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## *ESSAY*

### ESSENTIALLY ELECTIVE: THE LAW AND IDEOLOGY OF RESTRICTING ABORTION DURING THE COVID-19 PANDEMIC

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#### INTRODUCTION

The COVID-19 pandemic has put on full display the physical and doctrinal isolation of abortion from health care more generally.<sup>1</sup> In early 2020, several states proclaimed that abortions had to be stopped or delayed for lengthy or indefinite periods of time in order to help fight the pandemic. Those actions provoked litigation seeking emergency relief to keep abortion clinics open.<sup>2</sup> No similar lawsuits have been necessary to protect access to other medical procedures. So why was abortion singled out for disparate treatment?

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<sup>1</sup> See, e.g., David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 *Alb. L. Rev.* 833, 837–40 (1999); B. Jessie Hill, *The First Amendment and the Politics of Reproductive Health Care*, 50 *Wash. U. J.L. & Pol’y* 103, 103–04 (2016).

<sup>2</sup> The states in which litigation occurred are Alabama, Arkansas, Iowa, Louisiana, Ohio, Oklahoma, Tennessee, Texas, and West Virginia. Not all of the litigation has resulted in published opinions. I was involved as counsel in the litigation surrounding Ohio’s order and its application to abortion providers. Ohio was the first state to seek to enforce an elective-surgeries order against abortion clinics. Greer Donley, Beatrice A. Chen & Sonya Borrero, *The Legal and Medical Necessity of Abortion Care amid the COVID-19 Pandemic*, *J.L. & Biosciences* (forthcoming) (manuscript at 8–9), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3584728](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3584728) [<https://perma.cc/QL85-XHKQ>].

This Essay provides an overview of the litigation that ensued in the wake of some states' attempts to limit abortion access under the authority of executive orders limiting “non-essential,” “non-urgent,” or “elective” medical and surgical procedures. It argues that “abortion exceptionalism”—that is, “the tendency of legislatures and courts to subject abortion to unique, and uniquely burdensome, rules”—came into play in two ways.<sup>3</sup> First, the COVID-19 crisis allowed anti-abortion officials to rely on the narrow meaning of “elective” in the abortion context, as well as underlying ambiguity about the meaning of “elective,” to argue that abortions are medically unnecessary and can be halted indefinitely during a pandemic. Second, and relatedly, they used the exceptional treatment of abortion and the longstanding ambivalence about the place of abortion within health care to argue that abortion providers' demands to be treated like every other health care provider under these executive orders was in fact a claim for special treatment. This Essay ends by suggesting that, for long-term protection of abortion rights, abortion must be reframed as a medically necessary and appropriate treatment, and it must be rhetorically re-incorporated into health care more generally.

## I. LAW: AN OVERVIEW OF COVID-19 ABORTION LITIGATION

### *A. The Orders*

In a handful of states, shifting executive and judicial interpretations of orders banning non-urgent or elective surgeries resulted in a whiplash-inducing series of legal maneuvers and highly unstable circumstances on the ground for those seeking to access or provide abortion services during the COVID-19 pandemic. This controversy arose because, in mid-March 2020, states had begun adopting orders to limit the medical and/or surgical procedures that could be performed during the declared coronavirus emergency.<sup>4</sup> Broadly speaking, these orders were supported

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<sup>3</sup> Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 *Wash. & Lee L. Rev.* 1047, 1048 (2014); Caroline Mala Corbin, *Abortion Distortions*, 71 *Wash. & Lee L. Rev.* 1175, 1177 (2014); Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 *Mich. J. Gender & L.* 1, 3 (2012). This exceptionalism permeates abortion doctrine. For example, Professor Caroline Mala Corbin has described how courts set aside traditional free speech principles under the First Amendment when abortion-related speech is involved. Corbin, *supra*, at 1190–92.

<sup>4</sup> See, e.g., Ohio Dep't of Health, *Director's Order for the Management of Non-Essential Surgeries and Procedures Throughout Ohio* (Mar. 17, 2020) (rescinded Apr. 30, 2020),

by three justifications: (1) preserving hospital capacity in light of the likely influx of critically ill coronavirus patients; (2) conserving personal protective equipment (PPE), such as masks, gloves, and gowns, in short supply due to the pandemic; and (3) reducing the possibility of community spread of the virus by minimizing unnecessary provider-patient interactions.<sup>5</sup>

The question of how such orders should apply to abortion procedures arose almost immediately. On March 18, 2020, numerous professional organizations, including the American College of Obstetricians and Gynecologists (“ACOG”), issued a statement affirming that abortion is essential, time-sensitive health care that should not be delayed during a pandemic.<sup>6</sup> That statement noted: “[A] delay of several weeks, or in some cases days, may increase the risks or potentially make [abortion] completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being.”<sup>7</sup> Similarly, the American Medical Association issued a short statement on March 30, 2020, condemning the politicization of reproductive health care during the pandemic and asserting that “physicians—not politicians—should be the ones deciding which procedures are urgent-emergent and need to be performed, and which ones can wait, in partnership with our patients.”<sup>8</sup>

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ors-order-non-essential-surgery-3-17-2020 [<https://perma.cc/SXX3-2WTE>]; Tex. Governor Greg Abbott, Executive Order GA-09 (Mar. 22, 2020) (superseded Apr. 17, 2020 by GA-15), [https://gov.texas.gov/uploads/files/press/EO-GA\\_09\\_COVID-19\\_hospital\\_capacity\\_IMA-GE\\_03-22-2020.pdf](https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMA-GE_03-22-2020.pdf) [<https://perma.cc/Z876-HNLV>]; W. Va. Exec. Dep’t, Executive Order 16-20 (Mar. 31, 2020), <https://governor.wv.gov/Documents/EO%2016-20electiveprocedures.pdf> [<https://perma.cc/KS6A-FQ5E>].

<sup>5</sup> See sources cited *supra* note 4; see also, e.g., *Robinson v. Att’y Gen.*, 957 F.3d 1171, 1181 (11th Cir. 2020) (summarizing the state of Alabama’s justifications for its abortion restrictions related to the COVID-19 pandemic).

<sup>6</sup> ACOG et al., Joint Statement on Abortion Access During the COVID-19 Outbreak (Mar. 18, 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak> [<https://perma.cc/T8CA-K9QS>]. This statement was joined by the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine.

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

<sup>8</sup> Am. Med. Ass’n, AMA Statement on Government Interference in Reproductive Health Care (Mar. 30, 2020), <https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care> [<https://perma.cc/6SAC-PJD5>].

Several governors and other officials took the opposite tack, declaring that most “surgical” abortions—and in some cases even medication-induced abortions—must cease, at least temporarily, during the pandemic.<sup>9</sup> For example, Mississippi Governor Tate Reeves claimed that his executive order banning “elective procedures” would prevent abortions, just like the Texas order it was modeled upon.<sup>10</sup> In Oklahoma, the governor declared that all abortions, except emergent procedures or those necessary to avert a serious medical risk, would be suspended under a similar order.<sup>11</sup> In Ohio, abortion clinics initially believed they were allowed to continue providing services under the non-essential surgery order, since “time sensitive” procedures were permitted.<sup>12</sup> But not long after the order became effective, anti-abortion activists began calling abortion clinics to determine whether they were open, and then advocated with state officials to obtain an interpretation of the order that would halt abortions.<sup>13</sup> These efforts found success with the Ohio Attorney General, who subsequently issued cease and desist orders to several Ohio clinics.<sup>14</sup> In Ohio, as in several other states, litigation ensued.

### *B. The Litigation*

For the most part, courts decided that it was unconstitutional for states to ban nearly all abortions under the orders that were designed to minimize interpersonal contact, preserve PPE, and manage hospital

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<sup>9</sup> Abortions may be performed medically or surgically. Medication-induced abortions require only the taking of pills and are available through approximately ten weeks of pregnancy. So-called “surgical” abortions, which are available both early and later in pregnancy, are not surgeries in the traditional sense, since they do not usually involve any incision or a sterile opening. See, e.g., *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2316 (2016), as revised (June 27, 2016).

<sup>10</sup> Ashton Pittman, *Governor Attempts To Ban Mississippi Abortions, Citing Need To Preserve PPE*, Jackson Free Press (Apr. 10, 2020), <https://www.jacksonfreepress.com/news/2020/apr/10/governor-bans-abortions-mississippi-claiming-need/> [<https://perma.cc/S-CR5-9PE4>].

<sup>11</sup> Ryan Sharp & Carmen Forman, *Gov. Kevin Stitt Says Abortions Included in Suspended Elective Surgeries*, Oklahoman (Mar. 27, 2020), <https://oklahoman.com/article/5658751/governors-office-clarifies-executive-order-to-include-abortions> [<https://perma.cc/3CJ3-3326>].

<sup>12</sup> Ohio Dep’t of Health, *supra* note 4.

<sup>13</sup> CreatedEqualFilms, *#StopTheSpread: Abortion Centers Pose Serious Health Risk of COVID-19 Spread*, YouTube (Mar. 20, 2020), <https://youtu.be/KKROXMyZ18A> [<https://perma.cc/LW2J-T5SH>].

<sup>14</sup> *Preterm-Cleveland v. Att’y Gen.*, No. 1:19-CV-00360, 2020 WL 1957173, at \*3 (S.D. Ohio Apr. 23, 2020).

capacity. District courts in Alabama, Arkansas, Ohio, Oklahoma, Tennessee, and Texas all granted temporary relief against attempts to enforce the orders so as to prevent abortions in all but the most limited circumstances, such as where the pregnant patient's life is in danger.<sup>15</sup> Appeals courts were more of a mixed bag, with the Fifth and Eighth Circuits permitting only a narrow subset of abortions to continue, whereas the Sixth and Eleventh Circuits found a wider range of abortion procedures to be constitutionally protected, even during the pandemic.

The state surgery orders all differed somewhat in their wording and their duration.<sup>16</sup> For example, most orders banned “elective” or “non-essential” surgeries but then listed several criteria to define those terms—generally in such a way that time-sensitive procedures could still go forward. A small number prohibited all “procedures” with the exception of those that are “immediately medically necessary” or those necessary to treat “an emergency medical condition.”<sup>17</sup> Moreover, most orders referred to surgeries and medical “procedures”; as such they appeared only to limit surgical abortions, although they were interpreted in some states to encompass medication abortion as well.<sup>18</sup> Some orders were designed to

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<sup>15</sup> *Preterm-Cleveland*, 2020 WL 1957173, at \*17 (granting preliminary injunction); *S. Wind Women's Ctr. LLC v. Stitt*, No. 20-CV-00277, 2020 WL 1932900, at \*10 (W.D. Okla. Apr. 20, 2020) (granting preliminary injunction); *Adams & Boyle, P.C. v. Slatery*, No. 3:15-CV-00705, 2020 WL 1905147, at \*7 (M.D. Tenn. Apr. 17, 2020) (granting preliminary injunction), *aff'd as modified*, 956 F.3d 913 (6th Cir. 2020), modified, No. 3:15-CV-00705, 2020 WL 2026986 (M.D. Tenn. Apr. 27, 2020); *Little Rock Family Planning Servs. v. Rutledge*, No. 4:19-CV-00449, 2020 WL 1862830, at \*11 (E.D. Ark. Apr. 14, 2020) (granting temporary restraining order), order vacated in part, No. 4:19-CV-00449, 2020 WL 2079224 (E.D. Ark. Apr. 22, 2020); *Robinson v. Marshall*, No. 2:19-CV-00365, 2020 WL 1847128, at \*16 (M.D. Ala. Apr. 12, 2020) (granting preliminary injunction); *Planned Parenthood Ctr. for Choice v. Abbott*, No. A-20-CV-00323, 2020 WL 1815587, at \*7 (W.D. Tex. Apr. 9, 2020) (granting temporary restraining order), mandamus granted, order vacated in part sub nom. *In re Abbott*, 956 F.3d 696 (5th Cir. 2020).

<sup>16</sup> A helpful chart can be found in Donley, Chen & Borrero, *supra* note 2, at 6–8.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at 4. In Texas, for instance, the district court issued a temporary restraining order enjoining the state from banning medication abortion during the pandemic. *Planned Parenthood Ctr. for Choice v. Abbott*, No. A-20-CV-00323, 2020 WL 1502102, at \*4 (W.D. Tex. Mar. 30, 2020). After the Fifth Circuit Court of Appeals vacated the injunction, see *In re Abbott*, 954 F.3d 772, 779 (5th Cir. 2020), the plaintiff clinics moved for a second temporary restraining order, resulting in a narrower injunction that blocked the order from being applied to, *inter alia*, medication abortions. *Planned Parenthood Ctr. for Choice*, 2020 WL 1815587, at \*7. After the Fifth Circuit stayed that injunction, see *In re Abbott*, 800 F. App'x 293, 296 (5th Cir. 2020), Planned Parenthood asked the U.S. Supreme Court for an emergency order vacating the stay as applied to medication abortions. Emergency Application to Justice Alito To Vacate Administrative Stay of Temporary Restraining Order Entered by the United States

stay in effect until they were rescinded, whereas others had set expiration dates.<sup>19</sup>

Where states interpreted their orders to prohibit abortion, courts' differing understandings and applications of the relevant doctrinal framework dictated whether those abortion bans were found to be constitutional. In particular, courts differed in how they understood the key Supreme Court precedent pertaining to the government's public health powers in *Jacobson v. Massachusetts*,<sup>20</sup> and its interaction with the key abortion-rights precedents in *Planned Parenthood of Southeastern Pennsylvania v. Casey*<sup>21</sup> and *Whole Woman's Health v. Hellerstedt*.<sup>22</sup> *Casey*, of course, stands for the proposition that the state may not prevent a pregnant person from accessing abortion altogether before viability, nor may it impose an "undue burden" on the ability to do so.<sup>23</sup> *Whole Woman's Health* clarified that courts applying this standard should balance the asserted health benefits of the law against the law's burdens on abortion access; if the benefits are outweighed by the burdens, then the

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Court of Appeals for the Fifth Circuit at 1, *Planned Parenthood Ctr. for Choice v. Abbott*, No. 19A1019 (Apr. 11, 2020). Before the Supreme Court could act, the Fifth Circuit dissolved its own stay only as applied to medication abortions, finding that it was unclear whether the Governor's order was meant to prohibit them. In re *Abbott*, 809 F. App'x 200, 202–03 (5th Cir. 2020). Subsequently, however, that same court issued an opinion holding the second temporary restraining order invalid and allowing the state to prohibit all abortions (including medication abortions), except for women whose pregnancies were close to the legal limit for obtaining a pre-viability abortion. *Abbott*, 956 F.3d at 724.

<sup>19</sup> Compare, e.g., La. Dep't of Health, Healthcare Facility Notice/Order #2020-COVID19-All-007, at 2 (Mar. 21, 2020), <http://ldh.la.gov/assets/oph/Coronavirus/resources/providers/LDH-UPDATED-Notice-Med-Surg-Procedures32120.pdf> [<https://perma.cc/K94T-YB6S>] (stating the order would remain in effect "until further notice"), and Ohio Dep't of Health, supra note 4 (stating the order would remain in effect until the state of emergency no longer exists or the order is rescinded or modified), with Tex. Governor Greg Abbott, supra note 4 (specifying an expiration date of Apr. 21, 2020).

<sup>20</sup> 197 U.S. 11, 22–23 (1905).

<sup>21</sup> 505 U.S. 833, 844–45 (1992).

<sup>22</sup> 136 S. Ct. 2292, 2309–10 (2016).

<sup>23</sup> *Casey*, 505 U.S. at 872–74; see also *Whole Woman's Health*, 136 S. Ct. at 2309 (same).

burden is “undue.”<sup>24</sup> In addition, courts are not to defer uncritically to legislatures’ findings regarding the medical benefits of a particular law.<sup>25</sup>

Seemingly uncomfortable with engaging in business as usual during a public health crisis, the courts also turned to *Jacobson*, a 1905 Supreme Court case involving a constitutional challenge to Massachusetts’s compulsory smallpox vaccination law. In *Jacobson*, the Court upheld the vaccination requirement, stating that courts normally lack “power . . . to review legislative action in respect of a matter affecting the general welfare,” except if the action “has no real or substantial relation to” public health, morals, or safety, or if the action “is, beyond all question, a plain, palpable invasion of rights secured by the [Constitution].”<sup>26</sup> They treated *Jacobson*, which appears to apply highly deferential review to state action, as providing relevant doctrinal principles for defining the scope of constitutional rights during a public health emergency.

However, it is not at all clear that *Jacobson*, a *Lochner*-era case considering the limits of the state’s police powers, has any application where an individual constitutional right is involved. Nor does it actually appear to be a case about emergency powers. The central question in *Jacobson*—which was decided long before the footnote in *United States v. Carolene Products Co.* urging heightened scrutiny for laws affecting fundamental rights<sup>27</sup> and long before the Court recognized an individual right to bodily integrity and decisional autonomy—was simply whether a compulsory smallpox vaccination requirement fell within the scope of state power. In *Jacobson*, the Court was not faced with any specific claim of an individual constitutional right—just a generic appeal to Fourteenth-Amendment “liberty.”<sup>28</sup> At the turn of the twentieth century, state laws were often subject to scrutiny on the ground that they violated individual

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<sup>24</sup> *Whole Woman’s Health*, 136 S. Ct. at 2309. In *June Medical Services, LLC v. Russo*, 140 S. Ct. 2103 (2020), the Supreme Court struck down a Louisiana law that was virtually identical to the Texas law at issue in *Whole Woman’s Health*. *Id.* at \_\_\_ (slip op. at 40). In so doing, a four-Justice plurality applied the balancing test set forth in *Whole Woman’s Health*. *Id.* at \_\_\_ (slip op. at 2–3). Chief Justice Roberts, who provided the critical fifth vote, concurred separately and questioned the validity of requiring courts to consider an abortion restriction’s benefits in relation to its burdens. *Id.* at \_\_\_ (slip op. at 2) (Roberts, C.J., concurring). Thus, the balancing test set forth in *Whole Woman’s Health* remains intact for now, although there are clearly five Justices—Chief Justice Roberts plus the four other conservative Justices—who would like to abandon it. See *id.* at \_\_\_ (slip op. at 1–2) (Kavanaugh, J., dissenting).

<sup>25</sup> *Whole Woman’s Health*, 136 S. Ct. at 2310.

<sup>26</sup> *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905).

<sup>27</sup> 304 U.S. 144, 152–53 n.4 (1938).

<sup>28</sup> *Jacobson*, 197 U.S. at 24, 26.

liberty and by the same token exceeded the extent of the state's power to legislate in the interest of health or safety;<sup>29</sup> *Lochner*-era substantive due process challenges thus generally asserted that a particular law was invalid because it was not actually a health law, or because it did not actually advance the state's interest in health and safety.<sup>30</sup> This claim did not turn at all on whether the law conflicted with the claimant's constitutional rights.

In addition, the scrutiny that the Court applied to the vaccination law in *Jacobson* was arguably stricter than its deferential language indicated.<sup>31</sup> As Professor Scott Burris has pointed out, the *Jacobson* Court made reference to the wide and deep medical consensus around the safety and efficacy of vaccination, citing two pages' worth of medical authority to that effect, in support of its finding that compulsory vaccination was an appropriate and legitimate health measure.<sup>32</sup> Indeed, *Jacobson* has often been treated as a precedent about the *limits* on states' public health powers, not a vindication of unlimited state emergency powers.<sup>33</sup> Moreover, if *Jacobson* was a case about the state's expansive power in emergencies, as the states claimed in asserting their authority to ban or delay abortions in a public health emergency, it is not clear why vaccination mandates have continued to be upheld on *Jacobson*'s authority more than a century later, regardless of whether the mandate addresses an actual public health emergency.<sup>34</sup>

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<sup>29</sup> See, e.g., Wendy E. Parmet, From Slaughter-House to *Lochner*: The Rise and Fall of the Constitutionalization of Public Health, 40 Am. J. Legal Hist. 476, 483 (1996) ("To [Justice Samuel] Miller, the Fourteenth Amendment did not prohibit states from exercising their police power. It only forbid them from exceeding that power."); *id.* at 493 ("[T]he Fourteenth Amendment challenges [around the turn of the twentieth century] asserted . . . that the states were denying individual freedom and acting beyond the purview of government.").

<sup>30</sup> See, e.g., *Lochner v. New York*, 198 U.S. 45, 58 (1905).

<sup>31</sup> Scott Burris, Rationality Review and the Politics of Public Health, 34 Vill. L. Rev. 933, 961 (1989). Indeed, the application of fairly rigorous review in fact, while using the language of rational basis review, is arguably the hallmark of cases from the *Lochner* era. See David N. Mayer, The Myth of "Laissez-Faire Constitutionalism": Liberty of Contract During the *Lochner* Era, 36 Hastings Const. L.Q. 217, 262 (2009).

<sup>32</sup> Burris, *supra* note 31, at 961–62.

<sup>33</sup> James G. Hodge, Jr. & Lawrence O. Gostin, School Vaccination Requirements: Historical, Social, and Legal Perspectives, 90 Ky. L.J. 831, 856–57 (2002) (deriving from *Jacobson* four limitations on the power of states to act in the interest of public health); cf. Parmet, *supra* note 29, at 493 (noting that "the concept of the police power" at the time of *Jacobson* "was used not only to define state power, but to limit it in the name of individual freedom").

<sup>34</sup> For example, in *Caviezel v. Great Neck Pub. Sch.*, 500 F. App'x 16 (2d Cir. 2012), the Second Circuit Court of Appeals applied *Jacobson* to uphold a general vaccination



Nonetheless, all of the courts considering challenges to abortion restrictions during the pandemic applied *Jacobson* to some degree. Some courts appeared to understand *Jacobson*'s language as requiring a higher showing of unconstitutionality and a greater mismatch between means and ends than if only *Casey* and *Whole Woman's Health* applied. For example, the Fifth Circuit treated *Jacobson* as requiring a form of arbitrariness review—a standard associated with rational basis scrutiny.<sup>35</sup> The Eighth Circuit also adopted this framework, suggesting that even an otherwise unconstitutional ban on all surgical abortions before viability might be constitutional in the context of a public health crisis.<sup>36</sup> Similarly, the dissenting judge in the Sixth Circuit case read the “basic principle of *Jacobson*” to be “that states may respond to emergencies in the face of substantive-due-process rights, so long as they act reasonably and don't single out specific rights or persons for disfavored treatment.”<sup>37</sup> Judged against the correct understanding of *Jacobson* in its historical context, however, this treatment of the case as requiring an elevated showing of

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requirement for public schooling and observed that the case generally demonstrates that the state interest in protecting against communicable disease outweighs the individual's interest in refusing unwanted medical interventions. *Id.* at 19 (citing *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990)); see also *Zucht v. King*, 260 U.S. 174, 176 (1922) (relying on *Jacobson* for the proposition that “compulsory vaccination” is within a state's “police power”); Wendy E. Parmet, *Rediscovering Jacobson in the Era of COVID-19*, 100 B.U. L. Rev. Online 117, 127, 130–31 (2020) (demonstrating that *Jacobson* has not been applied, and was not meant to apply, only to emergencies or outbreaks).

<sup>35</sup> *In re Abbott*, 956 F.3d 696, 704–05, 716 (5th Cir. 2020); *In re Abbott*, 954 F.3d 772, 784 (5th Cir. 2020); see also Parmet, *supra* note 34, at 118 (noting that the Fifth Circuit in *Abbott* treated *Jacobson* as “requir[ing] courts to limit their review of constitutional rights during a public health emergency”).

<sup>36</sup> *In re Rutledge*, 956 F.3d 1018, 1027, 1030 (8th Cir. 2020).

<sup>37</sup> *Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 934 (6th Cir. 2020) (Thapar, J., dissenting). Interestingly, in enjoining Kentucky's ban on drive-in religious services during the pandemic, the Sixth Circuit glided past *Jacobson* without applying, or in fact even mentioning, the language that appeared to require a less stringent level of review. In fact, the court summed up the only paragraph in which it cited *Jacobson* with the Delphic assertion: “While the law may take periodic naps during a pandemic, we will not let it sleep through one.” *Maryville Baptist Church, Inc. v. Beshear*, 957 F.3d 610, 615 (6th Cir. 2020). Meanwhile, the U.S. Supreme Court rejected a church's request for emergency relief against California's ban on larger in-person worship ceremonies. Concurring in the denial, Chief Justice Roberts cited *Jacobson* to suggest that the need for particular measures during a pandemic should be left primarily to the political process. *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613 (2020) (Roberts, C.J., concurring). Justice Kavanaugh, joined by Justices Thomas and Alito, dissented from the denial without so much as mentioning *Jacobson*. *Id.* at 1614–15 (Kavanaugh, J., dissenting).

unconstitutionality or a less strict form of review for state orders in public health emergencies appears remarkably anachronistic.

On the other hand, the Sixth and Eleventh Circuits held that *Jacobson*'s language must be reconciled with the more recent cases identifying a constitutional right to access abortion. Under this framework, those courts held that the orders violated patients' rights to access abortion.<sup>38</sup> Perhaps implicitly recognizing that *Casey* and *Whole Woman's Health* already required the court to balance state interests against individual rights, those courts focused on determining whether the burdens of the orders outweighed their benefits. This balancing test already required consideration of whether, to echo the language of *Jacobson*, the orders lacked a "substantial relation to" the public health goals they sought to advance.<sup>39</sup> In other words, as the Sixth Circuit explained, "context matters."<sup>40</sup> In the context of a pandemic, the *Whole Woman's Health* standard for deciding whether a burden is "undue" already allows courts to take into account the urgency and time-sensitivity of the state's interests in preserving hospital capacity, maintaining the supply of PPE, and limiting in-person contact. The court must then balance those benefits against the burden on the individual's right to access abortion—which, here, amounts to a total ban on abortion for the (possibly indefinite) duration of the orders.

Regardless of whether *Jacobson*'s language should apply, courts should have concluded that the elective surgery orders were unconstitutional as applied to abortion. These orders could be viewed as either completely banning abortion or as delaying individual abortions for a period of weeks or more. Viewed as bans on abortion, the orders would unquestionably be unconstitutional; neither the Supreme Court nor any federal appellate court has, since *Roe v. Wade*,<sup>41</sup> ever upheld a flat-out ban on abortion (as opposed to a regulation). Perhaps in order to avoid this clear precedent, some states argued that their orders required all abortions to be delayed during the pandemic except if the patient was nearing the gestational limit for obtaining a legal abortion (usually

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<sup>38</sup> *Adams & Boyle*, 956 F.3d at 927 (“[W]e will not countenance . . . the notion that COVID-19 has somehow demoted *Roe* and *Casey* to second-class rights, enforceable against only the most extreme and outlandish violations.”); *Robinson v. Att’y Gen.*, 957 F.3d 1171, 1182–83 (11th Cir. 2020).

<sup>39</sup> *Jacobson v. Massachusetts*, 197 U.S. 11, 19 (1905).

<sup>40</sup> *Adams & Boyle*, 956 F.3d at 927.

<sup>41</sup> 410 U.S. 113 (1973).

approximately 22–24 weeks of pregnancy).<sup>42</sup> Even understood as delays, however, the orders would unquestionably and palpably amount to undue burdens on the abortion right under *Casey* and *Whole Woman’s Health*. *Casey* upheld a 24-hour waiting period for women seeking abortions, the purpose of which was to ensure women are able to reflect on their decisions, but found the constitutionality of that provision to be a “closer question” than the constitutionality of other restrictions.<sup>43</sup> Given that the delays required by the COVID-19 pandemic would last weeks or longer, as explained below, the burdens on abortion access imposed by those bans outweigh the benefits by a substantial margin.

Pregnancy progresses inevitably and relatively quickly, and while abortion is an extremely safe procedure, the risks associated with abortion increase later in the pregnancy—approximately 38% per week of delay.<sup>44</sup> In addition, more complex surgical procedures are required at later gestational stages, sometimes even necessitating surgical visits on two separate days to complete.<sup>45</sup> Thus, at a minimum, the health risks are sufficiently grave if delaying an abortion would require a later and riskier procedure. In addition, however, every week of delay imposes unnecessary and therefore unacceptable health risks—especially since most courts were operating on the understanding that any patient who wanted an abortion had a right to receive one eventually, and thus that every abortion would still occur, but much later in the pregnancy.<sup>46</sup> The increased health risks to patients are therefore a serious burden to be weighed against the questionable benefits.

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<sup>42</sup> See, e.g., *Adams & Boyle*, 956 F.3d at 922; *In re Abbott*, 800 F. App’x 293, 296 (5th Cir. 2020).

<sup>43</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885 (1992).

<sup>44</sup> Linda A. Bartlett, Cynthia J. Berg, Holly B. Shulman, Suzanne B. Zane, Clarice A. Green, Sara Whitehead & Hani K. Atrash, Risk Factors for Legal Induced Abortion-Related Mortality in the United States, 103 *Obstetrics & Gynecology* 729, 731 (2004). Carrying a pregnancy to term—a process that also generally involves medical intervention—is several times riskier than abortion; thus, arguably all abortions avert serious health risks. See Suzanne Zane, Andreea A. Creanga, Cynthia J. Berg, Karen Pazol, Danielle B. Suchdev, Denise J. Jamieson & William M. Callaghan, Abortion-Related Mortality in the United States 1998–2010, 126 *Obstetrics & Gynecology* 258, 264 (2015), [https://journals.lww.com/greenjournal/Fulltext/2015/08000/Abortion\\_Related\\_Mortality\\_in\\_the\\_United\\_States\\_6.aspx](https://journals.lww.com/greenjournal/Fulltext/2015/08000/Abortion_Related_Mortality_in_the_United_States_6.aspx) [<https://perma.cc/D8C3-3XMH>]; CDC, Pregnancy Mortality Surveillance System 2, <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> [<https://perma.cc/4A6P-9GNH>].

<sup>45</sup> *Preterm-Cleveland v. Att’y Gen.*, No. 1:19-CV-00360, 2020 WL 1957173, at \*7 (S.D. Ohio Apr. 23, 2020); Bartlett et al., *supra* note 44, at 735.

<sup>46</sup> See sources cited *supra* note 42.

Those benefits were purported to be saving PPE, preserving hospital capacity, and minimizing personal contact. But given that under the states' positions, pregnant people would be able to receive abortions eventually—just later than they wished to—these interests would not be served. The later procedures would use just as much or more PPE; the personal contact would still occur, and hospitalization—while always unlikely with an abortion, which is a safe outpatient procedure—would if anything be *more* likely the longer the person remained pregnant and the later and more complicated the abortion procedure became. Thus, the Sixth and Eleventh Circuits correctly held that the COVID abortion bans lacked a “substantial relation” to their public health goals and were “plain[ly] and] palpab[ly]” unconstitutional under *Whole Woman’s Health*.<sup>47</sup>

Ultimately, most of the litigation surrounding non-essential surgery orders has been mooted or otherwise fizzled out. Many states' orders expired or else were replaced by more lenient orders that clearly allowed abortions to proceed along with most other outpatient surgeries.<sup>48</sup> Thus, the legal issue has died down for now, although litigation will likely recur if a new wave of COVID cases leads to a short supply of PPE and hospital beds.<sup>49</sup> But beyond its possible relevance to future litigation, the case law

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<sup>47</sup> *Robinson v. Att’y Gen.*, 957 F.3d 1171, 1182 (11th Cir. 2020) (quoting *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905)).

<sup>48</sup> See, e.g., Ohio Dep’t of Health, Director’s Stay Safe Ohio Order 3 (Apr. 30, 2020), <https://coronavirus.ohio.gov/static/publicorders/Directors-Stay-Safe-Ohio-Order.pdf> [<https://perma.cc/JD5F-CKMC>]; Tex. Governor Greg Abbott, Executive Order GA-15 (Apr. 17, 2020), [https://gov.texas.gov/uploads/files/press/EO-GA-15\\_hospital\\_capacity\\_COVID-19\\_TRANS\\_04-17-2020.pdf](https://gov.texas.gov/uploads/files/press/EO-GA-15_hospital_capacity_COVID-19_TRANS_04-17-2020.pdf) [<https://perma.cc/LYB7-L5T7>] (allowing non-medically necessary surgeries to proceed if they would not deplete hospital capacity or PPE). One notable exception is Arkansas, which replaced its stringent ban on abortions not “necessary to protect the life or health of the patient” with an order, adopted April 27, 2020, allowing virtually all “elective” surgeries to proceed but requiring even asymptomatic patients to provide a negative test result for COVID-19 within 48 hours of the surgery. Although some health care facilities presumably have access to such tests, this requirement proved nearly impossible for abortion clinics to meet. *Little Rock Family Planning Servs. v. Rutledge*, No. 4:20-CV-00470, 2020 WL 2240105, at \*4–5 (E.D. Ark. May 7, 2020).

<sup>49</sup> In Texas, for example, the Governor rolled back the state’s reopening and imposed new restrictions on elective surgeries, although the new elective surgeries order appears not to apply to abortions. Emma Platoff, *Texas Bans Elective Surgeries in More than 100 Counties as Coronavirus Hospitalizations Keep Climbing*, *Tex. Tribune* (July 9, 2020), <https://www.texastribune.org/2020/07/09/texas-coronavirus-hospitalizations-elective-surgeries/> [<https://perma.cc/TS6H-8EM7>]. Other states, too, have begun shutting down again in response to spikes in COVID-19 infection rates. See Jasmine C. Lee, Sarah Mervosh, Yuriria Avila, Barbara Harvey & Alex Leeds Matthews, *See How All 50 States Are Reopening* (and

arising out of the abortion restrictions adopted during the pandemic contains useful lessons about the rhetorical framing of abortion even during non-pandemic times.

## II. IDEOLOGY: THE LOGIC BEHIND THE COVID ABORTION BANS

The fight over abortion access during the COVID-19 pandemic has roots that stretch back well before 2020. Since the Supreme Court recognized a fundamental right to terminate a pregnancy in *Roe v. Wade*, a series of historical contingencies and intentional choices has led to abortions being provided primarily in freestanding clinics that are separate from “mainstream” medical institutions such as hospitals and physicians’ offices. This result has coincided with the development of a unique doctrinal framework for analyzing the constitutionality of abortion restrictions that is largely dissimilar to the framework for analyzing any other constitutional right, leading to the perception that abortion is *sui generis* in constitutional law.<sup>50</sup> This evolution has produced two kinds of abortion exceptionalism that make a recognizable appearance in the COVID abortion ban cases: considering most abortions to be elective, unlike comparable medical procedures, and framing abortion providers’ requests for equal treatment as requests for special treatment. As I discuss in Part III, these phenomena are problematic for abortion doctrine, both within the pandemic-orders context and outside of it.

### A. “Elective” Abortion

Most states’ orders temporarily banned “elective” or “non-essential” surgeries.<sup>51</sup> Those terms were then further defined in the orders. Yet,

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Closing Again), N.Y. Times (July 23, 2020), <https://www.nytimes.com/interactive/2020/us/states-reopen-map-coronavirus.html> [<https://perma.cc/SD6T-NW7X>].

<sup>50</sup> I discuss this phenomenon in a forthcoming article. B. Jessie Hill, *The Geography of Abortion Rights*, 109 *Geo. L.J.* (forthcoming 2021) (manuscript at 20–21, 21 n.97) (on file with author).

<sup>51</sup> The states temporarily banning “elective” surgeries were Arkansas, Iowa, Ohio, Oklahoma, and Tennessee. Arkansas Dep’t of Health, ADH Directive on Elective Surgeries (Apr. 3, 2020) (superseded Apr. 27, 2020), [https://www.healthy.arkansas.gov/images/uploads/pdf/Elective\\_Procedure\\_Directive\\_April\\_3.pdf](https://www.healthy.arkansas.gov/images/uploads/pdf/Elective_Procedure_Directive_April_3.pdf) [<https://perma.cc/8WBP-K2K2>]; Governor Kimberly K. Reynolds, Proclamation of Disaster Emergency (Mar. 26, 2020) (superseded Apr. 24, 2020), <https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.26.pdf> [<https://perma.cc/KDW8-CZ-AW>]; Ohio Dep’t of Health, Director’s Order for the Management of Non-Essential Surgeries and Procedures Throughout Ohio (Mar. 17, 2020) (rescinded Apr. 30, 2020),

because of this wording, anti-abortion officials were able to exploit a particular popular understanding of electiveness in the abortion context that would not apply to other medical procedures.

Strictly speaking, in medical terminology an “elective” surgery is simply one that can be scheduled ahead of time, as opposed to one that is emergently performed.<sup>52</sup> In popular parlance, by contrast, elective surgery is often understood to refer to procedures that are optional or not medically necessary, such as cosmetic surgery.<sup>53</sup> Yet it does not appear that either meaning was intended by those orders banning “elective” surgeries. Instead, the orders often outlined specific factors to define what constitutes essential, non-elective surgery. Generally, those factors included time sensitivity and aggravation of an underlying condition—thus allowing a range of procedures to go forward that would not necessarily qualify as emergent.<sup>54</sup>

As used in the abortion context, the term “elective” has yet another meaning, which state officials appeared to rely upon in claiming they should not be performed during the pandemic. In the abortion context, “elective” almost always refers to those abortions that are not performed

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<https://coronavirus.ohio.gov/wps/portal/gov/covid-19/resources/public-health-orders/directors-order-non-essential-surgery-3-17-2020> [<https://perma.cc/ZCT8-5GDU>]; Okla. Exec. Order 2020-07 (Fourth Amended) (Mar. 24, 2020), <https://www.sos.ok.gov/documents/-executive/1919.pdf> [<https://perma.cc/EAG4-KHP6>]; Tenn. Exec. Order 25 (Apr. 8, 2020) (expired Apr. 30, 2020), <https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee25.pdf> [<https://perma.cc/P5L3-N2SJ>].

<sup>52</sup> See, e.g., Michelle J. Bayefsky, Deborah Bartz & Katie L. Watson, Abortion During the Covid-19 Pandemic—Ensuring Access to an Essential Health Service, 382 *New Eng. J. Med.* e47(1), e47(2) (2020); Benjamin Elliot Yelnosky Smith, Deborah Bartz, Alisa B. Goldberg & Elizabeth Janiak, “Without Any Indication”: Stigma and a Hidden Curriculum Within Medical Students’ Discussion of Elective Abortion, 214 *Soc. Sci. & Med.* 26, 27 (2018) (“The word ‘elective’ has had a consistent medical meaning since as early as 1936 when it was used to describe surgeries that could be planned rather than done emergently.”).

<sup>53</sup> Smith et al., *supra* note 52, at 27.

<sup>54</sup> See, e.g., Governor Kimberly K. Reynolds, *supra* note 51; Ohio Dep’t of Health, *supra* note 4. Those states that did not use the term “elective” applied a variety of standards to identify the procedures that would be banned. Alabama initially banned “elective” procedures but then amended that order to permit only those procedures “necessary to treat an emergency medical condition” or “necessary to avoid serious harm from an underlying condition or disease, or necessary as part of a patient’s ongoing and active treatment.” *Robinson v. Marshall*, No. 2:19-CV-00365, 2020 WL 1847128, at \*2 (M.D. Ala. Apr. 12, 2020) (quoting Ala. Dep’t of Pub. Health, Order of the State Health Officer Suspending Certain Public Gatherings due to Risk of Infection by COVID-19 (Mar. 27, 2020) (internal quotation marks omitted)). In Texas, the order allowed procedures to go forward if the patient would otherwise “be at risk for serious adverse medical consequences or death, as determined by the patient’s physician.” *Tex. Governor Greg Abbott*, *supra* note 4.

for a reason relating to a separate or underlying medical condition of the pregnant person or the fetus.<sup>55</sup> Indeed, one study involving medical students planning to practice obstetrics and gynecology found that they used the term “elective” to contrast with medically necessary or medically indicated, by which they meant an abortion due to fetal anomaly or a separate health condition of the pregnant woman.<sup>56</sup>

On this definition of electiveness, the overwhelming majority of abortions in the U.S. are elective. In a 2005 study, only 12% of women indicated that they were choosing abortion at least partially because of a possible health issue, and only 4% indicated that it was the most important reason.<sup>57</sup> Another 13% indicated an issue with the health of the fetus factored into the decision, with only 3% stating it was the most important reason.<sup>58</sup> Instead, most women choose abortion in response to an unintended pregnancy for reasons related to their unreadiness or inability to parent a child (or an additional child).<sup>59</sup>

This problematic definition of “elective” abortion is a form of abortion exceptionalism, as it uniquely stigmatizes the abortion decision and adopts a concept of electiveness that would not apply to other surgeries. The notion that abortions chosen for particular reasons are somehow optional or non-therapeutic implies that the natural and expected course for all women and pregnant people is parenthood and that terminating a pregnancy is a “choice,” but continuing one is not. (We do not, for

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<sup>55</sup> Smith et al., *supra* note 52, at 27; Katie Watson, *Why We Should Stop Using the Term “Elective Abortion”*, 20 *AMA J. Ethics* 1175, 1176 (2018).

<sup>56</sup> See Smith et al., *supra* note 52, at 29. Similarly, in a recent case involving a challenge to an ordinance that attempted to exclude surgical abortion clinics from operating within a particular city, the parties disputed whether abortion services fell within a zoning provision allowing for facilities providing outpatient services that were “therapeutic, preventative or correctional.” *FemHealth USA, Inc. v. City of Mount Juliet*, No. 3:19-CV-01141, 2020 WL 2098234, at \*4 (M.D. Tenn. May 1, 2020). Drawing a distinction between therapeutic medical procedures and those it presumably deemed elective, the City claimed “abortion . . . is not preventative. It is not correctional. There are therapeutic abortions where the life or health of the mother is at risk.” *City of Mount Juliet’s Response to Motion for Preliminary Injunction at 11, FemHealth USA, Inc. v. City of Mount Juliet*, 2020 WL 2098234 (M.D. Tenn. Feb. 28, 2020) (No. 3:19-CV-01141).

<sup>57</sup> Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh & Ann M. Moore, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 *Persp. on Sexual & Reprod. Health* 110, 112–14 (2005).

<sup>58</sup> *Id.* Of course, as one scholar has pointed out, in another sense, “[e]very abortion is elective,” since even patients facing serious health risks can choose whether to have the procedure or undergo the risks to their health. Watson, *supra* note 55, at 1176.

<sup>59</sup> Finer et al., *supra* note 57, at 110–12.

example, generally speak of elective childbirth.) Indeed, the common rhetorical framing—or euphemizing—of the right to terminate a pregnancy as the “right to choose” may contribute to this unspoken understanding of abortion as a “choice.”<sup>60</sup> This framing stigmatizes the decision to end a pregnancy, while failing to apply similar scrutiny to the decision to become a parent. And it assumes that an abortion is acceptable if it results from a wanted pregnancy “gone wrong,” but not if it results from a mistake or a so-called “social” reason.<sup>61</sup> As Professor Katie Watson puts it, this framing valorizes “women who accept the social norms that women are meant to be mothers and that women cannot have sex solely for pleasure instead of for procreation.”<sup>62</sup> As she further points out, we do not generally label knee replacement surgery, for example, as “elective” simply because it is a way of resisting the natural deterioration of the knee cartilage, and we do not pass judgment on the decision to seek that surgery or the reasons for it, even if certain individual choices, such as deciding to play sports, contributed to the patient’s predicament.<sup>63</sup> Thus, using the concept of “elective” abortion in its popular sense further emphasizes the separateness of abortion from health care generally and treats it as a moral choice, rather than as a medical decision.<sup>64</sup>

Nonetheless, by relying on the meaning that the term “elective” usually has when it is applied to abortion, some states were able to clamp down on abortion access. In Texas and Oklahoma, for example, the state took the position that only abortions provided to avert a “medical emergency” could go forward.<sup>65</sup> Similarly, in Tennessee, the order was interpreted to ban all surgical abortions except those “required to . . . prevent rapid deterioration or serious adverse consequences to a patient’s physical condition.”<sup>66</sup> In Ohio, the state argued that the order allowed surgical abortions only to protect the patient’s life or health, or those that were

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<sup>60</sup> Thanks to Jonathan Entin for pointing this out.

<sup>61</sup> See Smith et al., *supra* note 52, at 29.

<sup>62</sup> Watson, *supra* note 55, at 1178.

<sup>63</sup> *Id.* at 1175.

<sup>64</sup> *Id.*; see also Smith et al., *supra* note 52, at 26 (“‘Elective’ negatively marked and isolated some abortions, and participants used the term to convey judgement about patients’ social and reproductive histories.”).

<sup>65</sup> *S. Wind Women’s Ctr. LLC v. Stitt*, No. 20-CV-00277, 2020 WL 1932900, at \*3 (W.D. Okla. Apr. 20, 2020); *Planned Parenthood Ctr. for Choice v. Abbott*, No. A-20-CV-00323, 2020 WL 1815587, at \*2 (W.D. Tex. Apr. 9, 2020).

<sup>66</sup> *Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 931 (6th Cir. 2020) (Thapar, J., dissenting).



close to the legal limit for performing a pre-viability abortion.<sup>67</sup> Similarly, the Eighth Circuit held that because medication abortions were allowed to proceed and because the clinics had not identified how many women would actually be affected by the ban (and therefore could not quantify the burden on abortion access), the “right to elective abortion”—meaning the right to reproductive autonomy—had not been clearly violated.<sup>68</sup>

In addition to exploiting this unique definition of electiveness, anti-abortion officials sometimes relied upon it to create uncertainty about the application of state orders in a way that put abortion clinics in a bind. In a number of cases, officials threatened enforcement actions while refusing to tell abortion clinics which abortions the state considered to be “elective” or medically unnecessary. In the case of Ohio, even after the clinics brought suit, the state refused to explain which abortions were permissible under the order—despite the fact that criminal penalties attached to a violation of the surgery order.<sup>69</sup> Similarly, in Alabama, the district court observed that the meaning of the state’s order with respect to abortion “was not immediately clear,” and that, “[i]n part because abortion providers in Alabama operate in an atmosphere of hostility, the [clinics] sought clarification of whether the restrictions allow the continued performance of abortions.”<sup>70</sup> The court further noted that “[r]epeated efforts to clarify the application of the medical restrictions to abortion, including by the plaintiffs and by [the] court . . . yielded multiple inconsistent interpretations” by the state.<sup>71</sup> This refusal to provide clarity left the clinics vulnerable to various civil and criminal sanctions and naturally had a chilling effect on their willingness to perform abortions.

Moreover, even in those states that specified a narrow understanding of which abortions qualified as medically necessary or non-elective, it was not self-evident what constituted a threat to a patient’s “health” or a “serious adverse consequence[] to a patient’s physical condition” in the

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<sup>67</sup> Combined Emergency Motion for Stay Pending Appeal and Merits Brief at 12–13, *Yost v. Preterm-Cleveland*, No. 20-3365 (6th Cir. Apr. 1, 2020).

<sup>68</sup> *In re Rutledge*, 956 F.3d 1018, 1028–32 (8th Cir. 2020).

<sup>69</sup> *Preterm-Cleveland v. Att’y Gen.*, No. 1:19-CV-00360, 2020 WL 1957173, at \*4 (S.D. Ohio Apr. 23, 2020). The state had also sent health inspectors to examine the records of three abortion clinics but never revealed whether it found any violations of the orders. *Id.*

<sup>70</sup> *Robinson v. Marshall*, No. 2:19-CV-00365, 2020 WL 1847128, at \*2 (M.D. Ala. Apr. 12, 2020).

<sup>71</sup> *Id.*

context of abortion.<sup>72</sup> For example, is the significantly increased risk brought about by any meaningful delay enough to qualify under this language?<sup>73</sup> Or is something more required? Even outside the reproductive health context, medical necessity is a poorly defined concept that is often left to individual physicians to apply.<sup>74</sup> The states that applied elective surgery bans to prohibit most or nearly all abortions—all of which had previously exhibited hostility to abortion rights—were able to exploit this underlying uncertainty.

### B. “Exempting” Abortion

The abortion-specific understandings of electiveness and medical necessity also led some courts to see the plaintiffs’ claims for equal treatment with other health care providers as asking for an *exemption* under the orders. This framing of requests for equal treatment as requests for special treatment was also a form of abortion exceptionalism.<sup>75</sup> Because abortion is understood as uniquely medically unnecessary or optional, in a way that other medical procedures are not, the requests of abortion providers to be treated like other physicians providing essential services was seen as aberrational.

Primarily, this reversal of plaintiffs’ claims for equal treatment took the form of state officials declining to afford abortion providers the sort of deference that other medical professionals likely would receive when deciding whether a surgery should proceed under the order. For example, in Alabama, state officials initially interpreted the surgery order to allow abortions only where necessary to preserve the life or health of the woman.<sup>76</sup> After the state changed its position, the district court sought an assurance that “[t]he reasonable medical judgment of abortion providers will be treated with the same respect and deference as the judgments of other medical providers,” and that “[t]he decisions will not be singled out

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<sup>72</sup> Adams & Boyle, P.C. v. Slatery, 956 F.3d 913, 931 (6th Cir. 2020) (Thapar, J., dissenting).

<sup>73</sup> See supra note 44 and accompanying text.

<sup>74</sup> B. Jessie Hill, What Is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act, 38 Am. J.L. & Med. 445, 450–57 (2012); Wendy K. Mariner, Patients’ Rights After Health Care Reform: Who Decides What Is Medically Necessary?, 84 Am. J. Pub. Health 1515, 1516–17 (1994).

<sup>75</sup> See sources cited supra note 3 and accompanying text.

<sup>76</sup> Robinson v. Marshall, No. 2:19-CV-00365, 2020 WL 1847128, at \*3 (M.D. Ala. Apr. 12, 2020).

for adverse consequences because the services in question are abortions or abortion-related.”<sup>77</sup> The state resisted this formulation, however, and refused to agree not to second-guess abortion providers’ decisions.<sup>78</sup> Similarly, in Ohio, the providers asked the court “for their case-by-case determinations regarding the essential nature of an abortion procedure to be treated the same as other Ohio healthcare professionals’ determinations regarding the essential nature of other procedures.”<sup>79</sup> This equal treatment clearly had not been provided. For example, the state contended it had received complaints about three abortion clinics purportedly performing elective surgeries, as well as a similar complaint about a urology clinic. Yet, while Ohio sent inspectors to review the surgery records of the abortion clinics, there was no evidence it had taken any steps to investigate the urology clinic.<sup>80</sup> In Texas, the state highlighted its tendency to view abortion as *sui generis* among medical procedures when answering a question posed to it in writing by the Fifth Circuit Court of Appeals. Trying to determine whether medication-only abortion was covered by the state order banning non-medically necessary procedures, the court asked the parties to explain “[w]hat medical acts should be considered analogous to medication abortion.”<sup>81</sup> The State of Texas answered: “Medication abortions are unique. Petitioners are unaware of other procedures that involve the use of medication to achieve a medical result that is not tied to treating or managing a disease or harmful condition.”<sup>82</sup>

Differential treatment of abortion providers is normalized by the stigma that permeates abortion provision, treats abortion services as outside of mainstream health care, and assumes almost all abortions are, by default, elective. Thus, the providers’ requests to be allowed to make their own determinations whether a particular surgery for a particular patient qualified as essential and non-elective were cast by states, and some courts, as requests for “blanket exemption[s].”<sup>83</sup> In fact, in *In re Rutledge*,

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<sup>77</sup> *Id.* at \*4.

<sup>78</sup> *Id.* at \*5.

<sup>79</sup> *Preterm-Cleveland v. Att’y Gen.*, No. 1:19-CV-00360, 2020 WL 1957173, at \*16 (S.D. Ohio Apr. 23, 2020).

<sup>80</sup> *Id.* at \*16 n.19.

<sup>81</sup> Petitioners’ Letter Brief at 4, *In re Abbott*, No. 20-50296 (5th Cir. Apr. 13, 2020).

<sup>82</sup> *Id.*

<sup>83</sup> *Preterm-Cleveland*, 2020 WL 1957173, at \*9; see also *Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 928 (6th Cir. 2020) (“[T]he State suggests that if we permit this one exemption, surely the joint-replacement surgeons, the cataract-removal specialists, and every other

this abortion exceptionalism led the Eighth Circuit down a perplexingly incorrect doctrinal path. In determining whether Arkansas’s surgery order could be mobilized to ban all surgical abortions in the state, the court declined to consider whether the order violated the Constitution as applied to abortion; instead, it only considered whether the directive itself—requiring suspension of all “elective” surgeries—was valid.<sup>84</sup> The court asserted that it could not “take a piecemeal approach and scrutinize individual surgical procedures or otherwise create an *exception* for particular providers, such as those performing non-emergency, surgical abortions.”<sup>85</sup> Not only does this formulation label nearly all abortions elective, but it also ignores the existence of the fundamental right to abortion and incorrectly applies Supreme Court precedent. Specifically, it ignores case law requiring courts to weigh the benefits and burdens of all restrictions on abortion as applied to abortion patients and providers—even those arising from laws that do not single out abortion but instead apply to other procedures as well. For example, in *Whole Woman’s Health v. Hellerstedt*, the Court considered whether Texas’s surgical-center law unduly burdened abortion access, although that law applied to (and remained valid as applied to) facilities other than abortion clinics.<sup>86</sup> But when the Eighth Circuit balanced benefits and burdens, it considered the benefits of the surgery order generally rather than with respect to abortion, stating that “the purpose of the . . . directive is to delay *all* non-emergency

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medical provider affected by EO-25’s bar on elective procedures will follow . . .”); In re Rutledge, 956 F.3d 1018, 1032 (8th Cir. 2020) (stating that the district court’s order allowing abortions to proceed during the pandemic “bestow[ed] on [surgical] abortion providers a blanket exemption from a generally-applicable emergency public health measure” (quoting In re Abbott, 954 F.3d 772, 795 (5th Cir. 2020))). At the same time, abortion providers were uniquely disabled in many cases from pursuing measures that would allow them to conserve PPE and limit exposure, such as using telemedicine for providing medication abortion. While telemedicine has been available and encouraged during the pandemic for most procedures, state laws requiring in-person visits for abortion inhibited its expansion to abortion services. See Ushma D. Upadhyay & Daniel Grossman, Telemedicine for Medication Abortion, 100 Contraception 351, 351 (2019).

<sup>84</sup> Rutledge, 956 F.3d at 1028–29.

<sup>85</sup> Id. at 1029 (emphasis added).

<sup>86</sup> 136 S. Ct. 2292, 2299, 2314 (2016), as revised (June 27, 2016); see also Women’s Med. Prof’l Corp. v. Baird, 438 F.3d 595, 603 (6th Cir. 2006) (“The generally applicable and neutral regulation in this case (the transfer agreement requirement) affects an abortion clinic, which is unable to satisfy the regulation’s requirements. Therefore, *Casey* and other relevant case law regarding state restrictions on abortion apply.”); Planned Parenthood of Greater Iowa, Inc. v. Atchison, 126 F.3d 1042, 1048 (8th Cir. 1997) (“[B]y requiring the plaintiff to undergo the CON review process, the defendants would impose a substantial and unconstitutional burden on the right of access to abortion.”).

surgeries so that the State may conserve its finite amount of PPE resources and limit social contact,” and that this purpose is advanced by the directive.<sup>87</sup> It then weighed that general benefit against the specific burden on abortion rights.

Because abortion is often burdened by facially neutral laws, and because undue-burden analysis requires courts to evaluate the specific benefits and burdens of a regulation as applied to abortion, this analysis is misguided. Moreover, it suggests that it would be singling out abortion for special treatment to consider the benefits of the law specifically as applied to abortion while declining to analyze the law in the same way with respect to other surgeries. But of course, other surgeries are not afforded the same constitutional protection as abortion, which has implications not just for pregnant people’s health, but also for their reproductive autonomy and their future.

### III. IMPLICATIONS

Officials who interpreted their elective surgery orders to ban abortion were working with a unique understanding of electiveness, applicable only to abortion, that cast the request of abortion providers for equal treatment as a request for a special exemption. Yet, abortion can and should be understood as non-elective, or medically necessary, for several reasons. First, as noted above, carrying a pregnancy to term is significantly riskier than ending a pregnancy; moreover, even carrying a pregnancy substantially longer than necessary or longer than desired brings additional health risks.<sup>88</sup> Second, abortion is the ultimate time-sensitive procedure, since it may be sought only during a particular window (which is often shortened by state laws prohibiting abortions after a specific point in the pregnancy). Finally, seeking an abortion is an exercise of reproductive autonomy; an abortion may be necessary to a person’s quality of life and ability to function at home, at work, and in society at large—just as other surgical procedures may be. Like other health conditions, pregnancy is a condition that, if allowed to progress, will result in physical changes, health risks, and very long-term consequences for the patient.

Of course, the person’s subjective attitude toward the pregnancy—whether those physical changes and effects on their life are wanted or

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<sup>87</sup> *Rutledge*, 956 F.3d at 1031.

<sup>88</sup> See *supra* notes 44–45 and accompanying text. |

unwanted—determines the medical appropriateness of abortion for them, just as an individual patient’s attitudes and values may determine the medical appropriateness of other medical interventions. But this fact does not imply that the pregnant person’s *reasons* for wanting or not wanting the abortion are relevant to its medical appropriateness—that is, to its “electiveness.”<sup>89</sup> The decision not to carry an unwanted pregnancy to term is a medical decision to protect one’s health and one’s body against undesired physical changes that will have a lifelong impact.<sup>90</sup>

This insight suggests that the framing of most, or even some, abortions as “elective” is deeply problematic. It not only stigmatizes the deeply considered decisions of patients, but it also distorts the doctrine, including by introducing abortion exceptionalism and uncertainty into the analysis of the surgery orders during the pandemic. Further, it aggravates the isolation of abortion providers from other health care providers, making it less likely that physicians will want to engage in abortion provision and leaving them more vulnerable to harassment and violence.<sup>91</sup>

The alternative approach would be to integrate abortion into the health care framework by viewing patients’ abortion decisions as analogous to other patients’ health care decisions. This would also mean that reproductive-rights scholars and advocates should avoid the use of terms like “elective”—which possess no clear meaning, except in the most limited contexts, in any case—and avoid using the term “choice” as a stand-in for abortion or abortion rights.<sup>92</sup> Moreover, abortion providers should be accorded the same respect as other health care providers, who were largely left alone during the pandemic to implement the orders through internal institutional policies that were not subjected to further review.

One concern with suggesting that abortion should be treated like other medical decisions is that it implies a sort of “leveling down” of the

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<sup>89</sup> See Katie Watson, *Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion* 170–74 (2018) [hereinafter *Watson, Scarlet A*]; *Watson*, supra note 55.

<sup>90</sup> As Professor Katie Watson and others have observed, the debate over when abortion is appropriate is thus really a debate about the moral value of the embryo or fetus vis-à-vis that of the woman. See, e.g., *Watson, Scarlet A*, supra note 89, at 173–74. I agree with this view but do not address that second question, regarding the moral status of the embryo or fetus, here since it is separate from the question of when, if ever, abortion is “elective” or medically unnecessary.

<sup>91</sup> See Hill, *The Geography of Abortion Rights*, supra note 50, at 24.

<sup>92</sup> Cf. Robin West, *From Choice to Reproductive Justice: De-constitutionalizing Abortion Rights*, 118 *Yale L.J.* 1394, 1410–11 (2009) (critiquing the rhetoric of choice on other grounds).

abortion right, insofar as other health care procedures do not generally enjoy the same constitutional protection as abortion. Indeed, the fact that abortion implicates reproductive autonomy—a constitutionally protected interest—implies that it should be singled out for especially favorable treatment, not unfavorable treatment, as compared to similar procedures. Yet, as the course of events during the COVID-19 pandemic has illustrated, other health care providers and procedures are more likely to be protected by the political process. Indeed, the repeal of elective-surgeries bans that largely ended the abortion-related litigation were likely motivated by concerns of hospitals and patients seeking other kinds of procedures.<sup>93</sup> News stories detailed the negative effects that elective surgery bans were having on patients as well as on the bottom lines of hospitals.<sup>94</sup> Those hospitals have enormous political clout.<sup>95</sup> Thus, if the interests of abortion providers and clinics were taken into account in the same way as those of other health care providers, and if they were considered an integral part of that larger group, they might be afforded the same degree of deference with respect to their decision making. In addition, as Professor Robin West has argued,<sup>96</sup> it is possible that engaging the political process rather than relying solely on courts for protection of abortion rights could, in the long run, enable a political discourse that argues for certain rights and benefits that cannot be accommodated within the current reproductive-rights framework—

<sup>93</sup> See, e.g., Laura Garcia, *San Antonio Hospitals Could Resume Elective Surgeries Under Abbott's New Order*, *San Antonio Express-News* (Apr. 18, 2020), <https://www.expressnews.com/business/health-care/article/San-Antonio-hospitals-could-resume-elective-15209439.php> [<https://perma.cc/X7V5-2WPN>].

<sup>94</sup> *Id.*; see also Jenny Gold, *Some Hospitals Continue with Elective Surgeries Despite COVID-19 Crisis*, *Kaiser Health News* (Mar. 20, 2020), <https://khn.org/news/some-hospitals-continue-with-elective-surgeries-despite-covid-19-crisis/> [<https://perma.cc/VA9Q-SZ6L>] (explaining the difficult financial calculus faced by hospitals in deciding whether to shut down elective surgeries in order to maintain public safety); C.J. LeMaster, *Ban on Elective Procedures/Surgeries Impacts Rural Hospitals Already at Risk of Closure*, *WLOX* (Apr. 21, 2020), [wlox.com/2020/04/21/ban-elective-procedures-surgeries-impacts-rural-hospitals-already-risk-closure/](https://www.wlox.com/2020/04/21/ban-elective-procedures-surgeries-impacts-rural-hospitals-already-risk-closure/) (detailing rural Mississippi hospital kept afloat by elective surgeries).

<sup>95</sup> See generally Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, *Fla. Bar J.* 23, 28, 28 n.55 (Feb. 2016) (noting that medical industry lobbying expenditures exceeded those of the defense, aerospace, oil, and gas industries combined); Jennifer Haberkorn, *Hospitals Flex Lobbying Muscle*, *Politico* (Jan. 7, 2013), <https://www.politico.com/story/2013/01/hospitals-flex-lobbying-muscle-to-bypass-some-cuts-085814> [<https://perma.cc/R8TV-EHC8>] (“Hospitals have some of the strongest lobbying muscle because every member of Congress has at least one in their district. They don’t just provide needed health care but are typically one of the largest employers, too.”).

<sup>96</sup> See West, *supra* note 92, at 1412–21.

including a right to positive goods like child care, health care, and protection from intimate violence, all of which are necessary for full reproductive dignity and autonomy.

On the other hand, it is possible that all health care should share a degree of constitutional protection. While it has largely been unnecessary to protect access to other medical procedures with a constitutional right, since legislators rarely see political benefits in attacking orthopedic surgery or restricting access to heart medications, there may nonetheless be constitutional limits on the extent to which the government can interfere in private health care decisions.<sup>97</sup> At a minimum, there is already a constitutionally protected right to make certain significant medical decisions, such as refusing treatment and accessing medication for severe pain.<sup>98</sup>

The rhetorical integration of abortion into health care may be a part of a post-*Roe v. Wade* strategy as well. If *Roe v. Wade* is one day overruled, and the permissibility of abortion is left to individual states, it is possible that some states will consider adopting bans on so-called elective abortion while permitting medically necessary abortions.<sup>99</sup> A robust understanding of abortion as medically necessary could be useful in combatting attempts to cabin abortion access in this way, either by making it unthinkable in some states to separate out so-called therapeutic from non-therapeutic abortions, or by bolstering the authority of individual patients and physicians to make decisions about which abortions are “medically necessary,” without second-guessing from the state. If abortion providers could draw on the political power of the broader health care community, it would also be more likely that abortion access would remain protected in a post-*Roe* world.

#### CONCLUSION

The litigation over the application of non-essential surgery bans exemplifies underlying tensions in the legal and popular understandings

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<sup>97</sup> This argument is made at greater length in B. Jessie Hill, *The Constitutional Right To Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 *Tex. L. Rev.* 277, 313–18 (2007).

<sup>98</sup> *Id.* at 329–32.

<sup>99</sup> Cf. Richard H. Fallon, Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 *St. Louis U. L.J.* 611, 626 (2007) (noting that the question of whether a state could regulate abortion even when it poses risks to the woman’s health would still arise in a post-*Roe* world).



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of abortion that are likely to have an impact beyond the end of the pandemic. Access to abortion is threatened by a tendency to single out abortion for uniquely unfavorable treatment within both law and medicine. Long-term protection of abortion rights could be advanced through rhetorical reframing of abortion and bolstering an understanding of abortion as a medically necessary and appropriate health care decision, regardless of the patient's reason for choosing it.