

Michigan Journal of Race and Law

Volume 26

2021

The Scales of Reproductive Justice: Casey's Failure to Rebalance Liberty Interests in the Racially Disparate State of Maternal Medicine

Mallori D. Thompson
University of Connecticut School of Law

Follow this and additional works at: <https://repository.law.umich.edu/mjrl>



Part of the [Civil Rights and Discrimination Commons](#), [Constitutional Law Commons](#), [Health Law and Policy Commons](#), and the [Law and Gender Commons](#)

Recommended Citation

Mallori D. Thompson, *The Scales of Reproductive Justice: Casey's Failure to Rebalance Liberty Interests in the Racially Disparate State of Maternal Medicine*, 26 MICH. J. RACE & L. 241 (2020).
Available at: <https://repository.law.umich.edu/mjrl/vol26/iss1/16>

<https://doi.org/10.36643/mjrl.26.1.scales>

This Article is brought to you for free and open access by the Journals at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in Michigan Journal of Race and Law by an authorized editor of University of Michigan Law School Scholarship Repository. For more information, please contact mlaw.repository@umich.edu.

THE SCALES OF REPRODUCTIVE JUSTICE: CASEY’S
FAILURE TO REBALANCE LIBERTY INTERESTS IN THE
RACIALLY DISPARATE STATE OF MATERNAL
MEDICINE

Mallori D. Thompson

ABSTRACT

Despite the maternal medicine crisis in the U.S., especially for Black women, legislatures are challenging constitutional abortion doctrine and forcing women to interact with a system that may cost them their lives. This Article proposes that because of abysmal maternal mortality rates and the arbitrary nature of most abortion restrictions, the right to choose an abortion is embedded in our Fourteenth Amendment right to not be arbitrarily deprived of life by the State. This Article is a call to abortion advocates to begin submitting state maternal mortality data when challenging abortion restrictions. The call for attention to life was central to the holding in Roe v. Wade and is central to rebalancing the scales of reproductive justice.

TABLE OF CONTENTS

INTRODUCTION	242
I. THE MATERNAL MEDICINE CRISIS	244
II. THE SHORTCOMINGS OF THE “UNDUE BURDEN” STANDARD	248
A. Planned Parenthood v. Casey.....	248
B. Whole Women’s Health v. Hellerstedt	249
III. ABORTION AS A RIGHT TO LIFE	250
A. <i>Waiting Periods</i>	252
B. <i>Parental Consent</i>	254
C. <i>Reporting Requirements</i>	257
CONCLUSION	259

The Scales of Reproductive Justice: *Casey's* Failure to Rebalance Liberty Interests in the Racially Disparate State of Maternal Medicine

MALLORI D. THOMPSON*

INTRODUCTION

We're talking about a woman who was far better than I ever deserved and made me far better than I ever thought I could be. We're talking about a woman that raced cars, who ran marathons, who had her pilot's license—talking about a woman who spoke four languages fluently and who taught me so much We walked into Cedars-Sinai Medical Center with Kira on April 12th of 2016 with a woman who was not just in good health, she was in exceptional health. . . . 8 O'clock comes, I'm begging, I'm pleading, my family is advocating for my wife. . . . At which point the staff at Cedars-Sinai Medical Center tells me, "your wife is not a priority right now." It was not until after midnight that they finally took Kira back to the O.R. . . . That was the last time I saw my wife alive. . . . Kira deserved better. My sons deserved better. Women all over this country deserve better. . . . There's no statistic that can quantify what it's like to tell an 18-month old that his mother's never coming home.

Charles Johnson,
advocating on behalf of his late wife,
Kira Johnson.¹

The United States has the worst maternal mortality rate among high-income nations—and it is only getting worse.² The numbers are

* Juris Doctor candidate, 2021, University of Connecticut School of Law. Many thanks to my faculty advisor, Professor Jamelia Morgan, who supported me throughout the entire writing process. Thank you to my undergraduate professors at Spelman College who taught me to value everyday feminism just as much as academic feminism. Finally, thank you to my mother, Lori, who taught me to question everything, to fight for what matters, and to create means where there are none.

1. 4KIRA4MOMS, *Charles Johnson Shares the Tragic Story of His Wife Kira's Death Hours After Giving Birth.*, YOUTUBE (June 7, 2018), <https://www.youtube.com/watch?v=05uBCBfrY4g> [<https://perma.cc/7XK9-A2TY>].

2. Nina Martin & Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR & PROPUBLICA (May 12, 2017, 10:28 AM), <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world> [<https://perma.cc/XY9T-TGXM>] ("More American women are dying of preg-

even more troubling for Black women in the United States, with rates three to four times higher than that of white women, “regardless of education, income, or any other socio-economic factors.”³ Abortion restrictions that do not confer medical benefits sufficient to outweigh obstacles imposed⁴ force women to give birth in the racially disparate state of maternal medicine—which could cost them their lives. The current undue burden framework⁵ is not protecting the interests in the life of Black women⁶ in the United States when it fails to consider the disparate risk of maternal mortality for Black mothers—although doctrine requires it. Both *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* discuss the insufficiency of states’ interests to outweigh the woman’s life,⁷ yet the standard that emerged from those cases is not being used to assess the woman’s interest in life, only the constitutionally protected personal liberty to choose. Because maternal mortality data so strongly intersects with the interest in protecting a woman’s life, courts should allow abortion advocates to incorporate maternal mortality data into the body of evidence in abortion cases.

Part I of this Note discusses the crisis facing Black women in maternal medicine. Most relevantly, the racial disparities manifest in maternal mortality rates, though Part I also examines the racial implications of discrepancies in epidural administration and how that informs this issue. Part II explains why, in consideration of the increased dangers facing pregnant Black women, the undue burden standard set forth by *Casey*,⁸ modified by *Whole Woman’s Health v. Hellerstedt*,⁹ does not go far enough to address the compelling interest “at the core of the constitutional liberty identified

nancy-related complications than any other developed country. Only in the U.S. has the rate of women who die been rising.”).

3. Suzanne Delbanco, Maclaine Lehan, Thi Montalvo & Jeffrey Levin-Scherz, *The Rising U.S. Maternal Mortality Rate Demands Action from Employers*, HARV. BUS. REV. (June 28, 2019), <https://hbr.org/2019/06/the-rising-u-s-maternal-mortality-rate-demands-action-from-employers> [<https://perma.cc/3RY3-8TBT>]; see also *Pregnancy-Related Deaths*, CDC (Feb. 26, 2019), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm> [<https://perma.cc/D3NL-RUMK>].

4. See *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (“The rule announced in *Casey*, however, requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”).

5. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 834 (1992).

6. For consistency with case law, this Note will use the term, “woman,” with this acknowledgement that transgender men and gender nonconforming people must also be included in the discourse on reproductive justice.

7. *Casey*, 505 U.S. at 880; *Roe v. Wade*, 410 U.S. 113, 164 (1973).

8. *Casey*, 505 U.S. at 834.

9. *Hellerstedt*, 136 S. Ct. at 2300.

in [Roe].”¹⁰ Part III asserts that the discriminatory state of maternal medicine and abortion restrictions, viewed in conjunction, violate a woman’s fundamental right to choose her own life. Part III also proposes a supplementary analysis to assess statutes that are potentially unconstitutional.

I. THE MATERNAL MEDICINE CRISIS

Racial bias in healthcare is not unique to maternal medicine.¹¹ “Extant research has shown that relative to white patients, black patients are less likely to be given pain medications and, if given pain medications, they receive lower quantities.”¹² A study conducted by four professors at the University of Virginia revealed that half of the medical students and residents surveyed endorsed false beliefs about biological differences between Black and white patients.¹³ Further, the participants that held those false beliefs made less accurate treatment recommendations.¹⁴ The study demonstrated “that beliefs about biological differences between blacks and whites—beliefs dating back to slavery—are associated with . . . inadequate treatment recommendations for black patients’ pain”¹⁵ and made it evident that science and medicine are not immune from American racism.¹⁶ Black patients receive less preventative care and lower-quality, less-intensive hospital care.¹⁷

But even within the context of maternal medicine, the studies regarding maternal mortality are numerous, well-supported, and alarming. The United States maternal mortality rate more than doubled from 1991 to 2014.¹⁸ Nearly sixty percent of pregnancy-related deaths are preventa-

10. *Harris v. McRae*, 448 U.S. 297, 316 (1980).

11. See generally Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites*, 113 PROCEEDINGS OF THE NAT’L ACAD. OF SCI. 4296 (2016) (discussing the impact of racial bias on medical treatment).

12. *Id.* at 4296 (citation omitted).

13. *Id.* at 4298-300.

14. *Id.* at 4300.

15. *Id.*

16. See David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FINANCING REV. 75, 76 (2000) (“Throughout the history of the United States, non-dominant racial groups have, either by law or custom, received inferior treatment in major societal institutions. Medical care is no exception.”).

17. Kevin Fiscella, Peter Franks, Marthe R. Gold & Carolyn M. Clancy, *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 J. AM. MED. ASS’N 2579, 2580 (2000).

18. Delbanco et al., *supra* note 3.

ble.¹⁹ In addition to the approximately 700 American women who die from pregnancy related complications each year, a staggering 65,000 nearly die from those complications.²⁰ Those numbers place the United States forty-sixth in the world in maternal mortality measures.²¹ American women are fourteen times more likely to die during childbirth than during an abortion.²²

The statistics regarding maternal death in the United States are already disturbing, but the crisis worsens when narrowing in on race. The CDC's recent numbers reflect 14.7 deaths per 100,000 live births for white women, yet 37.1 deaths per 100,000 live births for Black women.²³ To illustrate the disparity: "[A] black woman is 22 percent more likely to die from heart disease than a white woman, 71 percent more likely to perish from cervical cancer, but 243 percent more likely to die from pregnancy- or childbirth-related causes."²⁴ In certain American cities, the disparity is even greater: between 2011 and 2015, Black mothers in New York City were eight times more likely to die than their white counterparts.²⁵ The racial disparity in maternal medicine even persists beyond socio-economic factors: Black, college-educated women are still more likely to suffer severe, pregnancy related complications than white women

19. AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, RACIAL DISPARITIES IN MATERNAL MORTALITY IN THE UNITED STATES: THE POSTPARTUM PERIOD IS A MISSED OPPORTUNITY FOR ACTION 1 (2018) [hereinafter *Racial Disparities*]; Delbanco et al., *supra* note 3.

20. *Pregnancy-Related Deaths*, *supra* note 3; YWCA, MATERNAL HEALTH AND WOMEN OF COLOR 1 (2017), https://www.ywca.org/wp-content/uploads/BRIEFING_PAPER_MATERNAL_HEALTH_AND_WOMEN_OF_COLOR_FINAL.pdf [<https://perma.cc/F67T-GDPG>]; see also Nina Martin & Renee Montagne, *The Last Person You'd Expect to Die in Childbirth*, NPR & PROPUBLICA (May 12, 2017, 5:00 AM), <https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger> [<https://perma.cc/69D8-L7NJ>].

21. YWCA, *supra* note 20, at 1.

22. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *OBSTETRICS & GYNECOLOGY* 215, 215 (2012); see also Erwin Chemerinsky & Michele Goodwin, *Constitutional Gerrymandering Against Abortion Rights*, 94 *N.Y.U. L. REV.* 61, 64 (2019).

23. Nat'l Ctr. for Health Stat., *Maternal Mortality*, CDC, <https://www.cdc.gov/nchs/maternal-mortality/index.htm> [<https://perma.cc/YUG8-ULSV>] (last reviewed Nov. 20, 2019).

24. Nina Martin & Renee Montagne, *Lost Mothers: Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, NPR & PROPUBLICA (Dec. 7, 2018, 8:00 AM), <https://www.propublica.org/article/nothing-protects-Black-women-from-dying-in-pregnancy-and-childbirth> [<https://perma.cc/R3UK-7FZY>].

25. N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, *PREGNANCY-ASSOCIATED MORTALITY: NEW YORK CITY, 2011-2015* 5 (2020), <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2011-2015.pdf> [<https://perma.cc/6ZXM-NCPK>].

without a high school diploma.²⁶ It would be shortsighted for constitutional analyses regarding abortion restrictions to not begin considering the realities for Black women facing the current inadequacies of maternal care.

The international community has taken note of these failings. In 2008, the United Nations Committee on the Elimination of Racial Discrimination “validated charges that the U.S. has failed to actively combat racial discrimination in reproductive health care. . . . [and] called on the U.S. government to reduce high rates of maternal and infant mortality”²⁷ A Black woman in the United States has worse odds of surviving childbirth than a woman in Uzbekistan—where a significant percentage of the population is impoverished—while white women in the United States have maternal mortality rates more comparable to New Zealand.²⁸ In Arkansas, the state with the worst maternal mortality record, the rate is even higher than that of the occupied Palestinian Gaza Strip and West Bank.²⁹ In the developed infrastructure of the United States, the “common thread is that when black women expressed concerns about their symptoms, clinicians were more delayed [in their responses] and seemed to believe them less.”³⁰

Racial disparities in maternal medicine do not exclusively impact mortality rates—they are present throughout the birth experience. A study published by the American Society of Anesthesiologists found that Black and Hispanic women in labor are less likely to receive an epidural, even when adjusting for socioeconomic status, clinical risk factors, provider

26. Martin & Montagne, *supra* note 23.

27. Press Release, Ctr. for Reprod. Rts., U.N. Committee Finds U.S. is Falling Short in Tackling Racism in Reproductive Health Care (Mar. 7, 2008), <https://reproductiverights.org/press-room/un-committee-finds-us-is-falling-short-in-tackling-racism-in-reproductive-health-care> [<https://perma.cc/Z3QL-DS73>].

28. Amy Roeder, *America is Failing Its Black Mothers*, HARV. PUB. HEALTH (Winter 2019); CIA, *Country Comparison: Maternal Mortality Rate*, in WORLD FACTBOOK, <https://www.cia.gov/library/publications/the-world-factbook/fields/353rank.html> [<https://perma.cc/T69D-NEW7>] (last visited Aug. 20, 2020).

29. See CDC, *Maternal Mortality*, <https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html> [<https://perma.cc/DX5G-NL8G>] (last reviewed Aug. 13, 2020); CIA, *supra* note 27; Amnesty Int'l, *The Israeli Occupation*, <https://www.amnesty.org/en/latest/campaigns/2019/01/chapter-1-background/> [<https://perma.cc/8VU9-SK2B>] (last visited Aug. 20, 2020).

30. Roeder, *supra* note 27 (citing Dr. Neel Shah, an OBGYN at Beth Israel Deaconess Medical Center). Former Head of the Maternal and Child Health Bureau, Dr. Michael Lu, also attributed poor outcomes for Black women to “prolonged exposure to the indignities and dangers of discrimination,” a phenomenon known as “weathering.” Martin & Montagne, *supra* note 23.

effect, and more.³¹ Despite pain management being “an important domain of healthcare quality. . . . [f]ew studies have examined racial and ethnic differences in the treatment of labor pain.”³² This study found evidence that patients with private insurance receive epidural analgesia at higher rates than patients without insurance, but Black patients with private insurance receive the pain management drug at the same rate as white patients without insurance.³³ This study’s conclusions suggest that medical professionals perceive Black women’s pain to be lesser or their pain tolerance to be greater. Due to such perceptions, Black women are systemically undertreated in maternal medicine,³⁴ which assumedly, contributes to the higher rates of mortality for Black women. The care of Black women in all stages of maternal medicine warrants a closer look at the laws that conscript women into unwanted childbirth and force them to interact with this racist system.

The racial disparities that Black people face in medicine clearly have negative effects, but the outcomes for Black women in maternal medicine are so troublesome to the interest in life that it implicates the Constitution. In light of the grave inadequacies of maternal care, women have a heightened interest in avoiding the maternal medicine system through abortion care. Accessing abortion care is not free from racial inequity³⁵—which deepens the necessity to closely scrutinize any further restriction to abortion access.

This is not to say that a majority of women who die from pregnancy related complications sought abortions prior or would have chosen to terminate their pregnancies had they known their fate. But as *Casey* states, “[t]he proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.”³⁶ The law, and this analysis, is not applicable to women who would not have sought an abortion. Rather, deceased women who would have

31. Laurent G. Glance, Richard Wissler, Christopher Glantz, Turner M. Osler, Dana B. Mukamel & Andrew W. Dick, *Racial Differences in the Use of Epidural Analgesia for Labor*, 106 *ANESTHESIOLOGY* 19, 19 (2007).

32. *Id.*

33. *Id.* at 23.

34. *See id.* at 24.

35. Nikita Mhatre, *Abortion Restrictions Hurt Women of Color*, NAT’L PARTNERSHIP (Apr. 25, 2019), <https://www.nationalpartnership.org/our-impact/blog/general/abortion-restrictions-hurt-women-of-color.html> [<https://perma.cc/P3GY-LNXP>] (“Due to factors such as structural racism and discrimination, women of color face rampant income inequality and are more likely to be covered by Medicaid as a result. They are therefore disproportionately impacted by the Hyde Amendment, which bans federal funds for abortion care in Medicaid. . . . [A]nti-abortion organizations have targeted Black women and Latinas with false and harmful rhetoric . . .”).

36. *Casey*, 505 U.S. at 894.

sought abortions if not for arbitrarily restricted access were unconstitutionally deprived of life, as explained in Part III.

II. THE SHORTCOMINGS OF THE “UNDUE BURDEN” STANDARD

Following *Roe v. Wade*, the Supreme Court shaped abortion doctrine through *Planned Parenthood of Southeast Pennsylvania v. Casey* and *Whole Women’s Health v. Hellerstedt*. The undue burden standard emerged as the prevailing measure of the constitutionality of abortion restrictions. However, that standard has not—and possibly cannot—account for how those burdens contribute to deprivations of life that *Roe* condemned.³⁷

A. Planned Parenthood v. Casey

In reaffirming *Roe*,³⁸ the Court in *Casey* held that matters “involving the most intimate and personal choices a person may make in a lifetime . . . are central to the liberty protected by the Fourteenth Amendment,” and thus, women have the right “to choose to have an abortion before viability and to obtain it without undue interference from the State.”³⁹ The Court proceeds to define an undue burden as “a state regulation [that] has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”⁴⁰ The goal of the undue burden standard is to reconcile the State’s interest in protecting a potential life with a woman’s constitutionally protected personal liberty.⁴¹ However, that standard, in its articulation and application, is incomplete according to the very framework from which it derives, as it does not account for how those interests must be reweighed in light of the egregious racial disparities in pregnancy related deaths.

According to the plurality in *Casey*, “*Roe* forbids a State to interfere with a woman’s choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health.”⁴² *Casey* also cites to *Harris v. McRae*,⁴³ which articulates the focus on life even more definitively: “[E]ven the compelling interest of the State in protecting potential life after fetal viability [is] insufficient to outweigh a woman’s decision to protect her life or health[;] it could be argued that *the freedom of a woman*

37. *Roe*, 410 U.S. at 163.

38. *Roe*, 410 U.S. at 153 (“The right of privacy . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”).

39. *Casey*, 505 U.S. at 851, 846.

40. *Id.* at 877.

41. *Id.* at 876.

42. *Id.* at 880 (referencing *Roe*, 410 U.S. at 164).

43. *Id.* at 875.

to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in *Wade*.”⁴⁴ Additionally, the Court recently affirmed *Hellerstedt*’s focus on health benefits to the woman.⁴⁵ The United States Supreme Court has reiterated time and time again, that at the very core of abortion doctrine is a woman’s right to protect her life and the importance of her health,⁴⁶ yet the reigning standard addresses neither without considering racially disparate maternal mortality data. Without maternal mortality data, there is no way for courts to consider whether women in states with harsh abortion restrictions are dying from the pregnancies they intended to terminate.

Legislatures attempt to satisfy the requirement that State interests⁴⁷ yield to the life and health of the mother by including provisions for medical emergencies.⁴⁸ Medical emergency exceptions are insufficient, as a study published in the *American Journal of Obstetrics & Gynecology* found that a noteworthy number of low-risk pregnancies result in complications.⁴⁹ For Black women in the United States, too often the only way to know if she needs an “abortion of her pregnancy to avert her death or . . . serious risk of substantial and irreversible impairment” will be after she has already died.⁵⁰

B. *Whole Women’s Health v. Hellerstedt*

The Court in *Whole Women’s Health* reframes the undue burden standard articulated in *Casey* by requiring that regulations placing a “sub-

44. *Harris v. McRae*, 448 U.S. 297, 316 (1980) (emphasis added). In the paragraph immediately following, the Court departs from its declaration and held that it “does not follow that a woman’s freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.” *Id.*

45. *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2126, (2020) (affirming *Hellerstedt*).

46. *See, e.g., id.*; *Casey*, 505 U.S. at 880; *Roe*, 410 U.S. at 164. The Court in *Hellerstedt* demonstrated significant reliance on health benefits for women. *Hellerstedt*, 136 S.Ct. at 2300, 2310, 2318.

47. Ideally, State interest would genuinely be the life and the health of the mother, rather than a pretext for control over women’s bodies.

48. *See, e.g.*, 18 PA. CONS. STAT. § 3203 (2020) (defining a medical emergency as a “condition which, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function”).

49. Valery A. Danilack, Anthony Nunes & Maureen Phipps, *Unexpected Complications of Low-Risk Pregnancies in the United States*, 212 AM. J. OBSTETRICS & GYNECOLOGY 1, 1 (2015) (finding that of nearly 10.5 million pregnancies observed, twenty-nine percent of those consider low-risk faced at least one unexpected complication.).

50. *See supra* Part I.

stantial obstacle in the path of women seeking a previability abortion” confer “medical benefits sufficient to justify the burdens.”⁵¹ Texas implemented statutes that required abortion providers to have admitting privileges at a hospital within 30 miles and required the facilities to meet standards for ambulatory surgical centers.⁵² The lower court concluded that the admitting privileges requirement reduced the more than forty licensed abortion facilities by almost half; the number would have further reduced to only seven facilities in the entire state of Texas if the surgical-center provision had taken effect; the likelihood that the remaining providers could meet the demand was low; the requirements were particularly burdensome for poor women; and that the risks were not notably lower at ambulatory surgical centers than at nonsurgical centers.⁵³ In invalidating the admitting privileges requirement, the Court reasoned that the requirement did not bring the health-related benefit it claimed, and thus did not outweigh the extraordinary obstacle it imposed.⁵⁴

Even this more specific test, weighing benefits and burdens, however, does not address the woman’s life as abortion doctrine requires. In *June Medical Service v. Russo*, all notable mentions of life were in regard to the prospective life of the fetus—not the actual life of the mother.⁵⁵ Potentially, no standard that only aims to reconcile liberty interests with state interests will be sufficient to account for the racially disparate state of maternal medicine because liberty is not the only constitutional right at stake.

III. ABORTION AS A RIGHT TO LIFE

The disparate outcomes for Black women navigating the institution of maternal medicine are catastrophic. Therefore, abortion restrictions must account for obscenely high rates of maternal mortality to avoid arbitrary deprivations of life—a due process violation. To comply with doctrine’s mandate to consider the life and health of the woman, embedded in the due process guarantee to not be arbitrarily deprived of life must be the right to choose an abortion. State interests must be balanced against not only a woman’s liberty interests but the interest in her own life, a much more compelling interest requiring much stronger protections. To do so, maternal mortality data must be introduced in application of the undue burden standard in order to evaluate the nature of the burden—

51. *Hellerstedt*, 136 S. Ct. at 2300 (quoting *Casey*, 505 U.S. at 878).

52. *Id.*; TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a) (West 2015); TEX. HEALTH & SAFETY CODE ANN. § 245.010(a) (West 2015).

53. *Id.* at 2301-02.

54. *Id.* at 2311.

55. *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103 (2020) (affirming *Hellerstedt*).

liberty or life. Maternal care in the United States is a threat to life. Thus, arbitrary abortion restrictions that force women into unwanted pregnancies that put them under maternal care are unconstitutional threats to life.

The Court in *Casey* acknowledged that the Due Process Clause of the Fourteenth Amendment “declares that no State shall ‘deprive any person of life, liberty, or property, without due process of law,’” then stated that the controlling word in the cases before the Court was “liberty.”⁵⁶ As the maternal mortality rate since the 1990’s has more than doubled,⁵⁷ the Court may not have foreseen that the controlling word in the Due Process Clause should have been “life.” As discussed, the language of *Roe* calls for a right to life analysis given the maternal medicine crisis that followed the decision: “If the State is interested in protecting fetal life . . . it may go so far as to proscribe abortion during that period, *except when it is necessary to preserve the life or health of the mother.*”⁵⁸ In regards to maternal mortality, as discussed above, necessity would sometimes only be measurable after the woman has already died.⁵⁹ As the United States Court of Appeals for the Sixth Circuit has acknowledged, women “should not have to wait until [they have] been unconstitutionally deprived of [their] life or health” before challenging abortion restrictions.⁶⁰ Equity and justice require courts to accept data that is relevant to evaluating a state’s legitimate or actualized interest against a woman’s right to not be arbitrarily deprived of life.

The Fourteenth Amendment to the United States Constitution specifies that states are banned from depriving any person of life without due process of the law.⁶¹ This guarantee is largely absent from the Supreme Court’s jurisprudence, assumedly because the application it most easily lends to, capital punishment, is adjudicated under the Eighth Amendment. The Court has also mandated that claims of law enforcement officers using deadly force must be analyzed under the Fourth Amendment, rather than under a due process approach.⁶² However, the Court in *Tennessee v. Garner* still provided useful guidance to assembling an approach that evaluates individual interest in life as it pertains to abor-

56. *Casey*, 505 U.S. at 846.

57. Delbanco et al., *supra* note 3.

58. *Roe*, 410 U.S. at 163–64 (emphasis added).

59. *Danilack*, *supra* note 48, at 1.

60. *Women’s Med. Pro. Corp. v. Voinovich*, 130 F.3d 187, 196–97 (6th Cir. 1997) (establishing the standard of review for facial challenges to abortion statutes).

61. U.S. CONST. amend. XIV, § 1.

62. *Graham v. Connor*, 490 U.S. 386, 395 (1989) (“Today we make explicit what was implicit in *Garner’s* analysis, and hold that *all* claims that law enforcement officers have used excessive force—deadly or not . . . should be analyzed under the Fourth Amendment and its ‘reasonableness’ standard, rather than under a ‘substantive due process’ approach.”)(emphasis in original).

tion restrictions.⁶³ In its dicta, the *Garner* Court acknowledged that the suspect had an interest in his own life. The use of deadly force frustrated that interest. But against that interest was the governmental interest in effective law enforcement.⁶⁴ Pregnant women have an interest in their own lives. Draconian abortion restrictions limiting means necessary to terminate a pregnancy, amongst the highest maternal death rates of any high-income nation are frustrating that interest. That is what government interest must be weighed against.

Weighing state interest against the woman's interest in her life and health would require two main points of information: impact on abortion accessibility (undue burden) and the state's success with maternal health. A state with burdensome abortion restrictions and high maternal mortality rates increase the chance that one of those women denied an abortion will face maternal mortality—and even more so if she is a Black woman. If those restrictions did not offer significant medical benefit, then that death was an arbitrary deprivation of life under the Fourteenth Amendment. In states with the most abysmal of mortality records, only the most compelling, non-arbitrary abortion restrictions will stand under this analysis. And although the racial disparities in maternal medicine contribute to the necessity for focusing on the right to life, that does not preclude non-Black women from raising the argument. This is largely because the maternal mortality rate for all women in the United States is still so high that it cannot be ignored in the analysis for statutes that force unwanted pregnancies—leading to women's deaths. The following Parts apply this standard to current abortion restrictions in states with varying maternal mortality records: Pennsylvania's informed consent statute, Missouri's parental consent statute, and Arizona's reporting requirements.

A. *Waiting Periods*

Pennsylvania's informed consent statute requires physicians relay specific information to a woman seeking an abortion at least twenty-four hours prior to the procedure.⁶⁵ The impact of this statute on abortion accessibility and the state of Pennsylvania's maternal health system must be weighed against the actualized benefit to the state.

63. *Tennessee v. Garner*, 471 U.S. 1, 9-11 (1985); *see also* *Murtishaw v. Woodford*, 255 F.3d 926 (9th Cir. 2001) (finding that the petitioner would be deprived "of his life by the jury's potential confusion over the exercise of its statutory discretion," and thus violating due process).

64. *Garner*, 471 U.S. at 9.

65. 18 PA. CONS. STAT. § 3205 (1990).

Abortion Accessibility. The District Court findings in *Casey* raised many of the reasons why waiting periods impinge upon abortion access.⁶⁶ Due to the “distances many women must travel to reach an abortion provider, the practical effect will often be a delay of much more than a day because the waiting period requires that a woman seeking an abortion make at least two visits to the doctor.”⁶⁷ That delay would be felt most heavily by low-income women with few resources to support the two required trips and any necessary time off of work.⁶⁸ For some, “making the initial trip to an abortion provider is incredibly difficult; making a second trip is impossible.”⁶⁹ In addition to the delay, waiting periods also increase women’s exposure to harassment from anti-abortion protestors.⁷⁰

Beyond the impacts identified by the Court, studies have identified that waiting periods in Tennessee have increased the number of second-trimester abortions by no less than forty-eight percent, which limits the types of procedures available, and increases risks and costs.⁷¹ Although still notably safer than childbirth,⁷² the risks associated with a second-trimester abortion also rise by complicating what would have been a routine procedure.⁷³ The delay occasioned by waiting periods has added as much as \$645 to the already costly procedure, and up to a \$929 increase when accounting for childcare.⁷⁴

Maternal Health. As of May 2019, maternal mortality was continually increasing in Pennsylvania.⁷⁵ Like the national rate, Pennsylvania’s maternal mortality rate is not on par with other high-income countries.⁷⁶

66. *Casey*, 505 U.S. at 885-86 (citing 744 F. Supp 1332, 1351 (E.D. Penn. 1990)).

67. *Id.*

68. *Id.* at 886.

69. *Government-Mandated Delays Before Abortion*, ACLU <https://www.aclu.org/other/government-mandated-delays-abortion> [<https://perma.cc/ANT4-U74B>] (last visited Sept. 25, 2020).

70. *Casey*, 505 U.S. at 886.

71. Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*, NAT’L BUREAU OF ECON. RSCH. 1-2 (Working Paper No. 26228, 2019).

72. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 215 (2012).

73. ACLU, *supra* note 68.

74. Lindo & Pineda-Torres, *supra* note 70, at 20.

75. Press Release, Pa. Dep’t. of Health, *As U.S. Maternal Mortality Rates Rise, Department of Health Stresses Importance of Women’s Health Care* (May 13, 2019) <https://www.media.pa.gov/Pages/Health-Details.aspx?newsid=594> [perma.cc/XV4S-7X6J].

76. CDC, *MATERNAL MORTALITY BY STATE 2 (2018)* <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> [perma.cc/NKB5-KF3C]; CIA, *supra* note 20.

The state also has a wide racial disparity, as the maternal mortality rate for Black women is nearly double that of the general population.⁷⁷ Pennsylvania is also only one of five states that does not have a statewide Perinatal Quality Collaborative (PQC), which would take action to ensure healthcare organizations are implementing state recommendations.⁷⁸ The Governor of Pennsylvania signed legislation establishing a Maternal Mortality Review Committee, but because the programs, policies, and recommendations seem to still be developing,⁷⁹ it would be premature to take that into consideration.

As identified, women have a due process interest in their own lives, guaranteed by the Fourteenth Amendment.⁸⁰ Because Pennsylvania has much improvement to make regarding maternal care, the impact on abortion accessibility—extended delays, cost increases, risk increases, exposure to harassment—makes it too likely that the informed consent statute, as applied, will prevent a woman from receiving an abortion who will later die from pregnancy-related complications. The benefit of a required “period of reflection”⁸¹ is insufficient to justify that loss of life.

B. Parental Consent

A Missouri statute that went into effect in May of 2019 restricts abortions for minors unless the physician secures informed written consent from one parent and the consenting parent notified any other custodial parent in writing.⁸² The impact of this statute on abortion accessibility and the state of Missouri’s maternal health system must be weighed against the State’s concern for the minor’s best interest.

Abortion Accessibility. Minors largely consult parents before seeking abortion care without a legislative mandate to do so.⁸³ The teens that do not consult parents, usually have good reason not to—one in five pregnant minors have been abused by a parent.⁸⁴ One-third of teens who do

77. AMERICA’S HEALTH RANKINGS, HEALTH OF WOMEN & CHILDREN https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/population/maternal_mortality_a_black/state/PA (last visited Oct. 12, 2020).

78. *Id.*

79. Pa. Dep’t of Health, *supra* note 74.

80. U.S. CONST. amend. XIV.

81. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 885 (1992).

82. MO. REV. ST. § 188.028 (2019).

83. ADVOC. FOR YOUTH, ABORTION AND PARENTAL INVOLVEMENT LAWS, <https://advocatesforyouth.org/wp-content/uploads/2013/12/Parental-Involvement-Policy-Brief-2019.pdf> [perma.cc/JZS4-QMN8] (last visited Mar. 21, 2020).

84. *Id.*

not disclose their pregnancies either experienced violence, feared violence, or feared they would be forced out of their homes.⁸⁵ Yet, only fifteen of the thirty-seven states that require parent involvement have an exception for abuse, assault, incest, or neglect.⁸⁶ Although parental consent laws must be equipped with judicial bypass mechanisms,⁸⁷ foreseeable issues still exist for minors that do not have access to information on navigating the system or do not have access to the necessary transportation.

Both compelled parental involvement and judicial bypass provisions require a forfeiture of privacy and confidentiality that disincentivizes adolescents from seeking care.⁸⁸ Teens are already more likely to have later abortions—which are more difficult to obtain due to expense and availability of physicians willing to perform them—and “following enactment of Missouri’s parental consent law, the proportion of second-trimester abortion among minors increased by 17%.”⁸⁹ The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association, and the Society of Adolescent Medicine all agree that while healthcare providers have an obligation to encourage minors to talk to their parents regarding reproductive health care, “minors should not be forced to involve their parents in their decision to obtain an abortion.”⁹⁰ Not only is there no evidence that parental involvement laws improve family communication or affect outcomes, there is evidence of an increased risk of harm to the adolescent—a risk that judicial bypass provisions do not mitigate.⁹¹

Maternal Health. In Missouri, maternal mortality increased 42.8 % from 2016 to 2019.⁹² Black women in Missouri are more than twice as

85. GUTTMACHER INST., *The Impact of Parental Involvement Laws* (Oct. 1, 2008) <https://www.guttmacher.org/article/2008/10/impact-parental-involvement-laws#> [perma.cc/7Y3C-7Z9N].

86. GUTTMACHER INST., *Parental Involvement in Minors’ Abortions* (last updated Sept. 1, 2020), <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions> [perma.cc/JFR2-XA26].

87. *Id.*

88. CTR. FOR ADOLESCENT HEALTH & THE LAW, POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS 63 (Madlyn C. Morreale, Amy J. Stinnett & Emily C. Dowling eds., 2d ed. 2005) [hereinafter POLICY COMPENDIUM] <http://www.cahl.org/PDFs/PolicyCompendium/PolicyCompendium.pdf> [https://perma.cc/2KK7-WT2C].

89. ACLU, *Laws Restricting Teenagers’ Access to Abortion*, <https://www.aclu.org/other/laws-restricting-teenagers-access-abortion> [perma.cc/F2G4-X9L3] (last visited Mar. 20, 2020).

90. GUTTMACHER INST., *supra* note 84.

91. POLICY COMPENDIUM, *supra* note 87, at 63.

92. JESSICA ENGEL, LINDSEY NIENSTEDT, & LEAH KEMPEL, CTR FOR HEALTH ECON. & POL’Y, *MATERNAL MORTALITY IN MISSOURI: A REVIEW OF CHALLENGES AND STATE*

likely to die from childbirth than Black women in the United States, generally.⁹³ Although Missouri established a maternal mortality review committee in 2011, there have still been drastic increases in maternal mortality since then.⁹⁴ After nearly a decade, the Review Board published its first report in July 2020. The report includes promising recommendations—although none race-specific—including standardizing procedures across the entire healthcare system, increasing continuity of care, extending Medicaid coverage to one year postpartum, and more. When these recommendations materialize, that data will be relevant in reconciling state interests and a woman’s interest in her life. However, until then, the only data available to consider is the worsening of an already high mortality rate.

There is certainly a benefit in furthering the best interests of a child. If there was support for the premise that consent laws positively impacted minors, this would be worth engaging in a more nuanced analysis of the burdens and advantages. Because there is no support,⁹⁵ any pregnancy-related deprivation of life of a girl who would have terminated her pregnancy if not for the restriction, is arbitrary—and thus a due process violation. Because there is no evidence that consent laws have a significant impact on a minor’s decision to involve parents,⁹⁶ the Missouri law is not promising enough to overcome a girl’s interest in her life. The requirement is too loosely related to the minor’s best interest, as Missouri does not also require parental involvement in adoption decisions⁹⁷ or delivery care, which is far more dangerous than abortion procedures.⁹⁸ Missouri’s failing maternal care practices and the law’s potential to obstruct abortion access make it too likely that any of the girls prevented from receiving an abortion will later face maternal death. Thus, the statute is unconstitutional against the backdrop of high and racially disparate maternal mortality rates.

POLICY OPTIONS, (Oct. 2019) <https://publichealth.wustl.edu/wp-content/uploads/2019/10/Maternal-Mortality-in-Missouri-Final-oct-30.pdf> [https://perma.cc/2GLV-XSR7].

93. *Id.* (stating that Black women in Missouri die from childbirth at a rate of 91.9 deaths per 100,000 births).

94. *Id.*

95. POLICY COMPENDIUM, *supra* note 87, at 63.

96. GUTTMACHER INST., *supra* note 84; ADVOC. FOR YOUTH, *supra* note 82; POLICY COMPENDIUM, *supra* note 87, at 63.

97. GUTTMACHER INST., *Minor’s Rights as Parents* (Last updated Oct. 1, 2020) <https://www.guttmacher.org/state-policy/explore/minors-rights-parents> [https://perma.cc/LYS4-PEWR].

98. ACLU, *supra* note 68.

C. Reporting Requirements

Arizona recently expanded its abortion reporting requirements far beyond requesting data reasonably related to maternal health.⁹⁹ In addition to reasonable demands, such as any maternal health conditions and procedural complications, the law mandates an unsettling amount of additional information, including: the woman's educational background, marital status, and the number of miscarriages the woman has had; whether the abortion was elective, due to maternal or fetal health, or a result of rape or incest; the weight of the aborted fetus, statements by the physician and all clinic staff that the fetus was not delivered alive, and much more.¹⁰⁰ The need for this massive amount of information must stand up against its impact on abortion accessibility and the state of Arizona's maternal medicine system.

Abortion Accessibility. Almost all states require physicians providing abortions to submit regular reports.¹⁰¹ It is easy to see how states might serve their interests in public health by collecting information on the type of abortion procedure used, for example. It is much more difficult to understand how states would legitimately be furthering their interest in public health by collecting information on the weight of the aborted fetus and statements by the physician and all present staff that the fetus was not delivered alive. Having to prepare that type of statement for every abortion performed burdens providers and increases abortion costs due to the additional labor.¹⁰² Following enactment of Arizona's law, one abortion provider in the state had to hire additional staff to keep up with the over three hours a day devoted to complying with the statute.¹⁰³ To justify demanding information like this, states would need to prepare to defend their mandates with the precise ways in which the information is narrowly tailored to achieving a public health goal.

Maternal Health. The maternal mortality rate in Arizona ranks worse than the national rate at 22.3 deaths for every 100,000 births.¹⁰⁴ Of the 141 maternal deaths reviewed by the Arizona Maternal Mortality Review Board over a three-year period, the board considered eighty-

99. ARIZ. REV. STAT. ANN. § 36-2161 (2019).

100. *Id.*

101. GUTTMACHER INST., *Abortion Reporting Requirements* (Last updated Oct. 1, 2020) <https://www.guttmacher.org/state-policy/explore/minors-rights-parents> [<https://perma.cc/58YS-BJ9H>].

102. Garnet Henderson, *Anti-Abortion Lawmakers Want the State to Know Everything About Your Abortion*, VICE (Oct. 10, 2019, 6:00 AM) https://www.vice.com/en_us/article/xwe59n/abortion-reporting-laws-lawmakers-want-the-state-to-know-everything-about-your-abortion [<https://perma.cc/DAQ8-QHN2>].

103. *Id.*

104. CDC, *supra* note 75 at 2.

nine percent preventable.¹⁰⁵ Of note, Arizona is one of nine states to receive a large, five-year grant from the U.S. Department of Health and Human Services,¹⁰⁶ and it has an action plan that, at first glance, seems to be quite extensive. However, the enumerated performance measures mostly consist of non-specific phrases such as, “complete 100% of the action items in the recommendation brief,” and the plan is largely silent on race.¹⁰⁷ Although the report mentions the racial disparity in maternal mortality rates that presents for Native American women in Arizona, the plan mentions no race-specific methods to remedy that disparity and improve care for indigenous women, other than partnering with Indian Health Services.¹⁰⁸

Because of the state of maternal health in Arizona, in order to avoid arbitrary deprivations of life, the need for the mandated information should have to be so crucial that it outweighed an individual right to life. Situations in which that would be so are imaginable: if the information would assist public health officials in saving a non-negligible amount of lives, the risk that a woman denied abortion access would later die from pregnancy related concerns may be a risk the Constitution allows. There is no evidence that the weight of a fetus is such vital information that it will save a number of lives. Thus, the loss of life that could result from the statute is arbitrary and a violation of the Fourteenth Amendment.

Admittedly, under this analysis, states with identical statutes could face different outcomes—that is because the facts differ. Women in California are not as likely to die from pregnancy related complications and childbirth as women in Arkansas,¹⁰⁹ thus abortion restrictions in California do not pose the same threat to life as they would in Arkansas. This life interest analysis also does not replace the liberty interest analysis—it only aids it in a time of abysmal maternal care in the United States.

105. See CITADEL CABASAG, VIVIENNE RUBIO & DALLAS WILLIAMS, ARIZ. DEP’T OF HEALTH SERVS., ARIZONA MATERNAL MORTALITY REVIEW PROGRAM: PROGRAM REPORT 2012-2015 2 (June 1, 2019) (last updated June 12, 2019) <https://azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/maternal-mortality-review-2012-2015.pdf> [<https://perma.cc/VM3D-BBKK>]; see also Jeff Rosenfield, *Arizona Responds to Maternal Mortality Rates*, CITYSUNTIMES (Dec. 5, 2019) (last updated Aug. 27 2020) <https://news.citysuntimes.com/2019/12/05/arizona-responds-to-maternal-mortality-rates/> [<https://perma.cc/9PX5-Y9MR>] (“More than 80 percent of all maternal deaths in Arizona are believed to have been preventable . . .”).

106. Rosenfield, *supra* note 104.

107. ARIZ. DEP’T OF HEALTH SERVS., MATERNAL MORTALITY ACTION PLAN 8 (June 2019) <https://azdhs.gov/documents/operations/managing-excellence/breakthrough-plans/maternal-mortality-breakthrough-plan.pdf> [<https://perma.cc/K9HG-A375>].

108. *Id.* at 15.

109. CDC, *supra* note 103.

CONCLUSION

The Supreme Court, in *Casey*, *Hellerstedt*, and *June Medical Services*, purported to rely heavily on factual record.¹¹⁰ The facts here are that pregnancy and childbirth is claiming lives, especially Black lives, at a staggeringly high rate. While this is so, abortion restrictions cannot remain unmoved by this racially disparate state of maternal medicine. A standard that aims to assess the constitutionality of an abortion restriction can no longer only balance state interests against liberty interests—it must also balance state interests against a woman’s interest in preserving her own life.

Abortion advocates must incorporate maternal mortality data into the factual record for courts to consider whether states are affording women the opportunity to choose life; courts must accept that data as relevant to consideration of life that started with *Roe*. “Kira deserved better Women all over the country deserve better.”¹¹¹ Although the priority should be addressing the racial disparity in maternal mortality, demanding the proper constitutional protections is one way we can start to do better in the meantime—one way we can begin rebalancing the scales of reproductive justice.

110. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 834 (1992); *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2126 (2020).

111. 4KIRA4MOMS, *supra* note 1.

