371</sup> See *supra* notes 112–117 and accompanying text (discussing the induction abortion procedure).

<sup>372</sup> See Hann & Becker, *supra* note 282, at 508 (explaining that some patients request hand and footprints).

<sup>373</sup> *Id.*

choice of memory-making within their second-trimester abortion experience.<sup>374</sup> Many women with undesired pregnancies experienced some uncertainty surrounding their decision to terminate in the second trimester.<sup>375</sup> As a result, the woman likely spent more time thinking about the fetus and imagining her life if she continued the pregnancy; in some cases, she might have developed an emotional bond with the fetus as time went on. She might even be showing or have felt the fetus move.<sup>376</sup> In a study of second trimester abortion patients, half of the patients terminating due to fetal anomaly chose to view the fetus, as did 39% of women terminating for unintended pregnancy.<sup>377</sup> Both women who viewed the fetus and those who did not said that they did not regret their choice.<sup>378</sup> A 2020 survey of clinics offering patient viewing of fetal tissue also described that some women feel closure after the viewing.<sup>379</sup>

The choice of memory-making can also be empowering for women. Providers that already give patients the option of viewing pregnancy tissue after abortion believe doing so is part of their mission to allow the patient to make their own decisions.<sup>380</sup> This practice has been coined “patient centered pregnancy tissue viewing” or PCV to note that it is the patient’s choice, as distinct from legally-mandated viewings, like laws that force ultrasounds before abortion.<sup>381</sup> These providers believe that women who choose to view the fetal tissue benefit due to “exercising choice and control during the abortion.”<sup>382</sup> Providers believe that a patient’s “access to information” and the choice to see the fetus are integral to creating trust in the patient-provider relationship, whether the patient looks “to fulfill curiosity, to cope with or grieve the end of a pregnancy, or merely come to terms with the experience.”<sup>383</sup> Though fetal viewing may be empowering for some, only a minority of women are likely choose it. In Ludlow’s estimate, only about five percent

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<sup>374</sup> *But see* Hann & Becker, *supra* note 282, at 507–08 (“Providers note a stark contrast in patient-centered pregnancy tissue viewing (PCV) approaches for patients who have abortions due to fetal anomalies compared to patients who have abortions for other reasons.”).

<sup>375</sup> Ludlow, *supra* note **Error! Bookmark not defined.**, at 40.

<sup>376</sup> *Id.* at 41; *see also* SANGER, ABOUT ABORTION, *supra* note 214, at 132–33 (explaining that women who terminate pregnancies because of their circumstances—insufficient income, the lack of a supportive partner, the lack of other support, the lack of medical insurance—may wish their circumstances were different so that they could continue the pregnancy and may feel attached and grieve after termination).

<sup>377</sup> Anderson et al., *supra* note X, at 8.

<sup>378</sup> *Id.* at 19.

<sup>379</sup> Hann & Becker, *supra* note 282, at 504, 506–07.

<sup>380</sup> *Id.* at 505.

<sup>381</sup> *Id.* at 500, 505.

<sup>382</sup> *Id.* at 507.

<sup>383</sup> *Id.* at 505.

of women chose to see the “post-procedure fetus,”<sup>384</sup> but studies in the second trimester suggest that over a third of women might chose it if it were offered.<sup>385</sup> Though 75% of clinics offer viewing, three quarters of them only do so upon patient request, meaning that many women never realized it was an option, potentially diluting this service.<sup>386</sup> We are aware of no studies that demonstrate the prevalence of other methods for memory making that might be less emotionally difficult—including having footprints made or cremating the fetus.

It is important to note that giving women space and resources to mourn their abortion can only be accomplished effectively if women are also free from any pressure to grieve when they do not feel complex emotions. If optional memory-making became standardized, a risk of what Professor Carol Sanger calls “compulsory mourning” exists.<sup>387</sup> When “bereavement practices become officially entrenched, they may take on a prescriptive quality, providing a template for how one is supposed to respond to death.”<sup>388</sup> For instance, an Indiana law has been criticized for its requirement that women bury or cremate fetal or embryonic remains after an abortion, miscarriage, stillbirth as priming women to experience the emotional response of grief, regardless of their actual experience.<sup>389</sup> Sanger also argued against state-issued memorial birth certificates after stillbirth due to the risk of compulsory mourning.<sup>390</sup> Similarly, the very offer that women could make memories after abortion could make them feel as if they *should* be grieving. Compulsory mourning is

<sup>384</sup> Ludlow, *supra* note **Error! Bookmark not defined.**, at 46 (explaining that some women also chose to see because they are curious or want a sense of finality).

<sup>385</sup> Anderson et al., *supra* note X, at 19. “Clinics participating in a 2020 study on patient viewing of fetal tissue after abortion responded that it occurs only occasionally or rarely, though it was not certain whether women were aware they could ask to see their fetal tissue.” Hann & Becker, *supra* note 282, at 503.

<sup>386</sup> Hann & Becker, *supra* note 282, at 504.

<sup>387</sup> See Carol Sanger, “*The Birth of Death*”: *Stillborn Birth Certificates and the Problem for Law*, 100 CAL. L.R. 269, 300–02 (2012) (providing an overview of “compulsory mourning”).

<sup>388</sup> *Id.* at 300.

<sup>389</sup> Emma Green, *State-Mandated Mourning for Aborted Fetuses*, THE ATLANTIC (May 14, 2016), <https://www.theatlantic.com/politics/archive/2016/05/state-mandated-mourning-for-aborted-fetuses/482688/> [<https://perma.cc/2WJS-74TL>].

<sup>390</sup> Sanger, “*The Birth of Death*”: *Stillborn Birth Certificates and the Problem for Law*, *supra* note 387, at 301. Professor Lens counters Sanger’s arguments against stillbirth birth certificates. See Lens, *Miscarriage, Stillbirth & Reprod. Just.*, *supra* note 165, at 50–52 (discussing the cost potential out-of-pocket costs for autopsies following a stillbirth); see also Lens, *Tort Law’s Devaluation of Stillbirth*, *supra* note **Error! Bookmark not defined.**, at 1008–09 (discussing the “tension between abortion and recognition of still birth”). Importantly, like the choice to engage in memory-making, stillbirth birth certificates are voluntary. See TEX. HEALTH & SAFETY CODE ANN. § 192.0022 (West) (“a parent *may* obtain a certificate of birth resulting in stillbirth”) (emphasis added).

alienating to those who do not have that same response to abortion—those who do not feel loss.

Importantly, the risk of compulsory mourning is lessened if the offer of memory-making comes from the doctor or counselor instead of the state. For instance, abortion providers already refer to the fetus as a baby only if the woman does so.<sup>391</sup> It is very different for a doctor to follow the *woman's* lead by saying “baby” than for the state to officially classify a fetus as a baby or mandating the use of the word “baby” in informed consent statutes. Similarly, a doctor asking a woman if she is interested in burial or cremation is very different than a state requirement that parents bury their fetus's remains (and patients or providers pay for it). Even more on point, a doctor advising a woman of the availability of PHPC—which we recommend given its benefits—does not send the same signal as the state's requirement that a woman consider it—which we denounce. Finally, the consent-based framework we outlined above would also allow providers to offer the service only to those patients who are interested in learning more about it.

The risk of compulsory mourning may also be exaggerated. A 2020 study explained that there was a dearth of studies available examining women's experiences viewing their fetal tissue, but the few conducted revealed that although most women did not wish to see the fetal tissue, they appreciated having the choice to view.<sup>392</sup> A study done in Canada where abortion providers asked women if they wanted to view the products of conception after the abortion.<sup>393</sup> A little over a quarter said yes. The majority of women who participated (83%) reported that the experience did not make their abortion more emotionally difficult, although the study concerned first-trimester abortion.<sup>394</sup> In other words, so long as abortion providers are thoughtful in offering the options, making clear that many women will not be interested, it shouldn't necessarily signal expectations that a woman experience a particular response.

Needless to say, the method by which providers offer women opportunities for memory-making is important.<sup>395</sup> A woman should be told of its availability while making clear that not all women find any form of memory-making helpful, and maybe also that most do not. If women do choose to see

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<sup>391</sup> Ludlow, *supra* note **Error! Bookmark not defined.**, at 43.

<sup>392</sup> Hann & Becker, *supra* note 282, at 501.

<sup>393</sup> SANGER, ABOUT ABORTION, *supra* note 214, at 148.

<sup>394</sup> *Id.*

<sup>395</sup> In the Hann & Becker study, the clinics that allowed patient tissue viewing offered it in different ways. “The majority allow it if the patient requests (75%) and others offer PCV verbally (usually during pre-abortion counselling) or in writing via intake paperwork.” Hann & Becker, *supra* note 282, at 503. “Fifty-six percent of the clinics do not have a specific policy although PCV is available to those who ask.” *Id.*



the fetus as part of memory-making, they must be prepared. “Two clinics specified that patients undergoing second-trimester abortions receive more education prior to viewing to prepare them for seeing identifiable fetal parts.”<sup>396</sup> This additional education may be helpful.

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This Section picks up on the work of abortion providers who have sought to own the uncomfortable truths about abortion for the sake of transparency and honesty. We move the conversation forward by noting how embracing abortion dangertalk in the second trimester can rebut the woman-protective rationale and improve patient care. Though this openness comes with some risks, we argue that the benefits to abortion litigation and patient care outweigh them. By openly discussing the particulars of second-trimester abortion and recognizing the complexity of emotions after abortion, patients can have more options in their care and make more informed choices. And anti-abortion activists and states will be less able to argue that women need protection in the form of restrictive abortion laws.

#### CONCLUSION

Abortion rights, especially in the second trimester, are more vulnerable than ever. A swath of second-trimester abortion laws is likely headed for the Supreme Court, and they all rely—at least in part—on the argument that the laws are necessary to protect women. The uncomfortable truths associated with second-trimester abortion, including the nature of second trimester abortion procedures and the possibility of complex emotions about the abortion, makes the woman-protective rationale more intuitive to some. For too long, the traditional abortion rights narrative has chosen to avoid these uncomfortable truths. In this Article, we argue that the abortion rights movement and second trimester abortion patients would be better served by more openness regarding the nature of second-trimester abortion procedures and the possible range of emotional responses to the abortion. Avoidance of these dangertalk topics only capitulates the narrative on second-trimester abortion to the anti-abortion movement, who use the silence of abortion rights activists to their advantage. On the other hand, above-and-beyond transparency on these topics will counter the woman-protective rationale and improve patient care. We

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<sup>396</sup> See *id.* at 508 (“The identifiable fetal body in later abortions may resemble anti-abortion imagery, so providers take extra steps to ensure the patient is prepared for the viewing experience.”); see also Ludlow, *supra* note **Error! Bookmark not defined.**, at 45 (“We are . . . very careful to prepare the woman for what they are going to see.”); Purcell et al., *supra* note 39, at 179 (explaining that unprepared exposure to the fetus after a second-trimester abortion can be “highly distressing”).

imagine a world in which patients are provided with additional options for second-trimester abortion. This includes more choice over the type of procedure and the possibility of memory-making if they are experiencing complex emotions following the abortion, including grief.