
“PROTECTING” WOMEN’S HEALTH:
HOW *GONZALES V. CARHART*
ENDANGERS WOMEN’S HEALTH AND
WOMEN’S EQUAL RIGHT TO
PERSONHOOD UNDER THE
CONSTITUTION

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I. INTRODUCTION

“Call your lawyer before you give your patient your best care,” was Planned Parenthood President Nancy Northup’s reaction to *Gonzales v. Carhart*, a 2007 Supreme Court decision.¹ *Carhart* represents the first time in almost thirty years of abortion rulings that the Supreme Court recognized statutory restrictions on the right to choose and, more importantly, declined to affirm that preserving a woman’s health is a valid interest worth the state’s deference.² Moreover, *Carhart* reflects a conservative legal and social movement away from recognizing women’s autonomy under the law, and toward a paternalistic and protectionist legal approach that fails to safeguard the preservation of a woman’s health as part of her constitutional right to personhood. The Court’s failure to recognize women’s autonomy in the area of reproductive choice turns back the clock on gender equality to such a degree that it strips *Carhart* of any real legal validity, and suggests that the majority was motivated by its personal beliefs alone.

In analyzing the meaning of *Carhart*, I first plan to discuss abortion’s history as a legal and social right in America, both in terms of why abortion procedures arose, and how the Supreme Court has extended legal protection over women’s access to the procedures. I will argue that the Supreme Court previously interpreted a woman’s right to protect her health and to choose what happens to her body as within the right to privacy and personhood under the Fourteenth Amendment, and that *Carhart* thus represents a significant, unwarranted departure from that precedent. Moreover, I will assert that *Carhart* creates a very real practical problem for a woman whose pregnancies present health risks, because the Court’s reasoning allows states to decide when and how to protect that woman’s health, removing both the woman and her doctor from the decision-making process. Taken to its logical conclusion, *Carhart* diminishes the rights extended in *Roe v. Wade* so significantly that it suggests a de facto overruling of *Roe* is imminent.

1. John Gibeaut, *Ruling Changes Abortion Debate*, ABA J. E-REP., Apr. 20, 2007, <http://www.abanet.org/journal/ereport/a20abort.html> (last visited Feb. 12, 2008) (noting that the Court’s ban on future facial challenges to abortion restrictions would require pregnant women whose doctors face criminal sanctions to file complaints against such laws).

2. See *Gonzales v. Carhart*, 127 S. Ct. 1610, 1633 (2007) (finding the Partial-Birth Abortion Ban Act constitutional because the state interests represented—the respect for the dignity of “the life within the woman” and the “dignity and reputation” of doctors who perform partial-birth abortions—outweighed the legal need for keeping the far safer intact dilation and evacuations (“D&E”) procedure).

II. ABORTION'S LEGAL HISTORY IN AMERICA SUGGESTS THAT, AS KNOWLEDGE ABOUT ABORTION HAS INCREASED, AND ADVANCES IN MEDICAL TECHNOLOGY HAVE BEEN MADE, THE LAW'S RECOGNITION OF A WOMAN'S RIGHT TO PROTECT HER HEALTH AND KNOW BEST WHAT IS RIGHT FOR HER OWN BODY HAS DECLINED

Despite the commonly held view that women have gained more control of their reproductive choices over time, the history of abortion regulation in America suggests that women had more control over their bodies when science was ignorant about pregnancy.³ Initially, according to historian Richard Sauer, "abortion was probably not a subject that even entered the minds of most early Americans."⁴ However, as fertility among white, Protestant families declined at the height of immigration in the late nineteenth and early twentieth centuries, the law began to shift in its treatment of abortion to address fears that immigrants and freed slaves would begin to outnumber white Protestants and eventually dominate America's population.⁵ It is through this ethnocentric lens that the Supreme Court's reasoning in *Carhart* crystallizes, for without the fear of "the other," abortion restrictions may have remained a non-issue in America.⁶

A. *Pre-Industrial American Abortion Laws Reflected Medical Misconceptions About Fetal Development That Actually Empowered Women*

Early American abortion laws reflected the medical profession's lack of knowledge about pregnancy and how fetal gestation occurs. As a result, women were the sole experts on the process (and some would argue still are—an argument lost on the Court).⁷ The legal profession, taking its cues

3. Richard Sauer, *Attitudes to Abortion in America, 1800-1973*, 28 POPULATION STUDIES 1, 53-54 (1974) (noting that "quickening," the original standard for determining when a fetus was viable, occurred when a woman said she felt the fetus stirring within her womb, allowing the pregnant woman to control the alleged time of quickening and thus the choice of whether to abort the pregnancy).

4. *See id.* at 53 (finding that the average family consisted of about eight children, and that only rarely did women engage in abortion, either to protect their health in high-risk circumstances, or to prevent the societal shame of illegitimate births).

5. *Id.* at 59.

6. *See* Evelyn Nakano Glenn, *From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor*, 18 SIGNS 1, 6-8, 10-12 (1992) (revealing that white women subordinated poor, minority, and immigrant women from the nineteenth through the mid-twentieth century as domestic laborers to maintain the true womanhood image as that of a white mother, especially at a time when white birthrates were decreasing).

7. *See* Brief for Human Rights for Women, Inc. as Amicus Curiae Supporting Respondents at **11-12, *United States v. Vuitich*, 402 U.S. 62 (1971) (No. 84) (arguing that there is nothing more demanding upon the body and person of a woman than pregnancy, and the subsequent feeding and caring of an infant until it reaches maturity).

from women, decided when abortions were appropriate based on “quickening,” the point at which a woman alone could feel the fetus move internally.⁸ The use of quickening as the standard for whether abortion was legal allowed women, who were relied upon to care for the children, except in households that could afford outside assistance, to maintain some sense of autonomy by deciding when to carry out a pregnancy because, as “covered” individuals, it was doubtful that they otherwise could avoid their husband’s sexual advances.⁹

Surprisingly, the law was willing to trust women—white, Protestant women, that is—to be their own decision makers on this matter, perhaps also reflecting society’s belief at the time that these women were the source of “republican motherhood,” and thus their choices always would reflect what was best for the household and the state.¹⁰ Although we do not know precise abortion rates in pre-industrialized America, the suggestion is that proper society, including legislators and religious leaders, generally turned their heads to abortion.¹¹

B. In the Nineteenth Century, States Began to Regulate and Criminalize Abortions, Subordinating Women’s Control Over Their Bodies and Health Needs

The era of American industrialization saw a sharp decline in birthrates, and therefore society’s immediate reaction was to encourage white, native-born Protestant women to stay home and, as models of “republican motherhood,” to have more children.¹² As men moved into the industrial

some eighteen years later); see also Judith G. Waxman, *Privacy and Reproductive Rights: Where We’ve Been and Where We’re Going*, 68 MONT. L. REV. 299, 315 (2007) (asserting that a woman’s control over her body and her reproductive functions should be constitutionally protected because it implicates the meaning of personhood under the Constitution, a right that allows all of us the autonomy and self-determination to protect and advance ourselves through our individual choices).

8. See Sauer, *supra* note 3, at 54.

9. See NANCY F. COTT, *THE BONDS OF WOMANHOOD: “WOMEN’S SPHERE” IN NEW ENGLAND, 1780-1835*, 75-76 (1977) (determining that women frequently were overwhelmed with maintaining the heaven-on-earth standard at home that society demanded in the world of separate spheres, were forced to marry not for love but to support the man and, on his demand, bear and raise the number of children he desired, while getting little personal fulfillment in return).

10. See *id.* at 87 (suggesting that true womanhood meant women were the ultimate educators by not only schooling their children before formal education was commonplace, but also preparing their children to assume sex-based roles, with boys planning to become leaders in the outside sphere, and girls planning to follow in their mothers’ footsteps in the sphere of the home); see also Waxman, *supra* note 7, at 300 (finding that abortions were an option in the nineteenth century exclusively for the privileged few, not only because they determined the time of quickening, but also because they had the financial means by which to pay for abortions).

11. See Sauer, *supra* note 3, at 53.

12. See JOAN WILLIAMS, *UNBENDING GENDER: WHY FAMILY AND WORK CONFLICT*

workforce, husbands and wives no longer shared household duties as they had in the past.¹³ However, because these native women's interests in controlling their household burdens became more compelling as families moved to the less child-friendly cities and husbands moved into the public sphere, spending hours at work in factories, women began to approach doctors more frequently for abortion assistance.¹⁴

It was mostly women who constituted the sector of the medical profession that assisted with early abortion methods, and its most notable professional was a woman named Madame Restell.¹⁵ Finding that married, white, Protestant women were seeking abortions on a regular basis, and that other women were assisting in performing what abortion procedures or methods existed at the time, the male-dominated American Medical Association ("AMA") felt compelled to lobby against the growing demand for abortions because the procedures gave too much discretion and control to women patients and professionals.¹⁶ However, prosecutions against Madame Restell and other female abortion practitioners failed because at the time, most Americans did not have a moral problem with abortion, nor was abortion considered a crime.¹⁷

Nevertheless, states still chose to restrict abortions because the AMA's doctors put legislators on notice that these procedures, like so many others at this early stage of operative medicine, were dangerous and should not be entered into lightly.¹⁸ Horatio Storer, an early American author who co-wrote the book "Criminal Abortions" in 1868, said that state legislatures did not consider fetal life as an interest needing legal protection, but rather

AND WHAT TO DO ABOUT IT 21, 23-25 (Oxford Univ. Press 2000) (finding that in the nineteenth century, as the market economy grew in the United States, men ventured out to be the breadwinners while women were kept home under the premise of becoming "moral mothers," who had to remain selfless and put all their energy into satisfying their husbands and raising children).

13. *Id.*

14. *See* Sauer, *supra* note 3, at 54.

15. *See id.* (describing Madame Restell as "America's best-known abortionist" by 1838 who advertised her services in newspapers, providing "abortifacients" that allegedly induced abortion without injury to the woman, and who claimed to have served many married women in her time).

16. *Id.* at 54-55.

17. *See* Lori J. Kenschaft, Abortion and the Life and Times of "The Most Evil Woman in New York," Madame Restell, Speech at the Rutgers University Institute for Research on Women (May 1990), available at <http://www.kenschaft.com/restell.htm> (finding that although Restell was indicted six times for procuring abortions, judges deemed abortion "a private action" in which they primarily sought to protect patients' and doctors' rights).

18. *See id.* (determining that although New York's anti-abortion laws in the mid-1800s were intended to "protect women," the law punished guilty women with jail time and a large fine, failing to consider that childbirth was far more dangerous at the time than any abortion method).

sought to preserve only the life and health of the women seeking the abortions.¹⁹ Many early abortion restrictions also grew out of British common law, which again focused on preserving the woman’s health, by asking whether prohibiting certain abortion procedures actually caused greater physical danger to women and made them more of a “physical or mental wreck” because it forced those women to carry a troubled pregnancy to term.²⁰

Eventually, states began to apply criminal penalties against abortion providers and patients under the guise of protectionism, which at least were narrowly tailored to allow abortions when a woman’s health was at risk, but still reflected the state’s valuation of “true motherhood” as a stronger interest than allowing a woman to preserve her health, reinforcing the emerging separate spheres ideology that came with America’s industrialization and urbanization.²¹ Combined with the decline in white birthrates and the fear that immigrant or minority births would overwhelm the infant population, politicians could no longer risk allowing unsafe or medically unnecessary abortion procedures among native, white Protestant women.²²

Ironically, feminists in the nineteenth century did not fight for the right to choose these procedures or question the subordination theories on which they were based, largely because from 1850 until the turn of the century, the birthrates among less desirable immigrant women who did not represent the “true motherhood” ideal were double the rate of their white, Protestant counterparts who increasingly sought to lessen their housework by having fewer children.²³ Moreover, early feminists frequently subordinated minorities to obtain the rights that they sought, for example scoffing at Congress’s decision to give black men the right to vote before white women through the Fourteenth and Fifteenth Amendments, and trading in their housework to enter the public sphere by purposefully

19. Sauer, *supra* note 3, at 57.

20. See *Criminal Law: Abortion—Preservation of Health as a Justification*, 6 U. CHI. L. REV. 109, 109-10 (1938-39) (discussing the British case of *Rex v. Bourne*, in which a doctor was prosecuted for performing an abortion when his patient’s health was at risk, to support the fact that most American state laws had followed from the British common law, “generally permit[ting] [abortions] when necessary to save the life of a mother, and in three states an exception is made for the preservation of a woman’s health”).

21. See Sauer, *supra* note 3, at 58 (summarizing that the AMA, the Suffolk District Medical Society, and the Medical Society of New York agreed with Christian leaders that abortion was “infant murder” that degraded a woman’s role as mother, and thus advocated for stronger laws against doctors performing abortions that were not required to protect a patient’s health).

22. *Id.* at 59.

23. *Id.* at 54.

tracking black and immigrant women into underpaid domestic work.²⁴

C. In the Twentieth Century, Abortion Restrictions Diminished as Public Support for Women's Reproductive Choice Rose Through the Advent of Birth Control and Recognition of the Need to Protect Women's Health

Although the early women's movement did not argue for the right to choose, these women's efforts to obtain safe, alternative methods to control pregnancy, largely a result of the modern birth control movement started by Planned Parenthood founder Margaret Sanger, resulted in the legal shift toward supporting a woman's right to control her own body and protect her own health.²⁵ That shift in thinking forced twentieth-century lawmakers to confront a growing protest against abortion restrictions at the state level, with fertility rates continuing to fall through the 1930s.²⁶ Although the AMA approved of Sanger's assertion that birth control was less risky and more acceptable than abortion, women continued having abortions across the country through the 1950s because the public tacitly favored the procedure as a method of family planning.²⁷ Even the American Law Institute ("ALI") drew up a new abortion model code in 1959 that listed numerous grounds on which women should be allowed to undergo an abortion procedure that provided safeguards for a woman's health in all circumstances.²⁸

As a result of public pressure, states began to legalize abortion, a reflection of both the advancing Equal Rights movement and the medical and legal agreement that it was necessary to protect women's health by affording reproductive options.²⁹ Colorado was the first state to permit

24. See ELLEN CAROL DUBOIS, *WOMAN SUFFRAGE AND WOMEN'S RIGHTS* 95-96 (1998) (distinguishing the virtuous and chaste "feminine element" that would come with empowering white, Protestant women from the "degradation" that feminists said would occur if black men could continue to vote without the balance of white women voting); Glenn, *supra* note 6, at 8-9 (determining that white, Protestant women could not advance themselves into the public sphere without permanently subordinating minority and immigrant women into domestic labor roles).

25. See Waxman, *supra* note 7, at 301-02 (noting that, as a result of birth control's advancement as a prescription medication, mostly white, privileged women had access, though a number of states began distributing it to control the black population, which resulted in states loosening their abortion restrictions).

26. Sauer, *supra* note 3, at 60.

27. *Id.* at 62.

28. See National Right to Life, *Abortion History Timeline*, <http://www.nrlc.org/abortion/facts/abortiontimeline.html#1959> (last visited Feb. 11, 2008) [hereinafter National Right to Life] (listing the ALI's proposed legal reasons for abortions to include: (1) rape or incest exceptions; (2) mother's mental or physical health was at risk; and (3) fetal deformity, either mental or physical).

29. See Sauer, *supra* note 3, at 64 (referencing a Gallup poll in 1969, in which approximately forty percent of Americans approved of abortions for any reason before the twelfth week of pregnancy, and finding that when re-pollled in 1972, forty-six percent of Americans agreed with the right to abortion on demand).

abortions, basing its law on ALI’s 1959 Model Code; this provided a starting point for choice activists, who used loosened restrictions to seek national legalization of abortion.³⁰

III. THE SUPREME COURT’S INTERPRETATION THROUGHOUT THE
TWENTIETH CENTURY OF REPRODUCTIVE RIGHTS CASES TO REQUIRE
THAT THE STATE SAFEGUARD WOMEN’S HEALTH ENDED WITH *GONZALES*
V. CARHART

The Court’s decision in *Roe v. Wade* symbolized a long-coming metamorphosis in public attitudes and legal understandings about abortion from a secret procedure that women used in order to protect their health and ensure their freedom from the separate spheres ideology into a personal right that allowed women to decide what happens to their bodies with their doctor’s advice and consultation. Just as birth control was in the early twentieth century, abortion had become a legalized medical procedure that, like any other, existed for use at the election or need of the patient. However, state by state, conservatives pressured legislatures to limit a woman’s right to choose to have an abortion.³¹ Their movement succeeded in 2007, when the Supreme Court ruled in *Gonzales v. Carhart* that the generalized health exception to abortion restrictions—including in almost every state’s abortion laws since the early nineteenth century and reaffirmed by the Supreme Court for the last twenty-three years—no longer existed.

*A. Twentieth Century Supreme Court Decisions Legalized Abortion and
Recognized a Right to Privacy in the Abortion Choice That Ultimately
Reflected the Shared Interest of States, Women, and Doctors in Protecting
a Woman’s Health*

In the twentieth century, equal rights activists sought to privatize abortion in the same way that birth control had been pushed into the private sphere, with the hope that legislators and courts would give abortion choice the same deference given to decisions about birth control.³² Those seeking

30. See National Right to Life, *supra* note 28 (concluding that between 1967 and 1973 when *Roe v. Wade* legalized abortion nationally, one third of states began legalizing abortions “on request” up to the twenty-fourth week of pregnancy in order to protect a mother’s health, including California, Oregon, North Carolina, Hawaii, Alaska, New York, Washington, and the District of Columbia).

31. See Robin Toner, *Abortion Foes See Validation for New Tactic*, N.Y. TIMES, May 22, 2007, available at http://www.nytimes.com/2007/05/22/washington/22-abortion.html?_r=1&pagewanted=print&oref=slogin (last visited Mar. 25, 2008).

32. See David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 ALB. L. REV. 833, 835 (1999) (noting that early efforts to legalize birth control enhanced the rights of white, wealthy women because they could afford private doctors to come into the privacy of their homes to dole out the medicines or devices

to legalize abortion pointed to *Griswold v. Connecticut*, the Supreme Court case in which birth control first was presented as a privacy right, to argue that the Supreme Court already had recognized the right to control reproductive choices, citing the need for the law to respect the privacy of the home and, within it, the married couple.³³ Of course, *Griswold* reflected the separate spheres ideology in entrusting the reproductive choice to the man and woman joined, not the woman acting alone. Nevertheless, for the first time in the modern era, the law authorized women to have some legal protection for reproductive choice in *Griswold* because the Supreme Court read the “various guarantees” in the Bill of Rights as creating “zones of privacy,” which under a broad interpretation of the Fourth and Fifth Amendments include protection of individuals’ “sanctity of . . . home and privacies of life,” including the right to be left alone.³⁴

The Court recognized again the right to privacy to include reproductive choice when in 1972 it extended the right to choose and use birth control to unmarried persons in *Eisenstadt v. Baird*.³⁵ The Court explicitly stated that married couples should not receive preferential treatment because marriage is a union of two individuals who still maintain their own values and opinions, and therefore no cause exists to allow greater governmental intrusion regarding the choices of unmarried persons.³⁶ After the extension of the right to make birth control choices to women individually, rights activists sought the explicit application of the right to privacy to reproductive choices generally, and this set the stage for *Roe v. Wade*.

In *Roe*, the Supreme Court agreed that the Constitution’s personal rights penumbra permitted women to make a private choice of whether to terminate a pregnancy by abortion, holding that the choice was unfettered in the first trimester and then limited later in the pregnancy based on the doctor’s assessment of fetal viability.³⁷ More importantly, however, the Court recognized an overriding interest in protecting the woman’s health as

they needed).

33. 381 U.S. 479, 485-86 (1965).

34. *See id.* at 484-85 (quoting *Boyd v. United States*, 116 U.S. 616, 630 (1886)). The Court concluded that the right to privacy covers not only explicit constitutional rights, but also the right to protect against “invasion of [one’s] indefeasible right of personal security, personal liberty and private property.” *Id.*

35. 405 U.S. 438, 453 (1972) (declaring a Massachusetts law prohibiting unmarried persons from obtaining birth control unconstitutional on the basis that it would violate equal protection to allow married couples rights to certain medical options but not allow the same access to unmarried individuals).

36. *Id.* (defining the right to privacy in the context of reproductive choice as “the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”).

37. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

an exception to any trimester limits.³⁸ The Court did not convey an absolute right, but rather suggested that the decision to terminate must be weighed against the recognized state interests in protecting health, medical standards, and potential life.³⁹ The Court also said that the state’s interests did not become compelling until the point at which the fetus could survive outside the womb, and that using potential life as a compelling interest to promote abortion restrictions was only applicable where a woman’s health was *not* at risk.⁴⁰

Roe therefore not only protected the privacy of a woman’s right to choose, but ultimately protected a woman’s health and promoted the sound public policy of facilitating effective relationships between doctors and patients regarding reproductive choices. Moreover, when faced simultaneously with issues of the state’s interest in fetal viability and the state’s interest in a woman’s health, the Court named the woman’s health as a “separate and distinct” interest, and gave the two interests different weight depending on how far into the pregnancy a woman was considering having an abortion.⁴¹ The Court also spoke against any prohibitions that would detract from the woman’s health or safety.⁴²

The legacy of *Roe* was that the Court allowed women and their doctors to make decisions about the protection of personhood, and treated abortion ultimately as a private, medical choice, not a public choice that would subject patients to society’s moral scrutiny and judgment. Choice activists succeeded by essentially following Sanger’s private sphere model that made birth control accessible and the choice to use it a private one between doctors and patients, for which the shared interest among doctors, patients, and the state was, once again, the patient’s health and safety.

In *Planned Parenthood v. Casey*, the Court reaffirmed *Roe* by recognizing its importance in allowing women to participate equally in the social and economic life of America and by ensuring that women’s liberty and privacy interests in reproductive choice would continue to be

38. *Id.* at 153 (deciding that the right to privacy specifically extends to women’s choice of whether to carry a pregnancy to term, suggesting *inter alia* that the medical and psychological harm in forcing a woman to carry a baby to term should require that she alone decide).

39. *Id.* at 155.

40. *Id.* at 163-64.

41. *See id.* at 162-63.

42. *See id.* (suggesting that because unborn fetuses are not considered “persons” for purposes of constitutional protection, courts must always weigh the woman’s health against a state’s asserted interest in potential life, as women do receive constitutional protection as persons, and therefore, have an overarching right to protect their own health and well-being that is compelling throughout the pregnancy, not just in the last trimester).

protected.⁴³ More specifically, the Court upheld a provision within Pennsylvania's abortion statute requiring abortions to be available in cases of medical emergency, expanding the state's interest in protecting a woman's health by making that interest the basis on which courts decide whether a statute restricting abortion is constitutional, regardless of when viability begins.⁴⁴ Furthermore, the Court required the state to satisfy strict scrutiny when it passed a law that placed an "undue burden" on a woman's ability to get an abortion during pregnancy, before the fetus becomes viable.⁴⁵

Most importantly, *Casey* ensured that an undue burden included any health regulations that create substantial obstacles to women seeking abortions; therefore, a state could not use its long-standing interest in protecting a woman's health and safety as a pretext for actually restricting recognized abortion procedures and thus detract from the state's interest in preserving a woman's health.⁴⁶ The practical impact of the undue burden standard was that it forced the states to make a woman's health the top priority throughout her pregnancy, allowing a woman to get abortions in any trimester of pregnancy if her health was at risk.

Reaffirming again that a woman's health is the determinative factor in whether a statute restricting abortion is legal, the Court in *Stenberg v. Carhart* decided that a Nebraska statute prohibiting partial-birth abortions violated a woman's liberty interest in reproductive choice.⁴⁷ Following *Roe* and *Casey*, the *Stenberg* Court determined that the statute failed to meet the undue burden test because Nebraska's assertion that "a health exception is 'never necessary to preserve the health of women'" was not supported by either *stare decisis* or by medical knowledge regarding the different types of abortion procedures that must be available to protect a woman's health should her pregnancy take a turn for the worse.⁴⁸

43. *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 855-56 (1992) (plurality opinion).

44. *See id.* at 860 (finding that post-viability is still the only point at which the state's interest in restricting abortions is recognizable, but that the interest in potential life trumps only nontherapeutic abortions—those that are solely a method of birth control).

45. *Id.* at 877 (defining an undue burden as any law that places substantial obstacles in the path of a woman seeking a pre-viability abortion).

46. *Id.*

47. 530 U.S. 914, 930 (2000) (applying *Roe* and its affirmation in *Casey*, the Court held that the Nebraska statute that prohibited both options for post-viability partial birth abortions was unconstitutional because the law requires health exceptions to validate post-viability abortion restrictions, and the Nebraska statute left too few safe options to protect the woman's health).

48. *See id.* at 938 (determining that where substantial medical authority concludes that certain procedures must be available to protect a woman's health and safety, a statute must bow to that authority, which is an extension of the *Casey* decision that more clearly defined the privacy right to protect one's health found in *Roe*).

Although the Nebraska statute had aimed to prohibit only certain types of procedures, the Court held that the statute’s undue burden arose mainly because of the overbroad statutory language, which easily could be read as a de facto ban on all types of late-term abortion procedures.⁴⁹

B. In Light of the Twentieth Century’s Social and Legal Developments, Particularly in the Area of Gender Equality, Gonzales v. Carhart Was a Significant Departure From the Law and Represents a Partial Nullification of Women’s Rights as Persons in the Constitutional Sense

After the *Stenberg* decision in 2000, the sum total of the Court’s precedents favored a woman’s right to protect her health, her liberty interest in the choice of whether to carry a pregnancy to term, and her right to privacy in the doctor-patient decision-making process. Precedent also required that a state have a compelling interest when it places an undue burden on any of these rights or interests, and that states must maintain a health exception no matter what procedure or trimester was at issue. However, the Court’s composition changed after 2000; Chief Justice Rehnquist passed away and Justice O’Connor retired, leaving two open seats in a matter of months on the Supreme Court and allowing both to be filled by President George W. Bush, a conservative who made promises of a pro-life Court during his campaigns.⁵⁰

Organizations like the Pro-Life Action League were overjoyed when Bush nominated Judge John Roberts for Chief Justice who, along with his wife, has made it a personal goal to end reproductive choice.⁵¹ Almost equally exciting for pro-life conservatives was the nomination of Judge Samuel Alito from the U.S. Court of Appeals for the Third Circuit, suggesting that adding another conservative Justice could signal the end to abortion options in America, subjecting privacy rights to state legislators’ personal attitudes on abortion that almost entirely focused on protecting fetal life.⁵²

49. *See id.* at 939-40, 950 (deciding that Nebraska’s ban was overbroad because, when compared to other states’ statutes, Nebraska’s ban applied to all dilation and evacuation (“D & E”) and dilation & extraction (“D & X”) procedures, whereas Kansas’ law does not ban: (a) suction procedures; (b) suction-aspiration procedures; and (c) procedures that involve dismemberment *before* removal from the cervix, i.e., all versions of the D & E procedure).

50. Katha Pollitt, *Roe = Dred*, THE NATION, Nov. 1, 2004, available at <http://www.thenation.com/doc/20041101/pollitt> (last visited Mar. 23, 2008).

51. *See* Pro-Life Action League, *League Applauds Nomination of John Roberts to Supreme Court*, July 25, 2005, <http://www.prolifeaction.org/home/2005/roberts.htm> (last visited Feb. 11, 2008).

52. Darla Sutton, *Pro-Life Movement Energized by Alito’s Likely Confirmation*, CBN.com, <http://www.cbn.com/cbnnews/news/060125f.aspx> (last visited Feb. 11, 2008) (reporting that before Justice Alito was confirmed, five states already considered legislation knowingly contrary to *Roe*).

Not surprisingly then, the Supreme Court's 2007 decision in *Gonzales v. Carhart* ignored the principle of stare decisis⁵³ and, without good reason, eliminated a woman's right to protect her health and safety during pregnancy, no matter the trimester in which she faces complications.⁵⁴ Moreover, the Court mocked the role that a woman's mental health plays in the abortion decision, implying that women are not competent to make such serious decisions and must be saved from themselves by the state and the courts.⁵⁵ Not only did the Court eliminate crucial, long-standing rights for a significant segment of the population, but went even further in diminishing a woman's constitutional personhood as it has been interpreted since the beginning of women's collective push for equal treatment under the law.⁵⁶

1. Carhart Avoids Analyzing How the State's Interest in Preserving Women's Health Interests, Became Secondary to the State's Interest in Preserving Life When a Woman's Health is At-Risk

The *Carhart* Court overtly ignored the equal protection interest in a woman's right to choose and erased the state's interest in preserving women's health and safety established in *Roe* and reaffirmed in *Casey*. In doing so, *Carhart* turned the clock back on legal gender equality, relying upon the ideology of separate spheres to establish a need to protect women from the seemingly inevitable regret they will endure as a result of their choices.⁵⁷

53. See 127 S. Ct. 1610, 1641 (2007) (Ginsburg, J., dissenting) (finding the majority opinion "alarming" because its rationale does not comport with or reconcile precedential cases, such as *Casey* and *Stenberg*, and because it "blesses a prohibition with no exception safeguarding a woman's health," despite pleas and proof offered by organizations of medical professionals, including the American College of Obstetricians and Gynecologists).

54. See *id.* at 1641-42 (Ginsburg, J., dissenting) (referencing *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 327 (2006), *Carhart*, and *Casey* to reinforce that since *Roe*, the Court has not approved any abortion regulation that fails to include an exception for an abortion where it is necessary to protect a woman's health).

55. *Carhart*, 127 S. Ct. at 1634 (suggesting that although doctors rarely give unnecessarily disturbing details about procedures to patients, for late-term abortion patients it is precisely the "lack of information [concerning the way in which] the fetus will be killed" that is problematic because if women knew such facts, guilt would prevent them from agreeing to any late-term procedures).

56. See *id.* at 1649 (Ginsburg, J., dissenting) (surmising that the Court has resisted using generalizations about women's capabilities or presumptions of dependency and need for protection to determine that now, the *Carhart* majority bucks social trends as well as medical and legal authority in taking the most personal of choices out of women's hands); see also *United States v. Virginia*, 518 U.S. 515, 533 (1996); *Califano v. Goldfarb*, 430 U.S. 199, 207 (1977).

57. See *Carhart*, 127 S. Ct. at 1634 (finding that whether to have an abortion is a "difficult and painful moral decision," such that the law needs to protect "the bond of love a mother has for her child," and thus the potential regret an abortion may cause, over the woman's health).

a. To Justify Upholding the Partial-Birth Abortion Ban Act, the Carhart Majority Had to Ignore Legal Precedent for Reproductive Choice That Treats the Woman’s Health as an Overriding State Interest for Which an Exception Must Exist to Any Abortion Regulations

Carhart was decided wrongly because it evades *Casey*’s mandate requiring a health exception for women who seek late-term abortion procedures banned by a legislature, and blurs the *Casey* line on when the state’s interest in a woman’s health could prevail over its interest in fetal life.⁵⁸ Supreme Court precedent in the area of reproductive rights has been explicit in its requirement of a health exception whenever a legislature seeks to limit a woman’s choice of whether to carry out or terminate a pregnancy, as best explained in *Casey*.⁵⁹ *Casey*’s clarification of *Roe*—that the state’s interest in safeguarding a woman’s health cannot be excised by relying on its interest in protecting fetal life—was upheld in *Stenberg*, where the Court deemed the Nebraska ban on late-term partial birth abortions unconstitutional precisely because Nebraska’s statute lacked a health exception.⁶⁰

The Partial-Birth Abortion Ban Act (“the Act”) that the U.S. Congress passed then was a starkly biased reaction to *Stenberg* by conservative members of Congress.⁶¹ Congress wrote the Act to prohibit dilation and extraction (D & E) procedures unless the doctor “intends to remove the fetus in pieces from the outset,” drawing a fine distinction absent in the Nebraska statute in *Stenberg* by avoiding the language “substantial portion” in reference to the fetus’ removal, thereby insinuating that it was not subtracting from the state’s interest in preserving a woman’s health, but only adding to the state’s interest in protecting fetal life. The Act makes it appear that the only prohibited D & E procedures are those that would require delivery of a “living fetus,” and that such a distinction can be made reliably at the outset of the procedure.

58. *Id.* at 1650 (Ginsburg, J., dissenting) (highlighting that the majority focused almost entirely on the life issue, using “infanticide” as a standard to determine when and what type of late-term abortions were acceptable to ignore the state’s interest in preserving a woman’s health).

59. *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 845-46 (1992).

60. *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000) (finding the Nebraska law banning D & E procedures unconstitutional because it had no health exception to preserve the woman’s health and because the ban created such an undue burden for a woman seeking late-term assistance to terminate risky pregnancies that it left the woman with no choice but to carry out the pregnancy).

61. *See, e.g.*, 149 CONG. REC. 5731 (2003) (statement of Sen. Santorum) (“We are here because the Supreme Court defended the indefensible [in *Stenberg*]”); 148 CONG. REC. 14273 (2002) (statement of Rep. Linder) (arguing that the Supreme Court cannot keep Congress from “ban[ning] . . . this horrible practice”).

It is therefore unsurprising that the Act's authors relied on testimony from medical professionals who had never performed abortions but clearly opposed the practice, concluding, against direct medical authority, that late-term abortion procedures are never necessary to safeguard a woman's health.⁶² Unfortunately, *Carhart* uses these serious factual discrepancies to declare that medical uncertainty exists about whether these procedures ever help to safeguard a woman's health, and that Congress's support for such uncertainty was enough to conclude that the Act does not create an undue burden on women's health.⁶³ Although *Stenberg* declared that "... this Court has made clear that a State may promote but not endanger a woman's health when it regulates the methods of abortion," the *Carhart* Court did just that, extending its weak rationale—that the congressionally-created "medical uncertainty" was proof that the law posed no undue burden—to dismiss *Stenberg*, reasoning that without an undue burden there can be no "substantial medical authority" supporting the assertion that the Act places women's health in danger.⁶⁴

Carhart essentially and wrongly implies that it is unreasonable for a woman's health ever to be a priority over fetal life. Without offering any real alternatives, the Court simply surmises that a woman would have to file an as-applied challenge to show that in her particular situation, such a procedure is absolutely necessary to protect her health.⁶⁵ However, an as-applied challenge inherently reads like an undue burden, adding an unnecessary layer of bureaucracy to a decision-making process that the Court openly admits is emotionally overwhelming, highly personal, and private. Moreover, such a bureaucratic burden only serves to complicate an area of law that the Supreme Court worked to clarify for three decades.

62. See *Carhart*, 127 S. Ct. at 1644 (Ginsburg, J., dissenting) (referencing the Act's Congressional Record, to which many physicians submitted letters asserting that the Act's prohibitions endangered women's health, and to which nine professional associations submitted statements arguing for the safety advantages of the banned intact D & E procedure, to determine that the Act ignored or directly contradicted medical facts); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1019 (N.D. Cal. 2004), *aff'd* sub nom. *Planned Parenthood Fed'n of Am. v. Ashcroft*, 435 F.3d 1163 (9th Cir. 2006) (finding that the testimony "was not only unbalanced, but intentionally polemic" because, of the six physicians who testified in front of Congress about partial-birth abortions, none had performed abortions and one was not an obstetrician/gynecologist).

63. See *Carhart*, 127 S. Ct. at 1637.

64. See *id.* at 1638 (believing that because *Stenberg* requires protection for a woman's health and does not allow room for medical uncertainty, it presents a "zero tolerance policy" that prevents legislatures from imposing reasonable regulations, suggesting vaguely that alternative procedures exist for women if the Act is upheld).

65. *Id.* at 1638-39 (finding that women should have to file lawsuits seeking to reinstate a health exception only in individual cases in which a woman can present "discrete and well-defined" proof that her health would be at risk without access to certain late-term abortion procedures, and even then, a woman's health may not prevail over the state's interest in life).

b. Carhart’s Language Indicates the Majority’s Preference Toward Fetal Life and Virtually Eliminates Any Legal Recognition of the Woman’s Decision-Making Role in Her Own Pregnancy

Carhart includes language and accounts of abortion procedures that bias toward treating the fetus like a baby—and therefore like a person for constitutional purposes—and treating the doctors performing these procedures like heartless hacks, while leaving out the pregnant women’s interests entirely.⁶⁶ Launching into four pages describing late-term abortion procedures, commonly known as intact D & E, where the fetus is kept “intact” as the terminology suggests, the Court relies primarily on one nurse’s detailed account of her observations during an intact D & E and refers to the medical doctor’s presentation as “an abortion doctor’s clinical description.”⁶⁷ The nurse’s account uses language to describe the “baby’s little fingers” having a reflex reaction during the procedure “like a baby does when he thinks he is going to fall,” and the doctor’s actions as “suck[ing] the baby’s brains out . . . [then] thr[owing] the baby in a pan, along with the placenta and the instruments he had just used.”⁶⁸

The Court then relies on Congress’s factual findings that a “moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion . . . is a gruesome and inhumane procedure that is never medically necessary and should be prohibited” to eliminate the precedential requirements safeguarding a woman’s health and to find against medical authority that a woman’s health never could be saved through one of these procedures.⁶⁹ Congress’s language and the Supreme Court’s reliance upon it, along with their tacit efforts to make fetuses sound like persons for constitutional purposes, created the “perfect storm” for an end-run around the precedents mandating a health exception. The Court therefore honored the false confusion that Congress created to suggest that medical evidence rejected these late-term procedures in order to counter the Eighth Circuit’s opinion, which relied on *Stenberg* to conclude that, without a consensus in the medical community against late-term procedures, legislatures must continue to ensure an exception for the woman’s health and safety in late-term abortion regulations.⁷⁰

66. *Id.* at 1623 (highlighting that “abortion doctors” have a single goal of ensuring fetal death before it leaves the womb, not to prevent risk to the mother or to protect her feelings, but to save the staff from seeing any movement of limbs because it makes them uncomfortable).

67. *Id.* at 1622.

68. *Id.* at 1622-23.

69. *Id.* at 1624.

70. *Id.* at 1625 (noting that the Eighth Circuit thought there needed to be substantial medical authority to exclude a health exception because such exclusion placed women at a greater health risk when medical options were being taken off the table to satiate

Moreover, rather than relying upon any record that women consistently regret their decisions or do not give informed consent to these procedures, the Court focused on a moral argument about the gruesomeness of the partial birth procedures as the foundation for removing control over reproductive choices from women's hands.⁷¹ The Court's assertion that it knows how best to "protect" women presumably now stands in place of the state asserting its interest in preserving a woman's right to choose how best to protect her own health through private decisions made with the advice of her doctor.⁷² In fact, the Court simply writes off the *Casey* reaffirmation that abortion restrictions can exist only where the state includes an exception for women's health.⁷³

Carhart therefore blazes a new and dangerous path, presenting the state's interests in protecting a woman's health and protecting fetal life as concurrent interests between which it can choose one to the full exclusion of the other.⁷⁴ All the while, the Court never suggests what would happen to the many women—particularly poor, minority women—who, as a result of *Carhart*, are compelled by the state to carry out their pregnancies despite serious health risks.⁷⁵

legislators' moral concerns).

71. *See id.* at 1633-34 (determining that Congress's goal in proscribing procedures that came close to resembling infanticide was proper because it makes the doctor's decisions less morally or ethically complicated, and reflects the apparently "self-evident" principle that, presuming a woman regrets her choice even where her health was at risk and an abortion was medically necessary, she "must struggle with grief more anguished and sorrow more profound" if she learns only after-the-fact about the procedure's details).

72. *See id.* at 1634 (finding that although doctors may prefer not to describe the procedures to women in full detail beforehand, if a woman really knew the procedural details, she would be too mortified to have the procedure, even where medically necessary or medically advisable).

73. *Id.* at 1636 (emphasizing the "documented medical disagreement" about whether women's health would be safeguarded through a health exception to conclude that what the *Casey* Court really meant to say was that legislatures can ban procedures regardless of such disagreement to protect fetal life, giving no mention of *Casey*'s primary focus of ensuring the inclusion of a health exception).

74. *Id.* (deciding that the only issue it must address is "whether the [Partial-Birth Abortion Ban] Act furthers the legitimate interest of the Government in protecting the life of the fetus that may become a child," and determining that the *Casey* Court really intended to begin addressing the previously undervalued state interest in fetal life, but simply lacked the authority in the questions presented).

75. *See* Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 823, 830-31 (2007).

c. The Court’s Erasure of the Compelling Health Interest Therefore Diminishes Women’s Worth in the Eyes of the Law Solely to That of Their Procreative Ability

As Justice Blackmun said in *Casey*, the law “does not compensate women for their services; instead, it assumes that they owe this duty [to carry out a pregnancy rather than choose to abort] as a matter of course,” and such assumptions are what requires us to look at abortion through the lens of equal protection.⁷⁶ The Court’s classification of women’s health interests as secondary to fetal life and subject to massive self-doubt marks a reversal in gender equality that, *inter alia*, questions women’s collective ability to make informed decisions about their individual health circumstances as well as their other life circumstances.

By reducing women to mere procreative machines, the *Carhart* decision defies its own logic by punishing and patronizing all women who engage in family planning.⁷⁷ It is particularly ironic in light of the fact that many women seeking options to protect their health already have other children.⁷⁸ Moreover, the Court’s concern for human life seems transparent where, as Justice Ginsburg points out in her dissent, the Act targets what it considers morally contemptible abortion methods that are necessary to protect a woman’s health, but actually does nothing to preserve fetal life.⁷⁹

With moral concern as the primary basis for the Court’s reasoning, all women could lose decision-making autonomy when it comes to pregnancy as well as other issues that uniquely affect women in which the state has a potentially conflicting interest.⁸⁰ *Carhart* wrongly inflates Congress’s

76. *Id.* (informing that the undue burden analysis was developed to ensure that “abortion regulation not enforce the gender-stereotypical understandings of the separate spheres tradition,” such as requiring women to give birth because society wants to maintain true womanhood by forcing women’s choices about their own “sexual and economic lives” to take a backseat to others’ conceptions of their role in society).

77. *See Waxman, supra* note 7, at 315 (emphasizing that a woman’s ability to determine her childbearing plans is a liberty interest under the Constitution of equal import to the other choices a woman must be free to make, such as “how to pursue her education and her employment, how to support herself and her family, and how to participate in the larger world alongside men”).

78. *See HEATHER D. BOONSTRA ET AL., ABORTION IN WOMEN’S LIVES 4* (2006), available at <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf> (last visited Nov. 27, 2007).

79. *See Gonzales v. Carhart*, 127 S. Ct. 1610, 1647 (2007) (Ginsburg, J., dissenting) (finding that the Act fails the majority’s test of “whether the Act furthers the legitimate interest of the Government in protecting the life of the fetus,” because nothing in the Act actually protects fetal life, nor does it preserve the equally important interest in a woman’s health).

80. *See id.* at 1647-48 (Ginsburg, J., dissenting) (analogizing *Lawrence v. Texas*, 539 U.S. 558 (2003), in which the Court held that states cannot punish homosexuals for sexual interactions with their chosen partners inside the privacy of their homes to emphasize that the Court already decided that the state cannot use its power “to enforce

mere suggestion that the medical profession differs on whether women's health is at risk by not having access to intact D & E late-term procedures, while citing to three different district courts that actually agreed that these procedures had safety advantages, without citing to the contrary any medical studies showing that such advantages were, as the majority alleged, "based on speculation."⁸¹ In fact, as Justice Ginsburg points out in her dissent, many physicians and nine medical professional associations made statements to Congress "attesting that intact D & E carries meaningful safety advantages over other methods," while no other well-known, large medical associations contradicted the testimony or supported the Act's ban on such procedures.⁸² Ginsburg also points to the expert testimony given at the trial level in *Carhart*, wherein medical professionals offered specific reasons why the intact D & E was far safer than any other procedure for women with certain medical conditions or certain pregnancy-related conditions to lessen their chance of injury.⁸³

Furthermore, rather than addressing any statistics about risky pregnancies and the medical need for these late-term procedures, the Court ignores the plight of the woman patient altogether. The Court offers only vague alternatives to the banned procedures, as though they would provide sufficient safeguards to preserve women's health, in order to focus its ire on limiting "abortion doctors" in their practices because giving such doctors unregulated choice encourages an operational freedom that supposedly no other doctors have in their practices.⁸⁴

The Court then essentially overturns the *Stenberg* rule requiring a health exception "if substantial medical authority supports the proposition that banning a particular procedure *could* endanger women's health" solely because it believes that *Stenberg* gives medical professionals too much power.⁸⁵ Without any constitutional reasoning, the Court wrongly

[its moral] views on the whole society through the operation of the criminal law").

81. *Id.* at 1635-36 (finding that medical uncertainty exists whether intact D & E procedures preserve a woman's health, despite the District Court for the District of Nebraska and the District Court of the Northern District of California determining that intact D & E frequently is the safest abortion procedure available to women facing health risks, and the District Court for the Southern District of New York finding that a "significant body of medical opinion . . . holds that D & E has safety advantages" for women whose health is at risk).

82. *Id.* at 1644 (Ginsburg, J., dissenting).

83. *Id.* at 1644-45 (Ginsburg, J., dissenting) (summarizing that doctors find intact D & E is safer for women with late-term, high-risk pregnancies because it: (1) minimizes the physician's invasion of the cervix and uterus, therefore lessening the possibility of perforation; (2) makes it less likely that fetal tissue remains behind causing infection, hemorrhage, and infertility; (3) reduces exposure to the sharp bone fragments resulting from standard D & E; and (4) is a quicker procedure, which in surgical situations always reduces a patient's safety risks).

84. *Id.* at 1636-37.

85. *Id.* at 1638 (emphasis added) (disregarding *Stenberg*, because Congress's

determines that Congress’s decision to limit what power exists in the doctor-patient relationship is unreviewable, and that Congress is free, also without recourse or review, to paint the issue of whether a woman’s health *could* be at risk as one of “medical uncertainty” and rely on that baseless conclusion as a legally valid reason for stripping women of their privacy and personhood rights.

2. *Carhart’s New Limitation on Women’s Rights Has an Especially Disproportionate Effect on Poor, Minority Women, and Re-subordinates All Women Seeking Health Options to a Legal Status of Coverture*

In its roundabout and largely unsupported reasoning, *Carhart* certainly has stripped healthy, informed, affluent women of the ability to protect their health, particularly when confronted with high-risk pregnancies.⁸⁶ In her passionate dissent read from the bench, Justice Ginsburg cites the Court’s previous rulings that the health exception applies not only where a woman’s health is at risk because of her pregnancy, but also where prohibitions leave women with fewer and less safe choices in their medical procedures when considering abortion.⁸⁷ As Ginsburg points out, it is often younger, poorer, and minority women who are not aware that they are pregnant, who are less likely to know what kind of prenatal care they need, and who are more likely therefore to have high-risk pregnancies and require late-term abortions, a fact that the Court has known since the *Roe* days.⁸⁸

Thus, the role that race and poverty play in this issue is substantial. According to the Guttmacher Institute, the reason poor, minority women and, in particular, young women of color from poor backgrounds are more likely to have abortions is because they cannot afford access to contraception, such as birth control pills.⁸⁹ These women also tend to have

Commerce Clause power confers a right to regulate the medical profession and to decide whether such regulations meet the rational basis requirement).

86. *See id.* at 1642 n.3 (Ginsburg, J., dissenting) (concluding that the women having late-term abortions often experience fetal abnormalities, fetal health problems, or their own health problems that often do not surface or develop until later in the pregnancy); *see also* Schechtman, Gray, Baty, & Rothman, *Decision-Making for Termination of Pregnancies with Fetal Anomalies: Analysis of 53,000 Pregnancies*, 99 OBSTETRICS & GYNECOLOGY 216, 220-21 (2002).

87. *See Carhart*, 127 S. Ct. at 1641-42 (Ginsburg, J., dissenting); *see also* Stenberg v. Carhart, 530 U.S. 914, 931 (2000); Planned Parenthood of Southeastern Pennsylvania v. Danforth, 428 U.S. 52, 79 (1976).

88. *See Carhart*, 127 S. Ct. at 1642 n.3 (Ginsburg, J., dissenting); *see also* Brief for the Joint Washington Office for Social Concern et al. as Amici Curiae, *United States v. Vuitch*, 402 U.S. 62 (1971) (No. 84) (concluding that abortion restrictions do not affect affluent women who suffer high-risk pregnancies, most of whom are white, because abortions may easily be obtained with enough money, and thus the degree of legality finds its measure in the amount of money the women can afford to pay).

89. *See* BOONSTRA, *supra* note 78, at 5.

abortions because the largest factor in their decision-making—whether they feel they can care for the child at the time of pregnancy—relies greatly on their income, and many of them already have other children for whom they also must care.⁹⁰

The figures are stark: black women are most likely to have abortions, with Hispanic and Asian women running a close second, and white women being the least likely group to have abortions, which highlights the disparities for those who live at the intersection of traditionally subordinated races and genders, and the role that intersectionality plays in one's economic standing and ability to make autonomous life choices.⁹¹ Particularly interesting is that most abortions are paid for out-of-pocket, and most poor, young minority women have late-term abortions because either they are unaware that they are pregnant until much further along in the pregnancy due to lack of reproductive education, or because it takes them too long to raise the necessary funds.⁹²

Because so many poor, minority women experience pregnancy at a young age, *Carhart* ensures that their lack of knowledge, which is exacerbated by their lack of financial resources, will continue the cycle of preventing future generations of such women from exerting any autonomy over their lives and therefore the opportunity to advance themselves and avoid future dependency on the state.⁹³ The main problem with *Carhart*, therefore, is that it winds up giving the state ultimate control over which women can carry pregnancies to term, and which women will have actual choices regarding their reproductive health. This perpetuates the separate spheres ideology by pushing women down the path to republican motherhood and bringing women back under the cover of their husbands or, alternatively, the state.

As Ginsburg states in her dissent, “[e]liminating or reducing women’s reproductive choices is manifestly *not* a means of protecting them.”⁹⁴ With *Carhart*, the Court returns to its separate-spheres thinking of over one-

90. *See id.* at 8 (noting that most women who have late-term abortions do so because their “life circumstances have drastically changed” since becoming pregnant, which includes learning that their health or their fetus’s health is at risk, or having a marriage or family finances that suffer).

91. *Id.* at 20.

92. *See id.* at 29 (asserting that women who have delayed access to abortions and must take advantage of later-term procedures usually end up in such circumstances because they must divert funds from “rent, utility bills, food and clothing for themselves and their children”).

93. Waxman, *supra* note 7, at 315-16.

94. *See* *Gonzales v. Carhart*, 127 S. Ct. 1610, 1649 n.9 (2007) (Ginsburg, J., dissenting) (asserting facts from the World Health Organization that restrictions only encourage women to find less safe means of ending their pregnancies, which often result in death).

hundred years ago in *Bradwell v. Illinois*, in which it determined that it was protecting women when it held that women should stay home and mother their children before considering their own aspirations in the public sphere.⁹⁵ Furthermore, *Carhart* also contradicts the modern Court’s developments on equal protection; as recently as ten years ago, the Supreme Court decided that most classifications regarding women were premised on stereotypes that had to be deconstructed to ensure equal treatment for women as persons under the Constitution.⁹⁶

Finally, *Carhart* perpetuates the legacy of slavery for minority women, particularly poor minority women, allowing the state to continue its control over their ability to choose how to organize families and when to give birth. Ginsburg’s allusion to *Muller v. Oregon* in her *Carhart* dissent is well founded; a simple reading of both opinions suggests a parallel between the Court’s protectionist attitude in preferring the state’s interest in the well-being of the [white] race in *Muller* and the Court’s protectionist attitude in preferring the state’s interest in life in *Carhart*.⁹⁷

There is no question, therefore, that the *Carhart* decision seems motivated by a subconscious or even conscious concern for white birth rates, which today are far lower than birthrates among women of color in America.⁹⁸ *Carhart* follows America’s long history of keeping minority women under the cover of their masters and then the state, starting with their enslavement.⁹⁹ Slave women had no rights and could maintain no

95. See *Bradwell v. Illinois*, 83 U.S. 130, 141-42 (1872) (Bradley, J., concurring) (finding that women were incapable of protecting themselves, and therefore the state had to ensure coverture under their husbands because “[m]an is, or should be, woman’s protector and defender. The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. [. . .] The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother”).

96. *United States v. Virginia*, 518 U.S. 515, 533, 542 n.12 (1996) (holding that “overbroad generalizations” about women’s “talents, capacities, or preferences” have made women less than full citizens, and that equal protection guarantees these classifications receive intermediate scrutiny, thus overturning a rule that kept women from attending a state-sponsored military college).

97. See *Gonzales v. Carhart*, 127 S.Ct. 1610, 1649 n.9 (Ginsburg, J., dissenting) (citing *Muller v. Oregon*, 208 U.S. 412, 422-23 (1908), to assert that the majority decision to protect women by limiting their rights reflects “discredited” notions about women’s roles in society, such as in *Muller* where the Court upheld protectionist legislation limiting what work women could do and the number of hours they could work on the basis of their perceived physical abilities and the Court’s decision that women instead should be at home to mother their children).

98. BRADY E. HAMILTON ET AL., PRELIMINARY BIRTHS FOR 2004, available at http://www.cdc.gov/nchs/data/hestat/prelimbirth04_tables.pdf (last visited Mar. 24, 2008).

99. See Pamela D. Bridgewater, *Reconstructing Rationality: Towards a Critical Economic Theory of Reproduction*, 36 EMORY L.J. 1215, 1221 (2007) (finding that a slave master could rape female slaves without legal or social repercussions, and that any resulting children became his slaves).

property—including their own children—and were treated solely as capsules in which to breed new slaves.¹⁰⁰ *Carhart* is another example of how the state still uses reproduction as a method of controlling poor, minority women, whether in failing to safeguard their health as punishment for getting pregnant unintentionally, or encouraging these women have birth control medicines implanted in them in return for the state's assistance with their current needs, financial or otherwise.¹⁰¹ As long as the abortion “problem” is infecting “the other”—meaning poor women and women of color—*Carhart* suggests that the Court will continue to reflect a general attitude among conservative public officials that they may subordinate the needs of poor and minority women to satisfy their own moral values, the goals of which sometimes carry racial overtones or are predicated on disparate race and class distinctions.

IV. CONCLUSION: THE FUTURE, AS DETERMINED BY *CARHART*

Carhart's reasoning wrongly restricts women's rights based on a gender classification because only women can become pregnant and give birth. Furthermore, *Carhart* encourages an overbroad reading and application of any laws restricting abortion options because it classifies women's autonomy and health as a lower interest than other state interests relevant to the abortion argument. Taken together, these classifications lead to an equal protection failure because the Court easily could interpret them to require the abolition of all abortions.

Carhart effectively can and should be overruled by lobbying state legislatures to de-limit restrictions and require health exceptions, and by electing officials who support the safeguarding of women's health. Legislatures should have to maintain a health exception for women who suffer from pregnancies that pose a health risk, both as a matter of preserving women's constitutional rights as persons, and preserving public health standards. A health exception also protects existing children if their mothers would not be able to survive a risky pregnancy because they lack good health care or simply because of their body's biological composition.

Because the restrictions *Carhart* imposes place already-at-risk women in more dire health and financial situations, the effort to reduce abortions will put additional pressure on the overburdened public assistance programs and state entities that already cannot cope with existing problems that poor and

100. See Pamela D. Bridgewater, *Reproductive Freedom as Civil Freedom: The Thirteenth Amendment's Role in the Struggle for Reproductive Rights*, 3 J. GENDER RACE & JUST. 401, 411-13 (2000) (stating that masters promised to reward slave women or punish them less severely if they engaged in slave breeding, but would do the opposite if these women did not comply).

101. *Id.* at 422-23.

minority women face. The result will be increased dependency on the state, making it continually more difficult for poor, minority women—especially teenage girls—to overcome the legacies of sexual and racial discrimination endemic to our legal and social systems in America and to succeed as autonomous individuals outside the cycles of poverty and young motherhood in which so many young minority women now find themselves.