Reconsidering Law and Policy Debates

A PUBLIC HEALTH PERSPECTIVE

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BEYOND PRIVACY

A Population Approach to Reproductive Rights

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For at least forty years, Americans have debated whether women should have a legal right to safe abortions and effective contraception. This unusually contentious battle over “reproductive rights” has been waged in numerous arenas with arguments that reflect diverse worldviews as well as distinct disciplines, including theology, medicine, constitutional theory, sociology, and political theory. Among the arguments and perspectives that have at times been employed are those that purport to be based on public health. In recent years, such public health arguments have gained new prominence, especially among opponents of reproductive rights¹ and the Supreme Court.² This chapter considers the impact of this development on reproductive rights. I begin by exploring how each side in the reproductive rights debate has employed public health arguments and the impact of those arguments on the courts’ recognition of reproductive rights. I conclude by contrasting the current use of public health arguments in the ongoing debate about reproductive rights to a fuller embrace of a public health perspective and ask what such an approach might bring to the table.

Public health focuses on the health of one or more populations.³ In the debate over reproductive rights, the population that has generally been at issue is the population of women, especially women of childbearing age. Do reproductive rights advance or endanger their health? And in either case, what is the impact of that essentially empirical question on how we think about reproductive rights?

For many years, advocates of reproductive rights were the ones who were most likely to use “public health talk,”⁴ arguing that the recognition of reproductive rights was not only conducive to but essential
for protecting the health of women as well as their children. Thus in the early years of the twentieth century, Margaret Sanger and other birth control advocates claimed that access to birth control was "an integral part of public health" and essential to ensuring the health of women and children. As scholars have noted, Sanger and other early birth control advocates often made arguments that echoed those of the eugenicists who sought to improve the human race by limiting the reproduction of people of supposedly inferior genetic stock.

By the 1960s, as the fight for contraception and abortion began to make its way into constitutional law, proponents of reproductive rights continued to argue that the criminalization of contraceptives and abortion harmed women's health. For example, in 1966, prominent abortion activist Lawrence Lader cited studies estimating between 1,000 and 10,000 deaths occurred in the U.S. per year due to illegal abortions. Lader wrote:

No study, moreover, could begin to measure the physical and psychological injury inflicted on women by quack abortionists, often virtual butchers. Nor could it encompass the damage women inflict on themselves in attempts at self-abortion.

Into the emergency rooms of our city hospitals flow the grim products of this system.

In effect, Lader argued that public health protection required the legalization of abortion.

In more recent years, advocates for legalized access to abortion and contraception have repeatedly pointed to the public health benefits ostensibly arising from such access. For example, proponents of over-the-counter access to Plan B, the so-called morning-after pill, claimed that it would "enhance the public health by reducing the risks of unintended pregnancies and the number of abortions." Likewise, pro-choice advocates have repeatedly pointed to the dangers of so-called back-alley abortions. Often using the hanger as their visual symbol, reproductive rights advocates refer to studies showing that the legalization of contraception and abortion is associated with significant declines in maternal morbidity and mortality.

In large measure, the claims of reproductive rights advocates have been supported by numerous studies and reports documenting the
health risks that follow from the criminalization of abortion and the
denial of access to safe contraceptives (including, of course, con-
doms that provide protection against HIV and other sexually trans-
mitted infections). For example, a 2003 report by the World Health
Organization (WHO) estimated that worldwide, 65,000 to 70,000
women die each year due to unsafe abortions (which they define as
procedures not performed according to medical standards), and that
5 million women are hospitalized each year as a result of such proce-
dures. The WHO also reported that 1.7 million women are believed
to develop secondary infertility due to unsafe abortions.11

A more recent paper by WHO and the Guttmacher Institute con-
cluded that the “root cause” of induced abortion is unintended preg-
nancy, and that lack of access to contraception is critical to reducing
unplanned pregnancies.12 The paper added: “unrestrictive abortion
laws do not predict a high incidence of abortion, and by the same
token, highly restrictive abortion laws are not associated with low
abortion incidence.”13 In effect, these reports contend that laws that
impose barriers to abortion and contraception do not reduce the rates
of abortion; they merely lead to more unsafe abortions and more
maternal injuries and death.

Early abortion cases also stressed the health benefits of reproduc-
tive rights. For example, in Roe v. Wade,14 Justice Blackmun’s con-
troversial opinion for the Supreme Court first discredited the state’s
claim that the prohibition of abortion protected the health of women
by noting:

When most criminal abortion laws were first enacted, the
procedure was a hazardous one for the woman. ... Abortion
mortality was high. ... Modern medical techniques have altered
this situation. ... Mortality rates for women undergoing early
abortions, where the procedure is legal, appear to be as low as or
lower than the rates for normal childbirth. ... Of course, impor-
tant state interests in the areas of health and medical standards
do remain. The State has a legitimate interest in seeing to it that
abortion, like any other medical procedure, is performed under
circumstances that insure maximum safety for the patient.15

The Court then cited the opinions of both medical and public
health organizations16 to bolster its conclusion that the Constitution
prohibited the state from banning abortions in the first two trimesters. The Court also noted:

The detriment that the State would impose upon the pregnant woman by denying this choice [to terminate a pregnancy] altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. ... Psychological harm may be imminent. Mental and physical health may be taxed by child care.17

The Roe Court’s emphasis on women’s health was also evident in the limitations that it placed on the right to an abortion. Thus while the Court viewed the right to an abortion as supportive, if not essential, to protecting women’s health, it acknowledged that the state had a legitimate interest in protecting a woman’s health and that this interest became “compelling” and justified enhanced regulation at the start of the second trimester.18 Indeed, even in the first trimester, when the Roe Court viewed the right to an abortion as at its zenith (in large part because abortion at this point in the pregnancy was as safe as or safer than childbirth), the Court clarified that states could require that abortions be performed only by state-licensed physicians.19 Hence traditional and general regulations aimed at protecting public health could apply even during the first trimester. Finally, in the third trimester, when the state’s interest in the potential life of a fetus also becomes, according to the Roe Court, “compelling,” the state could not proscribe abortion “when it is necessary to preserve the life or health of the mother.”20 Thus throughout Roe, the Supreme Court viewed the constitutional right to choose an abortion as protective of women’s health and also limited by the state’s legitimate interest in women’s health.21

In the years between Roe and the Court’s watershed case in Planned Parenthood v. Casey,22 arguments based on the health of women remained a salient, albeit background, factor that the courts as well as pro-choice activists used to support reproductive rights. For example, in City of Akron v. Akron Center for Reproductive Rights,23 the Supreme Court struck down an ordinance that required all second-trimester abortions to be performed in a hospital. The City of Akron, not surprisingly, attempted to justify its ordinance using public health talk.
The city claimed that the regulation protected the health of women during the second trimester, an interest that the Court had found to be compelling in Roe. The Supreme Court rejected that claim not because it found that states could not protect women’s health during the second trimester, but because it discredited the city’s contention that the ordinance would indeed protect public health. According to the Court, “present medical knowledge” showed that abortions in the second trimester could be done just as safely in outpatient clinics as in hospitals. In effect, the Court accepted that the state could enact regulations to protect the health of women during the second trimester but failed to accept the legitimacy of the city’s rationale.

The dissenting justices were outraged. Justice O’Connor, writing for herself and Justices White and Rehnquist, declared that Roe’s trimester approach was unsustainable: “the State’s compelling interest in maternal health changes as medical technology changes, and any health regulation must not ‘depart from accepted medical practice.’ . . . [Thus] despite the Court’s purported adherence to the trimester [framework from Roe], the lines drawn . . . have now been ‘blurred’...” Justice O’Connor went on to argue that the state always had an important interest “in the areas of health and medical standards” and that those interests justified regulation throughout pregnancy.

In the years after Akron, the Supreme Court’s approach to abortion began to shift, as did its perception of the relationship between state abortion regulations and public health. Most critically, in Planned Parenthood of Southeastern Pennsylvania v. Casey, the decisive three-justice joint opinion (written by Justices O’Connor, Kennedy, and Souter) abandoned Roe’s trimester framework and held that states could regulate abortion throughout pregnancy as long as they did not impose an “undue burden” on a woman’s right to choose an abortion prior to viability. Nevertheless, the Court followed Roe in viewing women’s health as shaping the scope of a woman’s right to an abortion. The Joint Opinion stated: “[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion.” However, “[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right” and are therefore unconstitutional. Moreover, as in Roe, states were
only permitted to limit postviability abortions if exceptions were made for those cases in which "appropriate medical judgment" concluded that an abortion was necessary for the preservation of the life or health of the mother.\textsuperscript{31}

It was the latter holding from \textit{Casey} that the Court relied upon in \textit{Sternberg v. Carhart}, when a divided Court held that a Nebraska statute banning so-called partial birth abortions (known either as D & X abortions, for dilation and extraction, or as an intact dilation and evacuation, or D & E abortions) was unconstitutional in part because it did not include any exception for those times when the procedure might be necessary to protect a woman's health.\textsuperscript{32} According to the Court, "a State may promote but not endanger a woman's health when it regulates the methods of abortion."\textsuperscript{33} The Court added:

\begin{quote}
Our cases have repeatedly invalidated statutes that in the process of regulating the \textit{methods} of abortion, imposed significant health risks. They make clear that a risk to a women's (sic) health is the same whether it happens to arise from regulating a particular method of abortion, or from barring abortion entirely.\textsuperscript{34}
\end{quote}

To the majority, the fact that the state did not feel that there was a need for a health exception was unconvincing. Rather than deferring to the state's assertion that the banned procedure brought no health benefit, the \textit{Sternberg} Court relied on the trial court's finding that "significant medical authority" asserted that the banned procedure was at times the safest for a woman. Thus once again the Court used health claims to shape the contours of both the woman's right and the state's regulatory powers.

The use of public health arguments by supporters of reproductive rights reflects the enormous influence that such arguments wield in American law and discourse.\textsuperscript{35} Although particular actions and policies that states may undertake in the name of public health are frequently controversial, the importance of public health protection and the fact that the state should seek to further it via its laws and regulations is seldom contested.\textsuperscript{36} Moreover, science also carries great weight and legitimacy in contemporary American culture.\textsuperscript{37} By invoking public health arguments that sound in \textit{science} in support of reproductive rights, reproductive rights proponents and the jurists
who have recognized such rights have attempted to utilize the power and credibility of public health and science to support their cause.

Appeals to public health do not necessarily extinguish controversy, however. Most obviously, they do not quiet opposition that is based on theological or moral grounds. For those who believe that abortion constitutes the unjustified murder of innocent life, public health arguments showing that legalized access to abortion may save women’s lives are unconvincing. Even within the domain of public health talk, public health arguments may not be able to secure reproductive rights. To the contrary, they may actually jeopardize such rights (at least as they are currently understood) by invoking a legal tradition in which state regulation has traditionally been granted broad deference.38

Although opposition to abortion has generally centered on moral claims about the life of the unborn fetus, since the 1980s, abortion opponents have also relied on public health claims, making what Reva B. Siegel calls “women-protective justifications.”39 These justifications are based on the claim that abortions (and sometimes contraception and other reproductive technologies) are harmful to women and therefore should be regulated as are other threats to population health, such as unwholesome food or dangerous drugs. To many feminists and reproductive rights proponents, these arguments are inherently “paternalistic” and hearken back to an era in which the law assumed that women could not make decisions for themselves.40 But as public health law scholars know well, courts have traditionally permitted states to limit the autonomy of individuals (male as well as female), even in regard to very personal and intimate matters, in the name of public health.41 Moreover, public health does not necessarily disdain paternalism.42 To the contrary, public health values protecting the health of populations and the individuals within those populations even when those individuals do not appear to chose health-affirming choices. Thus, for example, public health supports reducing tobacco-related deaths even though such efforts may be viewed as paternalistic.

Opponents of reproductive rights have taken advantage of these attributes of public health talk and public health law to argue that access to abortion should be restricted not only for moral reasons but
to protect women’s health. Such use of public health talk by the pro-life movement goes back at least as far as the 1980s, when anti-abortion activists such as Vincent Rue began warning of the harm that abortion allegedly causes women. In the late 1980s, anti-abortion leaders pressured President Reagan into asking Surgeon General C. Everett Koop, a strong abortion opponent, to issue official findings that abortion jeopardized women’s health. Koop refused to do so, concluding that there was insufficient scientific evidence to support such a finding and arguing that the case against abortion should be based on its morality.

In subsequent years, opponents of reproductive rights have increased their reliance on public health arguments. Indeed, some vocal opponents of abortion have argued for what they call a public health strategy, suggesting that the pro-life movement should take a page from public health advocates’ campaigns against tobacco. David Reardon, a prominent proponent of the public health strategy against reproductive rights, has claimed that the public health evidence undermines the very foundation of Roe and hence a right to an abortion. According to Reardon, “pregnancy-associated deaths are actually two to four times higher for abortion women compared to delivering women.”

In recent years, abortion rights opponents have usually emphasized two different health risks that they claim are caused by abortion. One is breast cancer. Pointing to epidemiological studies going back as far as the 1950s, opponents of reproductive rights argue that epidemiological evidence firmly supports the so-called abortion-breast cancer link, known as the ABC link, a linkage that, they hypothesize, occurs because exposure to hormones in early pregnancy leads to changes in breast tissue that make the tissue especially vulnerable to cancer. These changes supposedly diminish at term, when the breast tissue completes the differentiation process and prepares to support lactation. According to biologist Joel Brind, one of the chief proponents of the ABC link, abortion’s impact on breast cancer constitutes a major public health threat. Brind writes, “[w]e have estimated that upwards of 10,000 cases of breast cancer each year presently, and to 25,000 per year in twenty or thirty years hence, are or will be attributable to induced abortion.”
To be sure, the ABC link is widely disputed by most medical and public health researchers. In 2003, the National Cancer Institute convened a workshop on the issue, which concluded that “[i]nduced abortion is not associated with an increase in breast cancer risk.” Several more recent studies have also failed to support the claim, though some scientists contend that the question warrants further research. Opponents of abortion rights, however, discount studies and reports that reject the ABC link, arguing that mainstream medical societies and researchers are allowing ideology and their own economic interests in abortion to trump science.

Opponents of abortion rights also argue that abortion (and sometimes even contraception) causes psychological harm, and that women who have induced abortions have higher rates of depression, suicide, and emotional distress than other women. They refer to what they call “postabortion syndrome,” or PAS, a condition they liken to post-traumatic stress, which presumably arises from regret and guilt that women experience as a result of abortions. (They seldom stop to ask, however, whether their own messages and advocacy help create an environment that may generate feelings of regret; rather they seem to assume that a woman’s regret or guilt for an abortion is natural and not influenced by her cultural environment.) Again this claim is disputed by most mainstream authorities. For example, the American Psychiatric Association’s Task Force on Mental Health and Abortion conducted a review of the empirical literature and concluded that there is “no evidence sufficient to support the claim that an observed association between abortion history and mental health was caused by the abortion per se, as opposed to other factors.”

Despite the fact that most mainstream researchers reject the public health claims made by abortion opponents, usually citing significant methodological flaws in the studies that find public health harms associated with or caused by abortion, these claims have gained traction in both state houses and the courts. For example, in 2005, the state of South Dakota convened a task force to study abortion. The Task Force’s Report began by listing the “incorrect assumptions” relied upon in Roe v. Wade, including the Supreme Court’s failure to recognize that from “the moment of conception,” a fetus is “a whole, separate human being.” But the Task Force did not rely simply
on moral arguments or even what it claimed to be scientific facts about the fetus. It also emphasized the purported negative impacts of abortion on women’s health. In particular, the Task Force found that abortion creates a wide range of physical risks for women, and that the Center for Disease Control and Prevention (CDC) statistics greatly underestimate the number of maternal deaths related to abortion.\textsuperscript{61} The Task Force also reported on the testimony of 2,000 women who had had abortions and reported feeling wounded and guilty because of that fact.\textsuperscript{62} Then, after summarizing the testimony of several well-known anti-abortion researchers about the negative mental health impacts of abortion (as well as women's limited ability to make informed decisions to have an abortion), the Task Force concluded that “it is simply unrealistic to assume that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering significant psychological trauma and distress.”\textsuperscript{63} This finding helped support the enactment of a South Dakota statute that, among other things, requires physicians to inform women seeking an abortion that the procedure causes an increased risk of suicide and suicide ideation.\textsuperscript{64}

Courts have at times been sympathetic to such anti-abortion/public health arguments. Most strikingly, in 2007 in \textit{Gonzales v. Carhart},\textsuperscript{65} the Supreme Court affirmed the federal “Partial-Birth Abortion Ban Act.”\textsuperscript{66} In upholding the law that criminalized what the Court called intact D & E abortions, Justice Kennedy, writing for the majority, first emphasized the differences between the federal ban and the Nebraska law struck down in \textit{Sternberg}.\textsuperscript{67} According to the Court, unlike the flawed Nebraska law, the federal statute was carefully written so as not to apply to the more commonly used method of late-term abortions, the so-called D & E procedure. Hence the federal law, the Court concluded, was not void for vagueness and did not impose an undue burden on a woman’s right to obtain an abortion.\textsuperscript{68}

More important, for our purposes, was the Court’s discussion of Congress’ rationale for banning the relatively rare intact D & E procedure. After all, if the ban would not prevent women from obtaining an abortion, what was its point? To this question the Court offered two illuminating answers. One was that the intact D & E procedure might have a detrimental impact on the sensibility of the “medical
community."⁶⁶⁹ In so doing, the Court invoked the traditional view that government may regulate the practice of medicine in order to protect the public’s health.⁷⁰ Perhaps more telling, however, was the Court’s second argument. The Court stated: "[w]hile we find no reliable data to measure the phenomenon, it seems unexceptional to conclude that some women come to regret their choice to abort the infant life they once created and sustained . . . . Severe depression and loss of esteem can follow," especially, the Court suggested, when women later learn that the procedure that was used to carry out the abortion was particularly gruesome.⁷¹ In other words, Congress could ban intact D & E abortions to protect the mental health of women, even in the absence of any empirical evidence showing that the banned procedure threatened women’s mental health.

A similar willingness to defer broadly to the legislature to protect the health of women was apparent in the Court’s explanation of why the statute’s failure to include a health exception did not render it unconstitutional. In Sternberg, the Supreme Court had followed Roe and Casey in requiring that a ban on intact D & E abortions have a health exception.⁷² In many ways, this exception focused on the health of individual women and gave weight to the clinical judgment of their own physicians. In Carhart, the Court moved away from this medical stance and viewed the health issue from a broader, population perspective from which deference should be given not to individual physicians’ thinking about the needs of their own patients, but to the legislature that, the Court concluded, was best positioned to make decisions about public health in the face of empirical uncertainty. The Court stated: "[t]he question becomes whether the Act can stand when this medical uncertainty persists . . . . The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."⁷³ The Court then went on to cite several cases, including, most interestingly, Jacobson v. Massachusetts,⁷⁴ perhaps the seminal public health law case, that upheld the state’s right to mandate vaccinations. In other words, as the Court saw the issue, when population health is at stake and scientific facts are contested, courts should defer to the superior fact-finding ability of legislatures, even if that means restricting access to a type of abortion and potentially endangering the health of particular
women. Indeed, the Court was willing to defer to Congress even though the District Court found, and the Supreme Court did not disagree with its conclusion, that some of the Act’s factual recitations were erroneous.75

From a public health law perspective, Justice Kennedy’s reasoning does not appear all that exceptional.76 Public health law 101 teaches that the states may use their police power broadly to protect public health.77 In so doing, states frequently limit the liberty of individuals, even for their own good. Thus states may require motorcyclists to wear helmets78 or prohibit individuals from driving without wearing a seatbelt.79 When public health is claimed, as B. Jessie Hill has recognized, claims of individual autonomy frequently yield.80 Moreover, when the health of a population is at stake, individuals may be forced to accept what they believe may jeopardize their own health.81 although there may be limits to how much risk a particular person must bear.82 Hence even in Carhart, the Court accepted that an as-applied challenge to the federal law brought by particular individuals who could show that the law had a deleterious impact on their own health might face a different fate.83

Carhart also followed public health law’s tradition of granting the legislature great deference in determining so-called legislative facts that are relevant to population health policy. Indeed, in Jacobson itself, the Court stressed that deference should be given to public health officials in deciding whether or not vaccination was an effective intervention against smallpox. Writing for the Court, Justice Harlan stated: “It is no part of the function of a court or a jury to determine which one of two modes was likely to be the most effective for the protection of the public against disease. That was for the legislative department to determine in light of all the information it had or could obtain.”84 Thus when issues are presented as about public health, rather than about the clinical care of discrete patients, courts frequently defer to the state. Of course, such deference should not apply when fundamental rights are at stake; but by invoking public health talk and public health legal norms, the Carhart Court demonstrated the vulnerability of even those rights that have been recognized as fundamental to the leeway that legislatures are granted when they claim to act in the name of public health.
Perhaps more importantly, the invocation of public health arguments reveals a significant flaw in the efforts of reproductive rights activists to base reproductive rights on the concept of privacy. After all, by claiming that the state has an interest and is required to alter its law to protect the health of women, reproductive rights activists have in effect conceded a vital point: The health of any woman, indeed of any person, is not solely a private matter. The state has a legitimate, if not at times compelling, interest in enacting regulations to promote women’s health. Thus if reproductive policy is viewed as presenting a contested question of public health, or as an empirical question about the best way to promote women’s health, there may be no place for upholding reproductive rights as rights of privacy totally immune from state regulation. Hence the application of public health arguments to the reproductive rights debate may not curtail the controversy, nor may it secure such rights. Rather it would seem to put such rights at the mercy of the elected branches. Or must it?

The discussion thus far has explored the use and impact of public health talk and public health law in the battle over reproductive rights. But the use of public health arguments, however, is not necessarily identical or even faithful to the application of a public health perspective. In this section, I want to consider how the issue would appear if one went beyond making arguments based on conflicting epidemiological evidence and adopted what I have elsewhere called population-based legal analysis – that is, an approach to law that embraces not just public health claims but also its population perspective.

According to Dan E. Beauchamp and Bonnie Steinbock, a population perspective refers to “the effort to understand the occurrence of disease from a group or community perspective.” As the Beauchamp and Steinbock definition makes clear, the population perspective focuses on the health of a “group or community” rather than the health of a single individual or patient. Therefore, the population perspective differs from the perspective that dominates medicine and medical ethics, which generally prioritizes the well being of individual patients. Finally, because of its emphasis on the health of groups of people, the population perspective values and relies on empirically derived epidemiological data rather than either the clinical examination of a patient or even legal precedent, and relies on
such data to better understand what harms and what protects the health of groups. As a result, a population perspective appropriately opens the door to empirically based debates about women's health. Nevertheless, the population perspective does not necessarily support either the conclusions or the reasoning of either side in the abortion wars. To the contrary, by insisting that we consider the population health impact of our policies and laws on varied populations and that epidemiological evidence be taken seriously, the population perspective may point to some directions that may please neither side.

Consider first the use of public health talk by the Supreme Court in Carhart. At first glance, these arguments seem to comport with a population perspective. They emphasized the health of a population — women — rather than the health of any individual woman. For example, in Carhart, the Court accepted the absence of a health exception by deferring to the legislature's determination about women's health rather than the claims of physicians about the possible needs of individual patients. By so doing, the Court seemed to accept that the focus should be on the health of the larger group rather than the health of discrete individuals (although as noted earlier, the Court left open the door to the possibility that individuals could bring claims based on the application of the law in their particular case). Moreover the Court deferred to the legislature's power to determine the appropriate policy for the public's health. In all of these ways, the Court appeared to have adopted a population perspective and by so doing demonstrated the challenge that such perspective presents for reproductive rights.

In many other ways, however, the Court failed to truly embrace a population perspective. In fact, a population perspective leads to a far more nuanced appreciation of the relationship between the protection of population's health and individual rights than the Carhart Court's opinion evidences. First, precisely because the population perspective values epidemiological evidence, it would reject the Carhart Court's willingness to draw epidemiological conclusions in the absence of any data or other empirical support. Hence while the population perspective would undoubtedly counsel courts to give legislatures broad leeway to address pressing public health problems even in the face of uncertainty, perhaps adopting a "weak" version of the precautionary
principle, it would not condone the open-ended deference, indeed blind credulity, that the Court displayed in *Carhart*. By permitting the legislature to reach any conclusion in the name of public health, even in the absence of any epidemiological evidence, the *Carhart* Court turned the population perspective upside down. Pretext prevailed over substance. Population health was used not as a valid concern of the law but as a label that could be employed to justify post hoc any policy, no matter its actual effect on health or other consequences.

Moreover, contrary to the views of many advocates on both sides of the abortion debate, a population approach does not insist that the law should simply tally up the deaths and illnesses associated with a particular practice and affirm a policy that, all other things being equal, leads to the lowest number of cases of a particular health problem, be that breast cancer or maternal deaths. In other words, although a population perspective places a very high value on the promotion and protection of public health – indeed it insists that the promotion of public health is one of the chief aims of law – it does not rely upon a crude form of act utilitarianism under which each legal decision is reached simply by looking at the discrete health impacts associated with the regulation under consideration. Thus a population perspective would not rely simplistically on a single study or even a multitude of studies that show that abortion is causally related to breast cancer to conclude that abortion should be outlawed. Nor would a population approach say that abortion must be made legal simply because it reduces abortion-related deaths. Rather a population perspective would, or should, recognize the complex and multi-factorial causality of human illness, as well as the overlapping and contingent shape of human populations. Hence a population approach is mindful not only of unanticipated and long-range consequences, including the health consequences that result from health regulations that protect short-term health by endangering the long-term well-being of a community, but also the fact that legal rules have different health consequences for different populations. After all, the abrogation of abortion rights to prevent breast cancer may have a very different impact on teenagers than it would on women over thirty. Moreover it is possible that even if abortion is causally related to breast cancer, the denial of legal access to abortion may not reduce the incidence of breast cancer,
never mind improve the overall health of various subpopulations of women, because the total number of abortions may not, as the WHO study suggests, actually diminish. A population perspective would be sensitive to such nuances and complexity and avoid the knee-jerk conclusion that any particular action that may harm the health of any population in the short run must necessarily be met with a ban.

Likewise, a population perspective does not preclude the recognition of other important values such as equality, self-governance, and respect for individual dignity, values that, when followed, may themselves enhance the health of populations. Although a public health perspective places a high regard on public health, it does not insist that public health is the only value that lawmakers should consider. A society of long-lived and pain-free slaves would be neither just nor healthy. Adoption of a population perspective does not require, and should not prompt, the neglect of other important values and perspectives, especially when those values can help promote and secure a population’s health.

Unfortunately in recent years, it has become far too common, especially among some policy makers and public health advocates, to view the struggle for public health in Manichean terms, as a struggle for the good of the many against the liberty of the individual. From this perspective, individual rights are viewed as being in opposition to the public’s health, indeed as a luxury that cannot be afforded in the dangerous times. As a result, highly coercive policies such as quarantine and forced vaccination are being discussed and have been considered as part of a program of “preparedness.”

This Manichean view of public health protection has long influenced public policy regarding human reproduction. In the early 1900s, poor women such as Carrie Bell were viewed as threatening to the public’s health for their reproductive potential. Then the Supreme Court in a memorable opinion by none other than Justice Oliver Wendell Holmes upheld Buck’s mandatory sterilization to protect the health and vigor of the race, noting famously “three generations of imbeciles are enough!” He, too, cited Jacobson.

In more recent years, pregnant women have been vilified for using alcohol or drugs while pregnant, for refusing HIV tests, or rejecting C-sections. In all of these cases, coercive actions have been taken
against women on the theory that their rights had to be limited to protect the public’s health. In all of these cases, the flag of public health has been used to justify harsh and often punitive treatment of women on the theory that this was required to protect the health of the many.

Today abortion opponents go further and argue that pregnant women endanger the public, as well as themselves, because the decisions they make increase their risk of cancer and lead to their own psychological trauma. Some advocates have even claimed that post-abortion trauma harms men and causes them to become violent.\textsuperscript{90} In all of these arguments, there is a tacit assumption that the good of the individual and the well-being of the public are in conflict. From this the conclusion drawn is that the rights of the individual women must be restrained – or sacrificed as in time of war – for the greater good.

Now, it is of course true, as Justice Harlan stated in \textit{Jacobson}, that life in society requires that limits be imposed on individual liberty.\textsuperscript{91} It is also true that a population perspective leads us to value the health of populations and to question the belief that individual choices are made in isolation and hence can be wholly private.\textsuperscript{92} Most fundamentally, a population perspective reminds us that we are all part of multiple communities and that the risks we face and the choices we make are all influenced by a host of social, cultural, economic, and environmental factors that operate upon the populations we inhabit. Law is, of course, one of those factors that influence our choices and decisions. To say that our choices must or can be private and hence apart from law is to ignore how law helps shape our choices in the first place.

But the recognition of population-wide influences does not and should not lead us to adopt laws that disempower individuals. Rather public health teaches that the common good is often strengthened by respecting individual liberty and enhancing the power given to historically disadvantaged groups. As a result, a population approach need not and should not overemphasize the opposition between individual rights and population health. Instead it should recall that the most effective public health interventions are often not those that prohibit individuals from making unhealthy choices but rather those that seek to restructure the environment to offer people healthier options.
For example, in the late nineteenth century, infectious diseases were
controlled not primarily by quarantines or other liberty-limiting mea-

sures, but by providing people with clean food and water and sanitary
sewage disposal. More recently, public health practitioners have
come to recognize the utility of interventions such as indoor smok-
ing laws that alter the environment in which people make decisions
affecting their health. Such broadly based, environmental inter-
ventions can often be more effective in promoting public health than are
punitive, liberty-limiting measures.

In addition, a population perspective recognizes that populations
are made up of individuals and that more often than not, populations
are healthier when the people that comprise them are respected and
empowered and are thereby able to care for themselves and their fam-

ilies. As a result, respect for individual agency and individual rights
can enhance public health. Thus looking at the case of HIV, the late
Jonathan Mann astutely and persuasively argued that respect for
women’s rights, including rights over their own sexuality and repro-
duction, was essential to containing the epidemic. More recently,
public health authorities have stressed the importance of respecting
the rights of individuals for combating the global epidemics of HIV
and TB. In such cases, granting legal rights to individuals, even
when that means granting them the right to undertake actions that
may harm their own health or the health of others, may be more pro-

tective of a population’s health than would be punitive laws seeking to
restrict individual rights.

Similarly, the previously cited WHO study suggests that in devel-

oping countries, the recognition of reproductive rights does not
increase the incidence of abortion; rather it lowers the incidence of
abortion-related morbidity. Likewise, public health and development
experts have emphasized the importance of increasing gender equal-
ity as well as the agency of women in order to decrease infant and
maternal mortality, as well as rates of HIV/AIDS. Hence even if it
turned out, as abortion opponents claim, that abortion increases the
risk of breast cancer or depression, granting women the right to make
decisions about their own reproductive lives might still lead to greater
overall improvements in the health of women and children, or at least
in the health of some populations of women and children, than would
laws impeding access to abortion. As a result, even if one accepts the epidemiological case against abortion currently being put forth by anti-abortion advocates, it does not necessarily mean that the law ought to restrict or abolish reproductive rights. Rather it may mean that legal resources should be devoted to influencing the social and environmental factors, including limited access to contraception, that result in unwanted pregnancies.

So what would a population perspective, rather than mere public health talk, bring to the wars over reproduction? Certainly it would accept that the empirical debate that has been raised about the safety of abortion, as well as any method of birth control, is critically important. The relationship, if any, between abortion and breast cancer, as well as between abortion and mental health, should be studied and when and if there is credible epidemiological evidence suggestive not merely of association but also causation, it should influence public policy. A population-based approach to reproductive law would not assume, a priori, that empirical facts are irrelevant or that new evidence that points in one direction or another should automatically be dismissed. In that sense, from a public health perspective, reproductive rights could not be either absolute or unchanging; they would always be open to new evidence and modification.

As was previously noted, however, valuing empirical evidence and recognizing its relevance to reproductive rights does not mean that the courts ought to defer reflexively to legislative findings of scientific fact, regardless of their scientific merit. To the contrary, because a population approach takes empirical evidence seriously, courts utilizing that approach would engage in and be capable of assessing empirical claims. Thus courts applying a population approach would neither demand unobtainable certainty from scientific studies nor accept results that lack scientific plausibility and that were performed using methodologies that significantly depart from widely accepted scientific methods. Junk science should and would receive no more credence in reproductive rights cases than it does in tort cases.97

In addition, because a population approach emphasizes the relationship between individuals and populations, it would likely eschew the rhetoric of privacy. It would look for and consider the social, not necessarily the private, determinants of reproductive health and
construe the law in ways that facilitate positive social health determinants. Reproductive rights would be recognized to the degree that they would be not because reproduction is private, but because we value individual dignity and recognize the unique burden unwanted pregnancies place on women. 98 Likewise, reproductive rights would be respected not because individual rights trump the public good, but because empowering women and recognizing their dignity may provide a foundation for promoting their health as well as the health of their children.

Thus the recognition of the social and population context of reproductive health would not necessarily or even likely counsel for the significant evisceration of reproductive rights. Even if one accepts that certain reproductive choices, such as abortion, have some negative health consequences (and clearly that has hardly been proven), the question would remain whether the recognition of reproductive rights advances or thwarts the health of multiple populations. Moreover, a population approach would counsel us to ask whether the law would better advance the health of women and newborns by criminalizing abortion and restricting access to contraceptives, or by helping shape a social environment in which there are fewer unintended pregnancies. We would also want to ask whether restrictions on women’s agency would promote their health, or whether women’s health would be more firmly secured by empowering them to make decisions that are healthy for them and their families. In effect, a population approach requires us to ask whether reproductive rights are indeed helpful or harmful to the health of women broadly considered.

As the earlier discussion suggests, I suspect that a public health approach would support an altered but nevertheless robust role for reproductive rights. These rights might be less absolute and more contingent than they were under Roe. They would not be absolutes trampling on the power of the state, because the law would recognize that states have a legitimate role to play in shaping the social environment in which reproductive choices are made. But in other ways, these rights might be significantly broader because in recognizing the connections between an individual’s reproductive choices and health and a community’s well-being, a public health approach would embrace a more expansive, positive vision of rights – for example,
by concluding that reproductive rights encompass positive rights to contraception, sex education, and prenatal care. Thus a population approach might well reject the Supreme Court’s early rulings that government has no obligation to help indigent women effectuate their choice to have an abortion.99

True, many questions would remain. By being open to new empirical evidence, the population approach almost assures that the battle would continue as epidemiological studies, and their meaning, are debated. Indeed adoption of a population perspective would remind us that scientific facts, like social facts and ethical precepts, can be the subject of heated arguments. They do not end controversy, nor can we assume that claims made in the name of science are necessarily sound. Scientific claims themselves can be, as we have seen, hotly debated and highly contentious. But by emphasizing a goal that few reject – promoting the health of women and children – and by providing us with a tool – epidemiology, that we can use to measure that goal – even as we debate its findings, a population approach may alter the tone of the analysis and point the way to different, and perhaps more nuanced, understanding of reproductive rights.

Notes

4. The term is Reva Siegel’s. See Siegel, supra note 1, at 1724.

11. *Id.*


13. *Id.*


15. *Id.* at 148–150.

16. *Id.* at 141–146.

17. *Id.* at 153.

18. *Id.* at 162.

19. *Id.* at 165.

20. *Id.* at 163.

21. Commentators have noted that the Court’s opinion in *Roe* emphasized the role of the woman’s physician. Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 *Suffolk L. Rev.* 41, 44–48 (2008). The opinion also emphasized and relied in part on the opinions of medical and public health organizations. *Id.*


24. *Id.* at 437, quoting 410 U.S. at 163.

25. *Id.* at 452, 454–455 (O’Connor, J., dissenting).

26. *Id.* at 459, quoting 410 U.S. at 149–150.


28. *Id.* at 872–874 (Joint opinion of Justices O’Connor, Kennedy, and Souter).

29. *Id.* at 878.

30. *Id.*

31. *Id.* at 879.

32. 530 U.S. 914 (2000). The Court also found that the statute was so vague as to impose an undue burden on a woman’s ability to obtain an abortion.

33. 530 U.S. at 931.

34. *Id.*


36. In contrast, the state’s role in supporting or deciding upon medical care for individuals has been highly contested for decades, as is evident by the continuous political volatility of health care reform.

37. Dean M. Hashimoto argues persuasively that the Court often uses science rhetorically, calling upon its mythic power rather than relying upon it analytically to resolve questions. See Dean M. Hashimoto, *Science as Mythology in Constitutional Law*, 76 *Or. L. Rev.* 111 (1997).

40. *Id.* at 1000–1005.
44. Siegel, *supra* note 39, at 1016.
45. *Id.*
61. Id. at 49.
62. Id. at 33.
63. Id. at 47–48.
64. South Dakota House Bill 1166 (2005), codified at S.D.C.L. § 34–23A-10.1. The statute has been the subject of significant litigation. See Planned Parenthood of Minnesota v. Rounds, 530 F.3d 724 (8th Cir. 2008) (en banc) (vacating preliminary injunction); Planned Parenthood of Minnesota v. Rounds, Civ. 05–4077 KES (D.S.D. Aug. 20, 2009). In 2009, the federal district court struck down the provision cited in the text while affirming other parts of the state’s informed consent law. See id.
68. 550 U.S. at 147.
69. Id. at 157.
70. See West Virginia v. Dent, 129 U.S. 114 (1889).
71. 550 U.S. at 159.
73. 550 U.S. at 163.
74. Id. citing 197 U.S. 11, 30–31 (1905).
75. 550 U.S. at 165–166.
76. See Hill supra note 38, at 318–324.
77. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 91 (2d ed. 2008).
79. For example, State v. Hartog, 440 N.W.2d 852 (Iowa 1989).
80. Hill, supra note 38, at 295–304. It should be noted, however, that they generally do not yield quite so readily to fundamental rights of the sort that are at issue here.
82. 197 U.S. at 38–39.
83. 550 U.S. at 167. The dissent noted the impracticality of such a challenge. 550 U.S. at 169, 189–190 (Ginsburg, J., dissenting).
84. 197 U.S. at 30.
86. DAN E. BEAUCHAMP & BONNIE STEINBOCK, NEW ETHICS FOR THE PUBLIC’S HEALTH 25 (1999).
91. 197 U.S. at 26.
92. See Parmet, supra note 3, at 141–161.
98. See Siegel, supra note 1, at 1736–1790.