Medical Judgment and Maternal Health Exceptions in the New Era of Abortion Criminalization

Melissa Morgan*

As reproductive justice advocates focus on medical exceptions to abortion bans as a means of expanding access to care in the near term, we must consider what would make medical exceptions genuinely usable. The medical exceptions that states have so far enacted are confusing and absurdly restrictive, so that hospitals are turning away patients on death's door. This Article considers the standards for medical judgment that these exceptions embody, asking how regulating doctors' discretion would affect the exceptions' utility. Under a "reasonable medical judgment" standard, preferred by the anti-choice, the State can second-guess and ultimately punish doctors' judgments. By contrast, pro-choice advocates have promoted a "good faith" standard, which could alleviate the chilling effect on abortion care by vesting doctors with greater discretion. But amid a web of draconian statutory restrictions on medical care, good faith judgment cannot practically be exercised. To consider what a workable good faith regime would look like in practice, this Article takes up British abortion law as a case study. A broad good faith medical exception like Britain's can make abortion widely accessible, but it comes with dangerous consequences: enabling disparities, punishing abortions outside the medical establishment, and turning doctors into gatekeepers at the expense of individual autonomy. Good faith medical exceptions therefore represent a step in the right direction, albeit a partial and imperfect one. Reproductive justice advocates should advocate for expanded good faith exceptions that will save lives while maintaining a clear vision that medical exceptions will never be enough to realize true choice and autonomy.

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INTRODUCTION

In states that have restricted abortion access, patients and their advocates tell many iterations of a now-familiar story.[1] While hoping their conditions are serious enough to qualify for a legal abortion under opaque medical exceptions, women hemorrhage;[2] they become septic;[3] they vomit and shake uncontrollably.[4] Women bleed: they soak through their clothing as they wait for their uterus to rupture;[5] they bleed on the bathroom floor after doctors send them home;[6] and when emergency room staff will not

[1] This Article uses terms including women, patients, and pregnant people or individuals interchangeably to describe abortion bans and their consequences. I use all these terms in recognition of the gendered purpose behind abortion restrictions and their impact on women, as well as to acknowledge that abortion access is essential for people of all gender identities.

[2] Nadine El-Bawab et al., *Fighting for Their Lives: Women and the Impact of Abortion Restrictions in Post-Roe America*, ABC NEWS (Dec. 14, 2023), https://www.goodmorningamerica.com/news/story/fighting-lives-women-impact-abortion-restrictions-post-roe-105563174 [https://perma.cc/CK4U-JJSP].

[3] Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN (June 20, 2023), https://www.cnn.com/2022/11/16/health/abortion-texas-sepsis/index.html [https://perma.cc/TYK5-S7KE].

[4] Nadine El-Bawab, *Woman Said She Went Into Sepsis Before She Could Get Lifesaving Abortion Care in Texas*, ABC NEWS (May 15, 2023), https://abcnews.go.com/US/woman-sepsis-life-saving-abortion-care-texas/story?id=99294313 [https://perma.cc/U6HW-TRU2].

[5] Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion*, PROPUBLICA (March 14, 2023), https://www.propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy [https://perma.cc/26MX-THEG].

[6] Rosemary Westwood, *Bleeding and in Pain, She Couldn't Get 2 Louisiana ERs to Answer: Is it a Miscarriage?*, NPR (Dec. 29, 2022), https://www.npr.org/sections/health-shots/2022/12/

treat a miscarriage, they bleed for over ten days.[7] Waiting for patients to be so close to death that they can be sure a medical exception will apply, doctors "look at them like a ticking time bomb and wait for the complications to develop."[8] Hospitals tell patients: "[T]he best we can tell you to do is sit in the parking lot, and if anything else happens, we will be ready to help you. But we cannot touch you unless you are crashing in front of us or your blood pressure goes so high that you are fixing to have a heart attack."[9]

Pregnant cancer patients are denied treatment until they can leave the state for an abortion.[10] People who learn their pregnancies are nonviable agonize over whether to flee the state as well: "I don't want to bring her into this world to suffer for an hour or two just so I can say I held her."[11] They may travel over 1,000 miles to make this choice,[12] or deliver only to watch their babies die within hours.[13] Patients who cannot leave know their options are limited: "Sit and wait in the hospital for however long it took for [the fetus's] heartbeat to either stop, or for infection to set

29/1143823727/bleeding-and-in-pain-she-couldnt-get-2-louisiana-ers-to-answer-is-it-a-miscarria [https://perma.cc/AGU8-62FT].

[7] Frances Stead Sellers & Fenit Nirappil, *Confusion Post-Roe Spurs Delays, Denials for Some Lifesaving Pregnancy Care*, WASH. POST (July 16, 2022), https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care [https://perma.cc/8BFD-CHN5].

[8] Roni Caryn Rabin, *Texas Abortion Law Complicates Care for Risky Pregnancies*, N.Y. TIMES (Nov. 26, 2021), https://www.nytimes.com/2021/11/26/health/texas-abortion-law-risky-pregnancy.html [https://perma.cc/QM9T-48NH].

[9] Selena Simmons-Duffin, *How Hospitals Decide What Qualifies as a Life-Threatening Emergency to Allow Abortion*, NPR (April 25, 2023), https://www.npr.org/2023/04/25/1172005589/how-hospitals-decide-what-qualifies-as-a-life-threatening-emergency-to-allow-abo [https://perma.cc/GW8W-VATZ].

[10] Shefali Luthra, *State Abortion Bans are Preventing Cancer Patients From Getting Chemotherapy*, 19TH (Oct. 7, 2022), https://19thnews.org/2022/10/state-abortion-bans-prevent-cancer-patients-chemotherapy [https://perma.cc/Y7MX-4BDB].

[11] Michael Daly, *Abortion Ban a 'Nightmare' for Woman with Doomed Pregnancy*, DAILY BEAST (Feb. 28, 2023), https://www.thedailybeast.com/tennessee-abortion-ban-a-living-nightmare-for-woman-with-doomed-pregnancy [https://perma.cc/E6WG-UNWS].

[12] Timothy Bella, *Fla. Woman Forced to Fly to D.C. for Abortion Returns for State of the Union*, WASH. POST (Feb. 7, 2023), https://www.washingtonpost.com/politics/2023/02/07/state-of-union-abortion-florida-anabely-lopes [https://perma.cc/9TNC-P6ZW].

[13] Maya Yang, *Florida Couple Unable to Get Abortion Will See Baby Die After Delivery*, GUARDIAN (Feb. 18, 2023), https://www.theguardian.com/world/2023/feb/18/florida-abortion-law-couple-birth [https://perma.cc/7353-FMN5].

in or for me to bleed to death."[14] Waiting for an abortion that may never come, patients are left to wonder, "They're just going to let me die?"[15]

These horrors are the predictable result of state abortion bans that are both absurdly restrictive and dangerously vague. Since *Dobbs v. Jackson Women's Health Organization* eviscerated the constitutional right to abortion in 2022,[16] around half the states have banned or restricted abortion access.[17] In thirteen states, the procedure is banned in almost all circumstances; eight more set low gestational limits; and in two, courts have blocked bans from taking effect, at least for now.[18] All these bans contain some provision allowing abortion where the pregnant person's life is in danger and many contain exceptions for certain health risks,[19] but these exceptions are narrow and indecipherable. For example, most states with health exceptions permit abortion where there is "a serious risk of substantial and irreversible impairment of major bodily function," yet "major" and "substantial" remain undefined.[20] How close to death or catastrophic injury must a patient be before doctors can intervene? Doctors don't know, and patients suffer.[21] Dr. Alison Haddock, an emergency physician in Houston, described the kinds of questions doctors now ask their hospital lawyers while valuable minutes pass: "Do we wait until the fetus is definitely dead, or is mostly dead good enough? If [our lawyers are] telling us to wait for the condition to be fully emergent, how much bleeding is too much?"[22] The President of the American Medical Association, Jack Resneck, summed up the problem this way: "Since the

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[14] Susan Szuch, *After Missouri Banned Abortions, She Was Left 'With a Baby Dying Inside.' Doctors Said They Could Do Nothing.*, SPRINGFIELD NEWS-LEADER (Oct. 19, 2022), https://www.news-leader.com/story/news/local/ozarks/2022/10/19/missouri-laws-abortion-ban-left-her-with-a-baby-dying-inside-pprom/10366865002 [https://perma.cc/K3WK-XJJ9].

[15] Neelam Bohra*, 'They're Just Going to Let Me Die?' One Woman's Abortion Odyssey*, N.Y. TIMES (Aug. 1, 2022), https://www.nytimes.com/2022/08/01/us/abortion-journey-crossing-states.html [https://perma.cc/3NU5-WBSM].

[16] Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

[17] *Tracking Abortion Bans Across the Country*, N.Y. TIMES (Sept. 29, 2023), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html [https://perma.cc/AP6T-RSQT].

[18] *Id.*

[19] Mabel Felix et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services [https://perma.cc/B7SX-3WDA].

[20] *Id.*

[21] *See id*. (describing example of woman with melanoma who fled Ohio to receive an abortion after her doctors could not determine whether she qualified for a health exception).

[22] Kate Zernike, *Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, N.Y. TIMES (Sept. 10, 2022), https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html [https://perma.cc/AF3D-9XW3].

Dobbs decision, health care in the United States has been thrown into chaos . . . . Physicians and other health care professionals must attempt to comply with vague, restrictive, complex, and conflicting state laws that interfere with the practice of medicine."[23] Indeed, a 2023 survey found that over half of OBGYNs in states with bans were concerned about their legal risk when making decisions about the necessity of abortion, and over one-third of OBGYNs nationally said their ability to practice within the standard of care had deteriorated.[24]

Doctors are desperate for guidance, and it's not clear who is flying the plane. State legislators insist their laws are clear and doctors should know what they mean.[25] Courts, too, throw up their hands and claim that doctors are the designated decisionmakers.[26] Doctors respond that they need to ask their lawyers, but their lawyers—lacking precedent on the parameters of the law and the likelihood of prosecution, not to mention medical training on what makes a risk serious—don't know either.[27] Hospital attorneys can suggest the more risk-averse path of denying care

[23] Press Release, American Medical Association, AMA Announces New Adopted Policies Related to Reproductive Health Care (Nov. 16, 2022), https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care [https://perma.cc/GZ2T-77NT].

[24] Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After Dobbs*, KFF (June 21, 2023), https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report [https://perma.cc/8KEX-BTA9].

[25] *See, e.g.*, Mary Tuma, *Time is Running Out for Texas Republicans to Clarify Exceptions in Their New Abortion Law*, THE NATION (May 16, 2023), https://www.thenation.com/article/society/texas-republicans-vague-exceptions-abortion-law [https://perma.cc/K7KL-MZ9Z].

[26] *See, e.g.*, In re State, 682 S.W.3d 890, 893 (Tex. 2023) (stating that "it is a doctor who must decide that a woman is suffering from a life-threatening condition during a pregnancy" that necessitates a life-saving abortion, or an abortion in order to "prevent impairment of a major bodily function"); Texas v. Zurawski, 690 S.W.3d 644, 653 (Tex. 2024) ("[a] physician who tells a patient, 'Your life is threatened by a complication that has arisen during your pregnancy, and you may die, or there is a serious risk you will suffer substantial physical impairment unless an abortion is performed,' and in the same breath states 'but the law won't allow me to provide an abortion in these circumstances' is simply wrong in that legal assessment.").

[27] *See* Zernike, *supra* note 22; Selena Simmons-Duffin, *Doctors Who Want to Defy Abortion Laws Say it's Too Risky*, NPR (Nov. 23, 2022), https://www.npr.org/sections/health-shots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky [https://perma.cc/82UK-G6HZ].

to avoid prosecution,[28] yet federal intervention[29] and malpractice suits[30] may follow. While states tell doctors not to provide abortions, the federal government tells them that there are instances where they *must*.[31] Hospital ethics committees mutate into abortion advisory boards, yet they were never meant to give legal or medical advice.[32] And the little guidance that state Attorneys General have bothered to release is decidedly unhelpful, merely reiterating the same vague wording embodied in the statutes themselves.[33]

Faced with life-threatening uncertainty, patients and doctors have demanded clarity, most prominently in the lawsuit *Zurawski v. Texas*.[34] Brought by the Center for Reproductive Rights, its plaintiffs were twenty-two women denied abortion care in Texas despite severe pregnancy complications, fatal fetal diagnoses, and life-threatening medical emergencies.[35] Because "pregnant people have been denied necessary and potentially life-saving obstetrical care because medical professionals throughout the state fear liability," the suit sought "a declaratory judgment

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[28] *See, e.g.*, Reese Oxner & María Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Group Says*, TEX. TRIB. (July 15, 2022), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws [https://perma.cc/NZX8-EQ86].

[29] *E.g.*, Kavitha Surana, *Hospitals in Two States Denied an Abortion to a Miscarrying Patient. Investigators Say They Broke Federal Law.*, PROPUBLICA (May 19, 2023), https://www.propublica.org/article/two-hospitals-denied-abortion-miscarrying-patient-breaking-federal-law [https://perma.cc/N9FK-D27P].

[30] *E.g.*, Harris Meyer, *Malpractice Lawsuits Over Denied Abortion Care May Be on the Horizon*, KFF (June 23, 2023), https://kffhealthnews.org/news/article/malpractice-lawsuits-denied-abortion-care [https://perma.cc/88MH-8RYK].

[31] U.S. DEP'T HEALTH & HUM. SERV., EMERGENCY MEDICAL CARE LETTER TO HEALTH CARE PROVIDERS (July 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf [https://perma.cc/K6CY-M3MN].

[32] Holly Fernandez Lynch et al., *'Is Abortion Medically Necessary?' is Not a Question for Ethicists to Answer*, STAT (Aug. 15, 2022), https://www.statnews.com/2022/08/15/deciding-abortion-medically-necessary-isnt-ethics-question [https://perma.cc/WU3K-PE8Z].

[33] *See, e.g.*, OKLA. ATT'Y GEN., MEMORANDUM FROM OKLAHOMA ATTORNEY GENERAL TO ALL OKLAHOMA LAW ENFORCEMENT AGENCIES RE: GUIDANCE FOR OKLAHOMA LAW ENFORCEMENT FOLLOWING *DOBBS V. JACKSON WOMEN'S HEALTH ORG*. (Aug. 31, 2022), https://www.oag.ok.gov/sites/g/files/gmc766/f/memo_to_law_enforcement_following_dobbs_8.31.22.pdf [https://perma.cc/B8KW-BP2S]; Press Release, Tex. Att'y Gen., Attorney General Ken Paxton Responds to Travis County TRO (Dec. 7, 2023), https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-responds-travis-county-tro [https://perma.cc/UW5E-ME7M].

[34] *See Zurawski v. State of Texas*, CTR. FOR REPROD. RTS. (March 6, 2023), https://reproductiverights.org/case/zurawski-v-texas-abortion-emergency-exceptions/zurawski-v-texas [https://perma.cc/49DL-5ZNN].

[35] *More Women Join Lawsuit Against Texas After being Denied Abortion Care Despite Dangerous Pregnancy Complications*, CTR. FOR REPROD. RTS. (Nov. 14, 2023), https://reproductiverights.org/plaintiffs-join-zurawski-v-texas-11-14-23 [https://perma.cc/5U3L-GSWB].

clarifying the scope of Texas's Emergent Medical Condition Exception to its abortion bans."[36] The complaint asserted that "inconsistencies in the language of these provisions, the use of non-medical terminology, and sloppy legislative drafting have resulted in understandable confusion throughout the medical profession regarding the scope of the exception."[37] Working under an opaque law coupled with harsh penalties, including "the threat of losing their medical licenses, fines of hundreds of thousands of dollars, and up to 99 years in prison lingering over their heads . . . it is no wonder that doctors and hospitals are turning patients away—even patients in medical emergencies."[38]

This Article addresses what *Zurawski* identified as the central uncertainty in Texas's law: the legal standard adopted for the exercise of medical judgment. The plaintiffs argued that "where an abortion ban provides an exception for patients in certain circumstances, a good faith standard, rather than a reasonable person standard, must apply."[39] In other words, the exception should apply when a doctor subjectively believes an abortion is medically necessary within the exception's bounds, and the doctor need not prove that her decision was objectively reasonable. This difference is critical: medical judgments are inherently fraught with uncertainty and prediction, and under an objective standard, "it is unlikely that the prosecution could not find a physician willing to testify that the physician [acted un]reasonably."[40] Indeed, in defending their anti-choice laws, states lean on testimony from fringe anti-choice groups masquerading as medical experts.[41] Because an objective standard provides an opportunity to convince a jury that a doctor's decision was not reasonable, it "leaves physicians uncertain whether the treatment decisions they make in good faith, based on their medical judgment, will be respected or will be later disputed."[42] Without the necessary confidence to exercise their medical judgment free from state interference and punishment, there has been "significant chilling in the provision of pregnancy-related care that involves abortion."[43] This is the case in Texas,

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[36] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 1, 5, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

[37] *Id*. at 65.

[38] *Id*. at 2.

[39] *Id*. at 67.

[40] *Id*. (quoting Women's Med. Prof'l Corp. v. Voinovich, 130 F.3d 187, 205 (6th Cir. 1997)).

[41] *See, e.g.*, Pl.'s Post-Hearing Proposed Findings of Fact & Conclusions of Law at 7–8, Preterm-Cleveland v. Yost, No. A 2203203 (Ohio Ct. Com. Pl. Oct. 11, 2022) (detailing the lack of qualifications of anti-choice 'experts' that testified for the state).

[42] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 67, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

[43] *Id*. at 94.

where the statutory scheme "contains conflicting language across the different sections regarding physician discretion and intent," with some provisions requiring reasonable medical judgment, others mentioning subjective belief, and still others silent as to intent.[44]

The difference between a subjective and objective standard may therefore be incredibly consequential for enabling the provision of care, so anti-choice legislators and activists see an objective reasonableness standard as essential to their success. After a Texas woman, Kate Cox, obtained an order from a Travis County court that she qualified for an abortion under the state's medical exception,[45] Texas Attorney General Ken Paxton challenged the order, doubling down on the reasonableness standard. In a public letter to Cox's healthcare providers, Paxton wrote:

> To fall within the medical exception, the physician must determine 'in the exercise of *reasonable medical judgment*, the pregnant female on whom the abortion is performed, induced, or attempted has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced.' Tex. Health & Safety Code § 170A.002(b) (emphasis added). The [order] states that Dr. Karsan "*believes in good faith*" that "abortion is medically recommended" for Ms. Cox. But that is not the legal standard—reasonable medical judgment and a life-threatening physical condition are.[46]

Paxton's emphasis on the reasonableness standard makes clear that the anti-choice movement sees it as more difficult to satisfy, and therefore more effective at chilling abortion care. The Texas Supreme Court agreed with Paxton and overturned the lower court order, by which time Cox had already fled the state to receive the care she needed.[47] The court wrote:

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[44] *Id*. at 67.

[45] *Texas Judge Grants Temporary Order Allowing Pregnant Woman to Access Abortion Care in the State*, CTR. FOR REPROD. RTS. (Dec. 7, 2023), https://reproductiverights.org/cox-v-texas-tro-abortion-access [https://perma.cc/7AZC-PEB4].

[46] The letter is only available to read as a social media post. Ken Paxton (@TXAG), X (Dec. 7, 2023, 2:49 PM), https://twitter.com/TXAG/status/1732849903154450622 [https://perma.cc/7KXZ-86UJ]. Even the official press release refers only to the X post. *See* Press Release, *supra* note 33.

[47] *Texas Woman Who Needs Emergency Abortion Forced to Flee State*, CTR. FOR REPROD. RTS. (Dec. 11, 2023), https://reproductiverights.org/texas-woman-who-needs-emergency-abortion-forced-to-flee-state [https://perma.cc/RH6N-E9YR].

> Though the statute affords physicians discretion, it requires more than a doctor's mere subjective belief. By requiring the doctor to exercise "reasonable medical judgment," the Legislature determined that the medical judgment involved must meet an objective standard . . . the trial court erred in applying a different, lower standard instead.[48]

The Texas Supreme Court thus affirmed that a reasonableness standard is the more demanding choice, and it made all the difference for Kate Cox.

When *Zurawski* reached the same court in May 2024, it again upheld the reasonableness standard, firmly rejecting plaintiffs' challenge.[49] According to the Texas Supreme Court, a reasonableness standard ensures that "[a] doctor may not disregard the requirement that a mother must have a life-threatening physical condition."[50] The Court rejected plaintiffs' call to clarify "what 'reasonable medical judgment' means—after all, the Legislature has defined it."[51] Although the Court claimed that "[t]he law does not require the life-threatening physical condition to have already caused damage before the physician can act," it did nothing to clarify what "serious risk" and "substantial impairment" are supposed to mean, simply stating once again that doctors' "reasonable medical judgment" will tell them.[52]

This Article examines the standards for medical judgment articulated in *Zurawski* and *Cox*—good faith versus reasonable medical judgment—to consider how medical exceptions could be written to better enable genuine access to care. As of this writing, seventeen ban states have adopted a "reasonable medical judgment" standard; only one state, Arizona, has clearly adopted "good faith clinical judgment"; one state, Utah, has adopted "best medical judgment"; and two states do not specify a standard at all.[53] Other states adopt still other standards, leading to a patchwork of laws.[54] Such statutory codification of medical judgment standards is a new problem, as abortion bans before *Roe* were largely silent

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[48] In re State, 682 S.W.3d 890, 894 (Tex. 2023).

[49] Texas v. Zurawski, 690 S.W.3d 644, 653 (Tex. 2024).

[50] *Id.* at 664.

[51] *Id.*

[52] *Id.* at 664–65.

[53] *Abortion Gestational Limits and Exceptions*, KFF (Dec. 20, 2023), https://www.kff.org/womens-health-policy/state-indicator/gestational-limit-abortions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/M48J-NC2T].

[54] *Id.*

on the matter.[55] Clear drafting with deference to physicians is essential, with the health and lives of pregnant people hinging on this choice.

This Article proceeds in four parts. First, I provide an overview of the medical standard of care and consider how abortion bans fundamentally depart from it. Medical and legal language in the abortion arena do not align, and doctors need discretion to provide individualized assessments that state laws make impossible. Next, I explore what a reasonable medical judgment standard would look like and why it is preferred by the anti-choice movement. I then consider the good faith alternative, examining how it could alleviate the chilling effect on abortion provision and provide greater deference to physicians. Yet even good faith judgment cannot practically be exercised when abortion bans implement specific restrictions on medical practice, such as limitations on qualifying health conditions and requirements to prioritize the life of the fetus. To consider what a workable good faith exception would look like in practice, I look to the abortion regime in Britain and consider its promises and pitfalls. I conclude that only a broad good-faith standard, free of restrictions on medical judgment, allows doctors to provide care where it is needed. Yet this kind of regime will always be insufficient where criminal penalties are still possible, where abortions outside the norm may be punished, and where pregnant individuals are not the ultimate decisionmakers on their own bodies and futures. In the end, good-faith medical exceptions will never be enough to realize true choice and autonomy. But in a world where abortion bans are a political reality for the foreseeable future, they could mean more lifesaving care, here and now.

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[55] Pre-*Roe* bans with medical exceptions largely did not specify standards for medical judgment, often leaving room for a legal abortion where simply "necessary to preserve [the mother's] life" or "under advice of a physician or surgeon." *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 302–330 (2022) (listing in an appendix all Reconstruction-era abortion bans). States that expanded medical exceptions in the late 1960s and early 1970s similarly did not specify medical judgment standards, even as they explicitly provided for abortion under doctors' direction. *See* Brian Pendleton, *The California Therapeutic Abortion Act: An Analysis*, 19 HASTINGS L. J. 242, 245 (1967) (describing medical exceptions introduced in California, Colorado, and North Carolina). In *Roe* itself, the Court invalidated a Texas ban that provided for exceptions upon "medical advice for the purpose of saving the life of the mother," holding that in the first trimester the "attending physician . . . is free to determine . . . in his medical judgment, that the patient's pregnancy should be terminated." Roe v. Wade, 410 U.S. 113, 119, 163 (1973). And in *Doe v. Bolton*, the Court considered Georgia's abortion ban, which provided for exceptions according to a physician's "best medical judgment," finding that it enabled "medical judgment [to] be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient . . . . This allows the attending physician the room he needs to make his best medical judgment." 410 U.S. 179, 192 (1973). The abortion bans we have seen before therefore regulated less stringently how doctors could exercise their medical judgment, another reason why doctors under the new abortion bans are navigating uncharted territory.

This Article is rooted in the premise that incremental change is better than none. A broad, clear, usable medical exception to an abortion ban can make the difference between life and death, between injury and safety. Some pro-choice advocates reasonably oppose any measure that falls short of fully repealing the bans,[56] seeing anything less as a concession to the anti-choice position that abortion can and should be limited. Yet we are facing opponents who will stop at nothing to ban all abortions, everywhere.[57] For example, in Tennessee, anti-choice lobbyists retracted endorsements from legislators who supported medical exceptions, calling them "loopholes" that make abortion bans "unenforceable."[58] In South Dakota, a pregnant Republican lawmaker, Taylor Rehfeldt, withdrew a proposed medical exception before bringing it to a vote, even though "[t]he language she and two other Republicans had landed on was still so slim, most national medical organizations and abortion-access advocates wouldn't support it. But even that had no chance."[59] Across the country, with pressure from anti-choice activists who envision a total ban without exception and constitutional protections for the fetus, lifesaving exceptions have failed.[60] Considering the issue in this light, it becomes clear that expanding medical exceptions isn't a concession to the anti-choice movement: it would make them concede to us. Perhaps it's time to take a page out of the anti-choice movement's book: after *Roe*, they didn't see incremental changes like gestational limits, waiting periods, and TRAP laws as concessions.[61] These were steps along the road to their

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[56] *See, e.g.*, *SB 35 – Exceptions Added to the Alabama Abortion Ban*, ACLU ALA. (2023), https://www.aclualabama.org/en/legislation/sb-35-exceptions-abortion-ban [https://perma.cc/P8FM-MWEP]. The Alabama ACLU opposed this proposed bill to create rape and incest exceptions to Alabama's abortion ban because:

> [p]eople should not need permission to access the care they need, and no one should be forced to disclose the reasons why they need abortion care. The call to add exceptions to abortion bans proves that one-size-fits-all laws don't work. In order for our laws to address all the possible circumstances that someone who is pregnant might face, we need to end abortion bans and make access to medical care the rule, not the exception. *Id.*

[57] Kavitha Surana, *Some Republicans Were Willing to Compromise on Abortion Ban Exceptions. Activists Made Sure They Didn't.*, PROPUBLICA (Nov. 27, 2023), https://www.propublica.org/article/abortion-ban-exceptions-trigger-laws-health-risks [https://perma.cc/J36Y-XZ9G].

[58] Kavitha Surana, *Tennessee Lobbyists Oppose New Lifesaving Exceptions in Abortion Ban*, PROPUBLICA (Feb. 24, 2023), https://www.propublica.org/article/tennessee-lobbyists-oppose-new-life-saving-exceptions-abortion-ban [https://perma.cc/2F6F-KRWP].

[59] Surana, *supra* note 57.

[60] *Id.*

[61] Janet Reitman, *The Stealth War on Abortion*, ROLLING STONE (Jan. 15, 2014), https://www.rollingstone.com/politics/politics-news/the-stealth-war-on-abortion-102195 [https://perma.cc/EUG4-KPZ6].

ultimate goal. Similarly, pushing for more usable medical exceptions is a lifesaving step in the right direction, and reproductive justice advocates can concurrently pursue more expansive and long-term strategies. As Katie Watson has written, "Hospitals in ban states can simultaneously fight for their right to treat women facing medical threats under bans and fight to escape their legislatively imposed role as gatekeepers to abortion access by advocating for the repeal of bans altogether."[62] An incremental win will only be a compromise if we stop there.

I. THE MEDICAL-LEGAL CONFLICT IN ABORTION BANS TODAY

States may insist that their medical exceptions delegate decision-making authority to doctors, yet across the board, these statutes are vague, restrictive, and unmoored from medical authority. In this Section, I examine how abortion bans profoundly diverge from the medical standard of care. In sum, these statutes prevent doctors from addressing patient needs on an individualized basis; contain language that is not medically defined or is inaccurate; and reject input from the medical community. This Section lays groundwork for the rest of this Article by establishing why abortion bans are so difficult for doctors to interpret and apply. Because the bans interfere with clinical judgment and adopt restrictions that are not based in medicine, doctors are unsure how they can comply with the bans while simultaneously exercising their best clinical judgment. For medical exceptions to work, they must provide a deference to medical expertise that is conspicuously lacking throughout the new abortion bans.

Fundamentally, abortion bans prevent doctors from practicing according to the medical standard of care by broadly restricting their ability to make patient-specific judgments. Major medical associations consistently emphasize that abortion-related decisions, like all medical care, must be made based on each patient's particular circumstances and with the patient's input.[63] The American College of Obstetricians and Gynecologists (ACOG) "recognizes that clinicians regularly practice and make medical decisions in gray areas, and each patient brings unique medical considerations to the table."[64] As a result, "there is no one-size-

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[62] Katie Watson, *Dark-Alley Ethics—How to Interpret Medical Exceptions to Bans on Abortion Provision*, 388 N. ENG. J. MED. 1240, 1244 (2023).

[63] AM. MED. ASS'N., AMA CODE OF MEDICAL ETHICS OPINION 4.2.7 (2016), https://code-medical-ethics.ama-assn.org/ethics-opinions/abortion [https://perma.cc/9VA5-9EAE] ("Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment.").

[64] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Aug. 15, 2022), https://ww

fits-all law that can take every individual, family, or medical condition into account, making legislative interference in the practice of medicine incredibly dangerous."[65] Yet abortion bans impose sweeping regulations, such as gestational limits, that apply regardless of patients' medical needs.[66] Even where medical exceptions exist, abortion bans broadly interfere with medical practice by allowing abortions only in narrow circumstances: for example, in Kentucky, "to prevent the serious, permanent impairment of a life-sustaining organ,"[67] and in Utah, when "the abortion is necessary to avert a serious physical risk of substantial impairment of a major bodily function."[68] But as ACOG asserts, "it is impossible to create an inclusive list of conditions that qualify as 'medical emergencies'" because "[t]he practice of medicine is complex and requires individualization . . . . No single patient's condition progresses at the same pace," and "[a] patient may experience a combination of medical conditions or symptoms that, together, become life-threatening."[69] When statutes broadly limit the circumstances where an abortion can be provided, they are fundamentally incompatible with the highly individualized nature of medical practice. What is more, ten states explicitly exclude mental health conditions from their medical exceptions,[70] even though mental health conditions are far and away the leading cause of pregnancy-related deaths.[71] Perhaps most extraordinarily of all, some bans require doctors to "make reasonable medical efforts under the circumstances to preserve . . . the life of the unborn human being."[72] Such medically baseless restrictions strike at the heart of the patient-clinician relationship, broadly preventing doctors from providing medically necessary care and therefore "harm[ing] the people seeking

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w.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions [https://perma.cc/98NK-QNSW].

[65] *Id*.

[66] KFF, *supra* note 53; *see also* Eric Boodman, *Legal at One Clinic, Illegal at Another: How Abortion Bans Make Gestational Age Even Less Precise*, STAT (Nov. 10, 2022), https://www.statnews.com/2022/11/10/abortion-bans-gestational-age-pregnancy [https://perma.cc/VK4E-SDCB] (describing the flaws in and consequences of gestational limits).

[67] KY. REV. STAT. ANN. § 311.772(4)(a) (West 2019).

[68] UTAH CODE ANN. § 76-7a-201(1)(a)(ii) (West 2023).

[69] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 64.

[70] Nada Hassanein, *Medical Exceptions to Abortion Bans Often Exclude Mental Health Conditions*, 19TH (Oct. 24, 2023), https://19thnews.org/2023/10/medical-exceptions-abortion-bans-mental-health-conditions [https://perma.cc/NL3H-KK24].

[71] Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 28, 2024), https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html [https://perma.cc/Y6PJ-PDNQ].

[72] KY. REV. STAT. ANN. § 311.772(4)(a) (West 2019).

essential healthcare and those providing it."[73] These burdens undoubtedly interfere with doctors' ability to exercise their clinical judgment.

The new abortion bans further disregard medical practice by using language that is medically undefined or inaccurate.[74] For example, doctors are unsure what an exception for a "substantial impairment" means for their practice.[75] Words like "substantial," which are common in abortion bans and in law generally, have no standard medical meaning.[76] Legal standards for medical decision-making also do not map neatly onto the medical standard of care. While in law, "objective" and "subjective" are clearly defined as evidentiary burdens,[77] medical guidance does not use this terminology, instead considering a mix of factors that could be characterized as objective or subjective.[78] In its guidance on understanding medical exceptions, ACOG emphasizes the importance of deferring to "the best currently available medical evidence and the physician's professional medical judgment," as well as the profession's fluidity, inherent uncertainty, and centrality of shared decision-making with the patient.[79] Finally, abortion bans use terminology that is downright misleading from a medical perspective. For example, states including South Carolina ban abortion after a "fetal heartbeat has been detected,"[80] defined as the point when cardiac activity can be registered, at about six weeks gestation.[81] While the term "fetal heartbeat" may be "medical-

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[73] *Abortion Policy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy [https://perma.cc/D677-MJZ8].

[74] The misleading use of medical-sounding terminology has long been part of the anti-choice playbook. For example, consider bans on dilation and evacuation (D&E) abortion, which anti-choice advocates call "partial-birth abortion" or "dismemberment abortion." *See* Gonzales v. Carhart, 550 U.S. 124, 132–56 (2007); LA. STAT. ANN. § 40:1061.1.3 (2022) ("Louisiana Unborn Child Protection from Dismemberment Abortion Act"); Julie Rovner, *'Partial-Birth Abortion': Separating Fact from Spin*, NPR (Feb. 21, 2006), https://www.npr.org/2006/02/21/5168163/partial-birth-abortion-separating-fact-from-spin [https://perma.cc/V48Z-EWR7].

[75] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 69, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

[76] *Id*. ("None of this terminology has standardized meaning in the medical profession, leaving physicians to guess at how to translate it into clinical practice.").

[77] *E.g.*, MICHAEL EVAN GOLD, A PRIMER ON LEGAL REASONING 228–29 (2018).

[78] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 64.

[79] *Id.*

[80] S.C. CODE ANN. § 44-41-630(B) (2023).

[81] *See* Jessica Glenza, *Doctors' Organization: Calling Abortion Bans 'Fetal Heartbeat Bills' is Misleading*, GUARDIAN (June 5, 2019), https://www.theguardian.com/world/2019/jun/05/abortion-doctors-fetal-heartbeat-bills-language-misleading [https://perma.cc/T63E-AU3X] ("Arbitrary gestational age bans on abortion at six weeks that use the term 'heartbeat' to define the gestational development being targeted do not reflect medical accuracy or clinical understanding").

sounding," it appears in these bans "in a misleading way": six weeks gestation is so early that, in the words of Dr. Jennifer Kerns, "What we're really detecting is a grouping of cells that are initiating some electrical activity. In no way is this detecting a functional cardiovascular system or a functional heart."[82] At six weeks gestation, the accepted medical fact is that there is simply no "heartbeat" or heart at all.[83] This disconnect between legal and medical definitions of "heartbeat" creates confusion for doctors and patients alike: patients may believe their fetus is more developed than it really is, while doctors grapple with how to treat patients under a medically inaccurate law.[84] Meanwhile, terms like "heartbeat" give the false impression that abortion bans are rooted in medicine and conjure an image that looks more like a baby than an embryo.[85] Abortion bans therefore adopt language that runs the gamut from irrelevant to inaccurate, with the effect that "most abortions are being halted as doctors wrestle with the murky legal definitions."[86]

Abortion bans adopt these medically baseless terms in large part because they were not written with—and indeed, are profoundly unconcerned with—input from the medical community. Despite overwhelming consensus from medical associations and testimony from doctors and patients on the harms of abortion bans, attempts to broaden or clarify medical exceptions have failed.[87] A ProPublica investigation found that, rather than prioritize medical evidence, legislators in the most conservative states "ultimately fell in line with highly organized Christian groups," with eight states rejecting "exceptions that would give doctors broader discretion to address health risks" after they were "overwhelmed by strong opposition from anti-abortion lobbyists."[88] States such as Tennessee "cut [doctors] out of the process"[89] and instead entertained testimony from anti-choice activists claiming, with no medical training,

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[82] Selena Simmons-Duffin & Carrie Feibel, *The Texas Abortion Ban Hinges on 'Fetal Heartbeat.' Doctors Call That Misleading*, NPR (May 3, 2022), https://www.npr.org/sections/health-shots/2021/09/02/1033727679/fetal-heartbeat-isnt-a-medical-term-but-its-still-used-in-laws-on-abortion [https://perma.cc/UQ3G-M6QU].

[83] *Id*.

[84] James Pollard, *South Carolina Abortion Ban With 'Fetal Heartbeat' Definition Creates Confusion, Doctors Say*, PBS (Aug. 25, 2023), https://www.pbs.org/newshour/politics/south-carolina-abortion-ban-with-fetal-heartbeat-definition-creates-confusion-doctors-say [https://perma.cc/QU58-9ECK].

[85] Simmons-Duffin & Feibel, *supra* note 82.

[86] Pollard, *supra* note 84.

[87] Surana, *supra* note 57.

[88] *Id*.

[89] *Id*.

that pregnancy complications "work themselves out."[90] In response, doctors are engaging in unprecedented political advocacy: filing petitions, releasing statements, organizing voters, and lobbying legislators on the dangers of abortion bans.[91] Maternal-fetal medicine specialists Drs. Maria Phillis, David Hackney, and Tani Malhotra argue that "physicians need to stand up" as leaders of abortion rights advocacy, as they are "uniquely positioned to engage with the media and public during this historic and consequential time."[92] Indeed, "[t]he historic silence of medical organizations has undoubtedly played a part in the slow erosion of abortion access in the United States."[93] Yet today, while physicians are more vocal than ever, legislators and powerful anti-choice lobbyists are working to silence them.

All told, the new abortion bans emerging across the country are fundamentally contrary to basic medical practice. In this landscape of hostility and uncertainty, it is critically important for doctors to know how much discretion they really have. In the next Section, I consider how abortion bans' standards for medical decision-making would fit into this landscape. Under a reasonableness or good faith standard, in a world where abortion as basic medical care is highly contested, what might be the consequences?

II. REASONABLE MEDICAL JUDGMENT

In most states that have enacted abortion bans, it is up to the physician's "reasonable medical judgment" to determine whether a patient's condition qualifies for a legal abortion under a health or life exception.[94] Consider the language of the Louisiana medical exception:

> It shall not be a violation of Subsection C of this Section for a licensed physician to perform a medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman. However, the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother

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[90] Surana, *supra* note 58.

[91] Cassandra Jaramillo, *Doctors Emerge as Political Force in Battle Over Abortion Laws in Ohio and Elsewhere*, PROPUBLICA (July 31, 2023), https://www.propublica.org/article/doctors-join-political-battle-over-abortion-laws [https://perma.cc/9XN4-QKHX].

[92] Maria Phillis et al., *The Urgent Need for Physician-Led Abortion Advocacy*, 5 AM. J. OBSTETRICS & GYNECOLOGY 1, 4 (2023).

[93] *Id*.

[94] KFF, *supra* note 53, at 8.

> and the life of her unborn child in a manner consistent with reasonable medical practice.[95]

In this Section, I consider what "reasonable" means and why anti-choice states broadly embrace a reasonableness standard for medical judgment.[96] Primarily, a reasonableness standard more effectively chills abortion care because it manufactures an opportunity to hale a doctor into court and persuade a jury to decide against her. When a state can put up its own anti-choice "expert" to explain why an abortion was not necessary, an objective standard increases the risk to physicians that their judgments will be scrutinized and punished. A reasonableness standard also provides a gloss of medical objectivity to laws that, in actuality, undercut medical discretion and shift burdens and blame onto doctors rather than the State. Finally, a reasonableness standard may import gendered assumptions and biases about what kinds of abortions are necessary or justifiable.

A reasonableness standard would seemingly function like the standard in a civil malpractice suit. In a typical medical negligence case, the defendant physician must show that she exercised the degree of care that a reasonable physician in similar circumstances would ordinarily exercise.[97] The parties are almost always required to use expert testimony to show whether this standard has been met.[98] Under this objective standard, the critical question is what a reasonable physician would have done in the circumstances—not what the defendant subjectively believed was right. Reasonableness standards in abortion bans appear to function similarly. For example, Texas's ban defines "reasonable medical judgment" as "a medical judgment made by a reasonably prudent physician, knowledgeable about a case and the treatment possibilities for the medical conditions involved."[99] In a prosecution of a doctor under this ban, both the State and defendant would invoke expert testimony to explain what a reasonable doctor would have done in the same situation, and to explain how closely the defendant's actions aligned with that

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[95] LA. STAT. ANN. tit. 40, §1061(F) (2022).

[96] "Reasonable medical judgment" has also appeared in other controversial medical settings, namely physician-assisted death. For example, Oregon's Death with Dignity Act (like several other states with similar laws) permits an adult to end her life with prescription drugs upon a doctor's determination "within reasonable medical judgment" that the patient has a terminal illness that will cause her death within six months. OR. REV. STAT. 127.800. §1.01(12). However, it appears there has been little to no litigation asking what "reasonable" means or challenging the standard for doctors' decision-making in this context.

[97] *See* Ronen Avraham & Max Schanzenbach, *Medical Malpractice*, OXFORD HANDBOOK OF L. AND ECON., 122–24 (2017).

[98] Steven E. Pegalis, 2 AM. L. MED. MALPR. § 8:1 (2023).

[99] TEX. HEALTH & SAFETY CODE § 170A.001(4) (West 2022).

standard. A jury would then decide whose evidence is more credible and whether the standard is met.

Under a reasonableness standard, anti-choice activists therefore have an opportunity to submit testimony by an anti-choice "expert" to persuade a jury that an abortion was not justified.[100] Anti-choice states increasingly lean on testimony from fringe anti-choice groups that contradict medical consensus, as well as doctors lacking relevant experience in abortion care. For example, in *Preterm-Cleveland v. Yost*, a challenge to Ohio's abortion ban, the State relied on Dr. Dennis Sullivan, even though "[h]e has no formal training in obstetrics, no training in clinical practice of abortion, and has never observed an abortion."[101] Moreover, he "has been a member of and held positions in Ohio Right to Life and the Christian Medical and Dental Association, two organizations with defined anti-abortion missions and position statements."[102] Another state witness, Dr. Michael Parker, "has not performed or assisted in performing an abortion in the last 29 years," and serves on the board of the Women's Care Center of Columbus, "an anti-abortion Crisis Pregnancy Center" that "measures its success by the number of women it discourages from getting abortions."[103] Meanwhile, anti-choice organizations like the Charlotte Lozier Institute have spent years producing "scientific" reports, designed to look objective and evidence-based, that "promot[e] bogus science" to "build the illusion of dissent or doubt over conclusions drawn by peer-reviewed scientific or medical research."[104] An investigation by Rewire News Group found that, between 2010 and 2014, states paid at least $658,000 for testimony in legislative and court hearings from anti-choice groups masquerading as research institutes, "paving the way for laws, policies, and legal opinions that are buttressed by 'facts' that are 'truthy' at best, or explicitly false at worst."[105] This anti-choice pseudoscience has become increasingly prominent in attacks on abortion

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[100] In *Zurawski*, the Texas Supreme Court rejected plaintiffs' argument that "doctors are susceptible to a battle of the experts" because "the burden is the State's to prove that *no* reasonable physician would have concluded that the mother had a life-threatening physical condition." Texas v. Zurawski, 690 S.W.3d 644, 663 (Tex. 2024). Yet, even if the Court has clarified that reasonable doctors may come to different conclusions, the problem remains that the parties must present conflicting experts to explain what "reasonable" means.

[101] Pl.'s Post-Hearing Proposed Findings of Fact and Conclusions of Law at 7, Preterm-Cleveland v. Yost, No. A 2203203 (Ohio Ct. Com. Pl. Oct. 11, 2022).

[102] *Id*.

[103] *Id*. at 8.

[104] Sofia Resnick & Sharona Coutts, *Anti-Choice 'Science': The Big Tobacco of Our Time*, REWIRE (Nov. 13, 2014), https://rewirenewsgroup.com/2014/11/13/anti-choice-science-big-tobacco-time [https://perma.cc/DD8K-AERR].

[105] *Id*.

access, as well as in attacks on transgender health care.[106] In notoriously anti-choice District Judge Matthew Kacsmaryk's decision invalidating federal approval of mifepristone, he "cites research based on anonymous blog posts, cherry-picks statistics that exaggerate the negative physical and psychological effects of mifepristone, and ignores hundreds of scientific studies attesting to the medication's safety."[107]

A reasonableness standard thus enables states to draw on decades of anti-choice pseudoscience to cast doubt on the medical necessity of abortion, a particularly dangerous possibility given the inherently uncertain nature of medical practice. As the *Zurawski* plaintiffs argued, while a jury may or may not be persuaded by the state's evidence, the threat that doctors' medical judgments will be "second guessed by the Attorney General, the Texas Medical Board, a prosecutor, or a jury" in lengthy court proceedings—which could ultimately result in loss of liberty and livelihood—is enough to prevent doctors from providing medically necessary care.[108] Anti-choice activists justify the reasonableness standard by suggesting it is merely designed to ensure doctors are providing care that is actually necessary. The lead lobbyist of Tennessee Right to Life, Will Brewer, said in testimony on the statehouse floor:

> [When] there is a condition here that some doctors would say constitutes an emergency worthy of a termination and other doctors would say, 'Let's pause and wait this out and see how it goes.' I wouldn't want the former to terminate

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[106] *See Gender-Affirming Care: Evidence-Based Reviews of Legislative Actions*, YALE SCH. MED. (2024), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/biased-science [https://perma.cc/3TZL-LGKS] (debunking comprehensively the medical errors committed by Texas and Alabama in their anti-choice laws); Irin Carmon, *The Shared Anti-Trans and Anti-Abortion Playbook*, INTELLIGENCER (Apr. 4, 2023), https://nymag.com/intelligencer/2023/04/anti-trans-anti-abortion-activism-playbook.html [https://perma.cc/M6UB-3NLG].

[107] Lauren Weber et al., *Unpacking the Flawed Science Cited in the Texas Abortion Pill Ruling*, WASH. POST (April 13, 2023), https://www.washingtonpost.com/health/2023/04/13/abortion-pill-safety. Sage Journals, which published two of the studies Kacsmaryk cited, has since retracted them, citing "fundamental problems with the study design and methodology, unjustified or incorrect factual assumptions, material errors in the authors' analysis of the data, and misleading presentations of the data" that "demonstrate a lack of scientific rigor and invalidate the authors' conclusions in whole or in part." Pam Belluck, *Journal Retracts Studies Cited in Federal Court Ruling Against Abortion Pill*, N.Y. TIMES (Feb. 9, 2024), https://www.nytimes.com/2024/02/09/health/abortion-pills-study-retraction.html [https://perma.cc/99PN-VQ4K].

[108] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 69, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

> when the latter says there's room to see how it goes before this is urgent enough.[109]

Yet, it is always possible that doctors may disagree on the urgency or necessity of a particular course of action, especially when tasked with making predictive judgments, such as the unquantifiable likelihood that a medical condition will pose a risk to a patient's life.[110] Moreover, given the individualized nature of medical care and the importance of the patient's input, ACOG asserts that "[t]here is no uniform set of signs or symptoms that constitute an 'emergency.'"[111] In this context, where medical decision-making is complex and largely indecipherable to laypersons, anti-choice "experts" stand ready to exploit uncertainty and misunderstanding to pass off their fringe views as fact.

Under a reasonableness standard, then, it will not be doctors ultimately deciding whether an abortion was medically necessary—it will be the legal system. Historian Evan Hart argues that this was the case in pre-*Roe* prosecutions of abortion providers:

> Court records indicate . . . that many physicians, nurses and midwives were tried and convicted for performing abortions after the legal system rejected their claims about medical necessity. Prosecutors, judges and juries decided what was medically necessary—not doctors and patients—leaving doctors at the whim of the legal system for exercising their best medical judgment.[112]

Abortion bans therefore evince a profound mistrust of the medical profession. While claiming to defer to doctors' judgment, abortion bans wield the criminal legal system as an oversight mechanism to deter and punish abortions, whether or not they are medically necessary. Anti-choice activists simply do not trust doctors with real discretion. According to the Tennessee Right to Life lobbyist, "Once one doctor is let off the hook in a criminal trial, it would be open season for other doctors who wanted to perform bad faith terminations."[113] To prevent the possibility that doctors

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[109] Surana, *supra* note 57. Of course, rather than "wait this out" as Brewer suggests, doctors are trained to address medical issues to prevent them from getting worse and reduce risks to patients. *See* Zernike, *supra* note 22.

[110] *See* Zernike, *supra* note 22.

[111] AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, *supra* note 64.

[112] Evan Hart, *Medical Exemptions in Abortion Bans Won't Protect Women's Health*, WASH. POST (Sept. 8, 2022), https://www.washingtonpost.com/made-by-history/2022/09/08/medical-exemptions-abortion-bans-wont-protect-womens-health [https://perma.cc/97X8-LU7H].

[113] Surana, *supra* note 58.

will provide care, Tennessee Right to Life "will accept an objective standard" only.[114]

Even as anti-choice activists mistrust the medical profession, they want the appearance that doctors are the decisionmakers for at least two critical reasons: to lend bans the gloss of legitimacy, and to have doctors take the fall when medical complications and deaths inevitably occur. As noted above, anti-choice activists understand that the medical establishment agrees abortion is a safe and essential medical procedure.[115] Further, the vast majority of Americans—82 percent, according to a 2023 Marist poll—"support abortion laws which would allow an abortion at any time throughout a pregnancy to protect the life or health of the pregnant person."[116] With overwhelming popular support for abortion among doctors, as well as the general public, statutory provisions appearing to defer to doctors may appease the public and create the appearance of medical legitimacy, making abortion bans politically possible.[117] Given abortion's popular support, anti-choice states also want unhappy constituents to blame doctors, not the law, for the miserable state of abortion access today. During oral argument in *Zurawski*, Texas argued that women should sue doctors, not the state, for delays and denials of care: "If a woman is bleeding, if she has amniotic fluid running down her legs—then the problem is not with the law. It is with the doctors."[118] An objective standard might therefore let the state have its cake and eat it too; it undercuts doctors' authority while making them appear to be the central decisionmakers, ultimately using them as scapegoats for the health disasters that inevitably follow.

While legal oversight of the medical profession through a reasonableness standard may be accepted in the civil malpractice context, it is far more concerning where criminal penalties are at stake.[119] Under

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[114] *Id*.

[115] Resnick & Coutts, *supra* note 104.

[116] *Abortion Rights in the United States*, MARIST POLL (April 26, 2023), https://maristpoll.marist.edu/polls/abortion-rights-in-the-united-states [https://perma.cc/7WEB-A23H].

[117] *See* Julie Rovner, *Abortion Bans With no Exceptions May be Politically Risky*, NPR (June 1, 2022), https://www.npr.org/sections/health-shots/2022/06/01/1102364461/abortion-bans-with-no-exceptions-may-be-politically-risky [https://perma.cc/Y9WC-T55N] (attributing Todd Akin's loss to Claire McCaskill to his endorsement of a no-exceptions abortion ban).

[118] Saul Elbein, *Texas AG's Office Argues Women Should Sue Doctors—Not State—Over Lack of Abortion Access*, THE HILL (Nov. 28, 2023), https://thehill.com/policy/healthcare/4331412-texas-ags-office-argues-women-should-sue-doctors-not-state-over-lack-of-abortion-access [https://perma.cc/FS9L-JP4U].

[119] The anti-choice Charlotte Lozier Institute argues that reasonable medical judgment should be accepted in the context of abortion bans precisely because "reasonableness" has long been used in malpractice cases. *Filed Brief: Zurawski v. Texas and Reasonable Medical*

the new abortion bans, doctors could be subject to exceedingly harsh sanctions. In Texas, for example, doctors who perform illegal abortions may face up to life in prison, a $100,000 fine, civil liability, and revocation of their license to practice.[120] With these punishments lurking, and the promise of their robust enforcement,[121] a more burdensome medical judgment standard should be highly suspect. As discussed above, the mere threat of a jury verdict is enough to chill care, whether or not a jury is actually persuaded to convict. Patients certainly need recourse when the standard of care is not met, yet this cannot justify such absurdly harsh criminal punishments on top of the preexisting malpractice regime. Far from protecting women as anti-choice activists claim,[122] criminalizing doctors for providing abortions makes it far more dangerous to be pregnant in America.[123]

Finally, a reasonableness standard bakes gendered assumptions about what kinds of abortions are necessary or justifiable into the law. Feminist legal theorists have long critiqued how "reasonableness," a basic idea defining appropriate conduct in many areas of doctrine, embodies male perspectives and assumptions.[124] Indeed, before legal standards considered the perspective of a "reasonable person," they measured conduct against the perspective of a "reasonable man."[125] Whether an

Judgment, CHARLOTTE LOZIER INST. (Mar. 11, 2024), https://lozierinstitute.org/filed-brief-zurawski-v-texas-and-reasonable-medical-judgment [https://perma.cc/Q6B5-GALC].

[120] TEX. HEALTH & SAFETY CODE § 170A.001–007 (2022); Eleanor Klibanoff, *Texans Who Perform Abortions Now Face Up to Life in Prison, $100,000 Fine*, TEX. TRIB. (Aug. 25, 2022), https://www.texastribune.org/2022/08/25/texas-trigger-law-abortion [https://perma.cc/UER6-EP4V].

[121] Paxton, *supra* note 46 (promising to robustly enforce Texas's abortion law).

[122] *E.g.*, S.B. 474, 125th Gen. Assemb., Reg. Sess. (S.C. 2023) ("The State of South Carolina has a compelling interest from the outset of a woman's pregnancy in protecting the health of the woman and the life of the unborn child.").

[123] *See, e.g.*, *The State of Reproductive Health in the United States: The End of Roe and the Perilous Road Ahead for Women in the Dobbs Era*, GENDER EQUITY POL'Y INST., at 3 (January 19, 2023), https://thegepi.org/wp-content/uploads/2023/06/GEPI-State-of-Repro-Health-Report-US.pdf [https://perma.cc/H8SH-86LC] ("Mothers living in a state that banned abortion after Dobbs were up to 3x as likely to die during pregnancy, childbirth, or soon after giving birth.").

[124] *See* Naomi R. Cahn, *Looseness of Legal Language: The Reasonable Woman Standard in Theory and Practice*, 77 CORNELL L. REV. 1398, 1404 (1992) ("The reasonable man standard remains an entrenched and pervasive standard by which courts measure potentially illegal conduct. Tort law, criminal law, and employment discrimination law all employ this standard to determine whether conduct is appropriate."); Catharine A. MacKinnon, *Rape Redefined*, 10 HARV. L. & POL'Y REV. 431, 450 (2016) (discussing rape law's focus on "what juries or judges think a so-called reasonable person in the position of the accused would have believed" and asking, "in societies of sex inequality, why should the defendant's ['reasonable'] beliefs, constructed in a rape culture that glorifies and normalizes male force in sexual relations, rather than his actions, determine his culpability?").

[125] Cahn, *supra* note 124 ("The male bias inherent in a standard that explicitly excludes consideration of women as reasonable actors is obvious.").

abortion was reasonable may therefore be determined with sexist assumptions and other biases in mind. Consider an example: in 1921, Belvie Duncan sought an abortion after typhoid left her bedridden for months and she struggled to care for her existing two children.[126] After complications developed, her physician was prosecuted for felony abortion.[127] The State called other doctors—who never examined Duncan themselves[128]—to testify that her abortion was not necessary, and they told the court that "her ailments were imaginary" and "she had a delusion."[129] Moreover, "because Duncan previously delivered two children without incident, the three physicians insisted that she could not be suffering from any life-threatening emergency during her third pregnancy."[130] The court sided against the doctor who provided Duncan's abortion, "reveal[ing] how physicians could easily differ on the line between an emergency and an emergent medical situation, leaving a doctor performing an abortion in legal jeopardy."[131] Further, the opinions of the State's doctors were rife with gender bias concerning Duncan's situation, relying on tropes of women as untrustworthy and hysterical. Despite Duncan and her doctor's own assessment of her medical needs, the State readily insisted that they must have been making it up. To ask whether an abortion was reasonable is therefore to invite second-guessing of women and their doctors, to scrutinize whether their reasons were real or invented, and to perpetuate the notion that women cannot be trusted to make decisions regarding their own bodies. If an abortion must be reasonable, then it must reflect society's expectations of reasonableness: an abortion that is strictly medically necessary, if any abortion at all. In this world, abortion becomes neither a basic medical procedure, nor a fundamental personal choice, but instead an opportunity to punish and control. A reasonable medical judgment standard may at first glance seem benign, as anti-choice activists would have us believe, but in reality it does not defer to medical judgment at all. Instead, it creates a standard under which medical judgment can always be questioned, refuted, and punished.

III. GOOD FAITH MEDICAL JUDGMENT

Given the dangers of the reasonable medical judgment standard, the *Zurawski* plaintiffs argued for good faith instead. A good faith standard is

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[126] Hart, *supra* note 112.

[127] *Id.*

[128] *Id.*

[129] State v. Johnson, 246 S.W. 894, 896 (Mo. 1922).

[130] Hart, *supra* note 112.

[131] *Id.*

rare among the new abortion bans; some states, like Idaho, adopt good faith in one provision and reasonable medical judgment in another, leaving physicians and patients uncertain as to what the standard really is.[132] Only one state with a new abortion ban, Arizona, has clearly adopted a good faith medical judgment standard.[133] The law bans abortion after fifteen weeks except in a "medical emergency," defined as:

> A condition that, 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 a major bodily function.[134]

In this Section, I consider the potential consequences and benefits of a good faith as compared to a reasonable medical judgment standard. Pro-choice advocates prefer a good faith standard because they believe it will alleviate the bans' chilling effect on emergency abortion care: if doctors know that their medical judgments will be respected, then they will have the security they need to provide care in medical emergencies. Under a good faith standard, doctors may be less likely to be dragged into court and can more easily show that their conduct fits within a medical exception. A good faith standard also signals trust in, and perhaps greater respect for, doctors' judgments and a view of abortion as common medical care. However, a subjective standard may lead to more variability in access and allow individualized biases—especially gendered and religious perspectives—to influence care, as I discuss in the case study of the British good faith regime below. And even a more flexible good faith standard cannot practically be exercised amid a web of draconian statutory restrictions on medical practice. As long as abortion bans contain specific restrictions on medical judgment, such as bars on treating mental health conditions or requirements to preserve the life of the fetus, even good faith judgment is not practically possible.

Critically, a good faith standard could alleviate the chilling effect on abortion care because it is more deferential to doctors, as well as easier to satisfy. In its review of Kate Cox's petition for a court order permitting her abortion, the Texas Supreme Court characterized good faith as a "mere

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[132] Complaint at 61–62, Adkins v. Idaho, No. CV01-23-14744 (Idaho Dist. Ct. Sept. 11, 2023).

[133] While this good faith standard stands alone among the new abortion bans, some states that allow abortion until fetal viability, including California, have adopted good faith as the standard for post-viability medical exceptions. *See* KFF, *supra* note 53.

[134] S.B. 1164, 55th Leg., 2d Reg. Sess. (Ariz. 2022).

subjective belief," which does not require the heightened showings of an objective standard.[135] A doctor prosecuted under a good faith standard would need only show subjective belief in her clinical judgment that the abortion was medically required within the bounds of the exception; an additional showing that a reasonable physician would have acted similarly is not necessary. Cox's petition asserted that her physician, Dr. Damla Karsan, had "reviewed her medical records, and believes in good faith, exercising her best medical judgment, that a D&E abortion is medically recommended for Ms. Cox and that the medical exception to Texas's abortion bans and laws permits an abortion in Ms. Cox's circumstances."[136] Substantiating this assertion would be insufficient to fulfill a reasonable medical judgment standard, but would satisfy good faith's lighter evidentiary burden.[137] According to the *Zurawski* plaintiffs, a good faith standard would therefore give doctors necessary confidence that "the treatment decisions they make in good faith, based on their medical judgment, will be respected."[138]

A good faith standard also blunts the force of the anti-choice pseudoscience discussed above. If it is not necessary to show what a reasonable doctor would have done in the same situation, then the physician's own perspective—not the testimony of ideologically-driven "experts"—is decisive. By the same token, however, a lighter standard could be more deferential to doctors who make mistakes or fail to provide abortions where others think them necessary, and I discuss this possibility further below. But because this standard would apply only in criminal prosecutions of doctors for illegally providing abortions, the problem of doctors who withhold abortions would have to be addressed another way, and patients would still have access to traditional malpractice remedies separately.

By providing greater deference to doctors' subjective judgments, a good faith standard also signals greater trust in them, and perhaps greater acceptance of abortion as a basic medical procedure. Anti-choice lobbyists have voiced their suspicions that under a good faith standard, doctors will intentionally violate the law and provide "bad faith terminations" on a

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[135] In re State, 682 S.W.3d 890, 894 (Tex. 2023). The Court affirmed this interpretation in *Zurawski*, characterizing good faith as examining "a doctor's intent instead of medical facts." Texas v. Zurawski, 690 S.W.3d 644, 663 (Tex. 2024).

[136] Proposed Temporary Restraining Order at 2, Cox v. Texas, No. D-1-GN-23-008611 (Dist. Ct. Travis Cnty. Dec. 5, 2023).

[137] In re State, 682 S.W.3d 890, 894 (Tex. 2023).

[138] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 67, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

whim.[139] Mary Ziegler, a legal historian of the anti-abortion movement, writes that anti-choice efforts to narrow or eliminate medical exceptions stem from "a twin skepticism of women and the medical establishment," which creates fear that providing too much deference to doctors will result in "the exception that swallows the rule."[140] By contrast, deferring to doctors' subjective medical judgments via a good faith standard suggests that those judgments can be trusted, and that doctors will be faithful to the law. While a good faith standard still exists within a scheme of criminalization, it provides greater deference more closely aligned with medical associations' positions; ACOG "steadfastly opposes legislative interference in the practice of medicine and the criminalization of our members for providing evidence-based care."[141]

A good faith standard is therefore a promising improvement, but neither good faith judgment nor reasonable medical judgment can practically be exercised when abortion bans impose specific restrictions on medical practice. In general, abortion bans' exceptions are so narrow, and the bar for medical intervention is so high, that doctors are prohibited from providing medically necessary care as their judgment indicates. According to the declaration of Dr. Amy Caldwell, plaintiff in a challenge to Indiana's abortion ban, the State's narrow "serious health risk" medical exception, which includes only "'substantial and irreversible physical impairment of a major bodily function' . . . does not allow physicians to rely on their expertise in evaluating both short- and long-term risks to the patient as a whole."[142] Doctors undertake "complex medical decision-making in concert with their patients [and] do not simply categorize risks" according to the statute's non-medical terminology.[143] Fundamentally, "it runs counter to the principles of medicine and medical ethics to withhold care until the risk of harm meets some arbitrary and ill-defined threshold set by lawmakers and contrary to those well-established in the medical standards of care."[144] When abortion bans restrict medical exceptions to particular circumstances, they therefore bar doctors from genuinely exercising their medical judgment.

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[139] *See* Surana, *supra* note 58.

[140] Mary Ziegler, *Why Exceptions for the Life of the Mother Have Disappeared*, ATL. (July 25, 2022), https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582 [https://perma.cc/6MQ2-NAVX].

[141] *Understanding ACOG's Policy on Abortion*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Sept. 22, 2023), https://www.acog.org/news/news-releases/2023/09/understanding-acog-policy-on-abortion [https://perma.cc/A3BU-UJ5Z].

[142] Declaration of Amy Caldwell at 6, 8, Planned Parenthood Great Nw. v. Med. Licensing Bd. of Ind., No. 53C06-2208-PL-001756 (Ind. Monroe Cnty. Cir. Ct. Nov. 9, 2023).

[143] *Id*. at 8.

[144] *Id*.

Two particularly concerning limitations on medical judgment further illustrate this problem. First, ten states explicitly exclude mental health conditions from their medical exceptions.[145] Consider Indiana's medical exception: the bill specifically "does not include psychological or emotional conditions. A medical condition may not be determined to exist based on a claim or diagnosis that the woman will engage in conduct that she intends to result in her death or in physical harm."[146] In other words, women who might harm or kill themselves if they cannot get an abortion will be forced to remain pregnant. Dr. Caldwell explains that this provision "ignores several key medical realities," including that "mental health is an element of health . . . rooted in biochemical and physiological causes," and physicians "are trained to pay attention to patients' mental health as an element of their overall health. And mental illnesses—just like other illnesses—can pose serious health risks to patients."[147] Indeed, mental health risks are acute during pregnancy: mental health conditions are the leading cause of pregnancy-related deaths,[148] and "recent studies suggest that up to 20 [percent] of women suffer from mood or anxiety disorders during pregnancy."[149] Many struggle to access mental health treatment during pregnancy, and "[d]octors can be reluctant to provide mental health care to pregnant people in part because of a lack of clinical research on the use of psychotropic medication during pregnancy."[150] Women of color are at a higher risk for pregnancy-related mental health conditions and less likely to access emergency mental health care postpartum.[151] Risk factors for pregnancy-related mental health conditions include "lower socioeconomic status, history of domestic violence, history of mental health conditions, lack of partner or social support, pregnancy complications, pregnancy loss, and poor infant health."[152] These facts

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[145] Hassanein, *supra* note 70.

[146] IND. CODE § 16-18-2-327.9 (2022).

[147] Declaration of Amy Caldwell at 10, Planned Parenthood Great Nw. v. Med. Licensing Bd. of Ind., No. 53C06-2208-PL-001756 (Ind. Monroe Cnty. Cir. Ct. Nov. 9, 2023).

[148] Trost et al., *supra* note 71.

[149] *Psychiatric Disorders During Pregnancy*, MGH CTR. FOR WOMEN'S MENTAL HEALTH (2024), https://womensmentalhealth.org/specialty-clinics-2/psychiatric-disorders-during-pregnancy [https://perma.cc/B4XH-37XC].

[150] Regan McCarthy, *Florida's Abortion Law Protects a Pregnant Person's Life, But Not for Mental Health*, NPR (April 19, 2023), https://www.npr.org/2023/04/19/1170553504/florida-abortion-life-of-the-mother-exception-mental-health-suicide-psychiatric [https://perma.cc/C55Z-BBSE].

[151] Kayla L. Karvonen et al., *Racial Disparities in Emergency Mental Healthcare Utilization Among Birthing People with Preterm Infants*, 4 AM. J. OBSTETRICS & GYNECOLOGY MFM 1, 1 (2022).

[152] *Id*.

illustrate a harrowing reality: under the new abortion bans, treating some of the most common and dangerous risks of pregnancy is a crime.

These provisions, in addition to perhaps reflecting ignorance or disdain toward mental health conditions generally, further reveal the anti-choice movement's mistrust of both women and the medical establishment.[153] Abortion bans do not enable doctors to use their medical judgment to treat mental health conditions because anti-choice activists fear that doctors will abuse the exceptions. The president of the Alabama Pro Life Coalition, Eric Johnston, said, "If you put [the exception] in there and don't closely define it, it's a hole big enough to drive a truck through."[154] Conservative psychiatrist Sally Satel speculated in the *New York Times* that mental health exceptions would encourage psychiatrists and patients to fabricate mental health problems.[155] Indeed, before *Roe*, a woman who said she was suicidal could often access abortion. Dr. Richard Schwartz, a psychiatrist at the Cleveland Clinic, wrote in 1972:

> Although the practice of abortion has been illegal in most states until recently, it has been an "open secret" that a woman can obtain a safe abortion in a licensed hospital if she can find a psychiatrist who will say she might commit suicide if her pregnancy is not terminated.[156]

To do this safely, of course, women needed money. Dr. John Skilling told the *Washington Post* in 1966:

> [A] Washington woman with $600 [*$4,700 in 2019*] can often get a safe, competently performed abortion in a local hospital. "You need $50 each for two psychiatrists," he explains. "They write up consultation sheets saying you have threatened to commit suicide because you are pregnant, and then you find a gynecologist who will do a TA (therapeutic abortion) for depression."[157]

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[153] *See* Ziegler, *supra* note 140.

[154] Lindsey Tanner, *Mental Crises Excluded From Some State Abortion Exceptions*, AP (Nov. 17, 2022), https://apnews.com/article/abortion-science-health-government-and-politics-arizona-fc2114ecfce72eeca65e21fb970ca62f [https://perma.cc/U7VJ-H6CB].

[155] *See* Sally L. Satel, *The 'Open Secret' on Getting a Safe Abortion Before Roe v. Wade*, N.Y. TIMES (June 4, 2022), https://www.nytimes.com/2022/06/04/opinion/sunday/psychiatrists-abortion-roe.html [https://perma.cc/24EQ-9TN4].

[156] Richard A. Schwartz, *Abortion on Request: The Psychiatric Implications*, 23 CASE W. RSRV. L. REV. 840, 840 (1972).

[157] Elisabeth Stevens, *When Abortion Was Illegal: a 1966 Post Series Revealed how Women Got Them Anyway*, WASH. POST (June 9, 2019), https://www.washingtonpost.com/history/2019/06/09/when-abortion-was-illegal-post-series-revealed-how-women-got-them-anyway [https://perma.cc/Q5ZZ-7S8B].

In the pre-*Roe* era, however, doctors often didn't believe that women were truly suicidal anyway. One Dr. Leon Marder noted: "The patient may consciously exaggerate all of her symptoms and frequently can be considered manipulative and malingering."[158] Psychiatrists therefore assumed a "troubled gatekeeper role";[159] troubling to the anti-choice who worried about dishonesty, and troubling to women struggling with mental health conditions who needed to convince male doctors to believe them. Meanwhile, anti-choice organizations have spent decades cooking up reports linking abortion to negative mental health outcomes "despite consistent repudiations from the major professional mental health associations."[160] Anti-abortion organizations further deny that abortions can be medically necessary for mental health reasons: a spokeswoman for the National Right to Life Committee defended mental health exclusions on the grounds that "[a] mother facing serious mental health issues should receive counseling and mental health care. Having an abortion will not mitigate mental health issues."[161] Exclusions of mental health care from medical exceptions, then, prevent doctors from exercising their medical judgment by design.

A second common restriction on medical practice highlights the anti-choice movement's reverence for the fetus over the pregnant person and her proper medical care. Several abortion bans' medical exceptions require that "the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of her unborn child in a manner consistent with reasonable medical practice."[162] Such a requirement to attempt to preserve the life of the fetus during an abortion seems absurd on its face, but it comes with dangerous practical consequences. For example, under this requirement a physician who would normally perform an abortion could instead be required to perform

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[158] Satel, *supra* note 155.

[159] *Id*.

[160] Susan A. Cohen, *Abortion and Mental Health: Myths and Realities*, 9 GUTTMACHER POL'Y REV. 8, 8 (Summer 2006), https://www.guttmacher.org/gpr/2006/08/abortion-and-mental-health-myths-and-realities [https://perma.cc/HSX5-J24J].

[161] Tanner, *supra* note 154.

[162] LA. STAT. ANN. tit. 40, § 1061(F) (2022); *see also, e.g.,* S.C. CODE ANN. § 44-41-630(B)(3) (2023) (*"*A physician . . . shall make reasonable medical efforts . . . to preserve . . . the pregnant woman's unborn child, to the extent that it does not risk the death . . . or the serious risk of a substantial and irreversible physical impairment of a major bodily function of the pregnant woman . . . "); KY. REV. STAT. § 311.772(4)(a) (2022) ("the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn human being in a manner consistent with reasonable medical practice").

a Caesarian section or induce labor and delivery of a dead or dying fetus.[163] These procedures would keep the fetus intact, even if it has no chance of survival and the physician's medical judgment suggests a typical surgical abortion or other intervention would be safer.[164] According to Dr. Louise King: "None of this makes any sense to me from a medical standpoint, because the fetus will not survive. And then you've quite severely injured the pregnant person."[165] Indeed, induction abortions—performed by inducing labor and delivery of a nonviable fetus—"can last anywhere from five hours to three days; are extremely expensive; and entail more pain, discomfort, medical risks, and recovery time for the patient—similar to giving birth—than procedural abortion."[166] Requirements to prioritize the life of the fetus will therefore lead to more invasive, dangerous, and unnecessary treatment for the pregnant person that contradicts basic medical practice—and that can cause emotional pain and suffering as well.[167]

In this maze of draconian restrictions, a good faith standard is far from the silver bullet the *Zurawski* pleadings imagined it would be. Even if the law says doctors can use their good faith medical judgment, additional statutory obstacles stand in the way of basic medical care, preventing medical exceptions from being practically usable in many cases. What would it take for physicians to be able, as the *Zurawski* plaintiffs envisioned, to "provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person," that it is medically necessary?[168] I turn to this question below.

IV. GOOD FAITH IN PRACTICE: LESSONS FROM BRITAIN

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[163] *See* Jamie Ducharme & Tara Law, *Doctors in Anti-Abortion States Now Have No Idea When They're Allowed to Save a Pregnant Person's Life*, TIME (July 7, 2022), https://time.com/6194397/abortions-lifesaving-ectopic-pregnancy [https://perma.cc/Z42C-QS7L].

[164] *See id*.

[165] *Id*.

[166] Complaint at 35, Adkins v. Idaho, No. CV01-23-14744 (Idaho Dist. Ct. Sept. 11, 2023) (citing *The Safety and Quality of Abortion Care in the United States*, NAT'L ACADS. OF SCI., ENG'G, & MED. (Mar. 2018), at 59–65, https://nap.nationalacademies.org/read/24950/chapter/4#54 [https://perma.cc/WZX7-4RDL]).

[167] *See* Nicole Karlis, *In Some States, Women Will be Forced to Carry Pregnancies with Lethal Fetal Anomalies*, SALON (July 1, 2022), https://www.salon.com/2022/07/01/in-some-states-women-will-be-forced-to-carry-pregnancies-with-lethal-fetal-anomalies [https://perma.cc/BP7M-S2LC].

[168] Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 1, 5, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

For a good faith medical exception to work in practice, what would the law need to look like? Here, I take up abortion law in Britain as a case study. The British regime is instructive for several key reasons. There, abortion is criminalized with a broad good faith medical exception,[169] providing a close parallel to what a criminal abortion law with such exceptions could look like in the United States. Since the Abortion Act was enacted in 1967,[170] Britain has had over 50 years to observe how the law has settled and evolved, an especially useful tenure given the highly unsettled nature of criminal abortion laws in the United States. As the home of the English common law, the British regime also evolved out of many of the same legal authorities as the American one, yet ultimately took a different path. While American courts, and especially conservative jurists, are loathe to consider authorities from abroad as potentially persuasive,[171] the *Dobbs* opinion lovingly cites several common law authorities going back to medieval England:

> The eminent common-law authorities (Blackstone, Coke, Hale, and the like) all describe abortion after quickening as criminal. Henry de Bracton's 13th-century treatise explained that if a person has "struck a pregnant woman, or has given her poison, whereby he has cause abortion, if the foetus be already formed and animated, and particularly if it be animated, he commits homicide." Sir Edward Coke's 17th-century treatise likewise asserted that abortion of a quick child was "murder" if the "childe be born alive" and a "great misprision." And writing near the time of the adoption of our Constitution, William Blackstone explained that abortion of a "quick" child was "by the ancient laws of homicide or manslaughter" (citing Bracton), and at least a very "heinous misdemeanor" (citing Coke).[172]

If the early English common law is the only external authority the current Court is willing to learn from, then let us see how England has interpreted and adapted that law in its own abortion regime into the present day. Important differences between Britain and the United States—

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[169] Abortion Act 1967, c. 87 (Gr. Brit.).

[170] *Id.*

[171] *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 598 (2003) (Scalia, J., dissenting) ("The Court's discussion of these foreign views . . . is therefore meaningless dicta. Dangerous dicta, however, since this Court . . . should not impose foreign moods, fads, or fashions on Americans") (citations omitted).

[172] Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 242 (2022) (citations omitted).

especially Britain's socialized health care and relatively less powerful anti-choice movement—make this case study naturally limited, yet it nonetheless contains useful lessons and warnings as we strive to create an abortion law at home that is both permissive and politically possible. As I describe here, Britain's example sheds light on what a good faith regime could look like in practice if the *Zurawski* plaintiffs had succeeded. While it may create access and equity issues, a good faith regime like Britain's—with deference to the medical profession baked into the law—is worlds apart from the restrictive reasonableness standard we see in most new abortion bans in the United States. Reproductive justice advocates should look to Britain to see how good faith medical exceptions can expand abortion access, as well as to understand how such exceptions carry their own complications that we must work to overcome.

Below, I provide an overview of Britain's Abortion Act and the reality of abortion access in the United Kingdom today. While abortion is criminalized, the law's medical exceptions are broad and deferential enough to the medical profession that abortion is widely accessible. This example teaches that for medical exceptions to work, they cannot contain the specific restrictions on medical practice that we see in states today. I then consider what other lessons we can learn from the British example over the last half century. First, when doctors' subjective judgments are decisive, their personal views and biases may impact care, leading to access and equity issues that were especially pronounced in the early years of the Abortion Act. Second, while the Abortion Act provides wide latitude to doctors, it remains a crime to provide or self-manage an abortion outside the prescribed medical grounds. As a result, we have seen a recent uptick in prosecutions of British women who terminated their own pregnancies, an especially concerning phenomenon given the rise of the pregnancy criminalization in the United States.[173] Finally and most fundamentally, vesting power to decide abortion access in the medical profession means pregnant people themselves are not the ultimate decisionmakers. Even if medical exceptions are broadly usable, abortion is not a basic right or a choice that individuals have the power to make for themselves. While medical exceptions providing doctors with real authority would constitute a lifesaving improvement to the status quo, maintaining an overall scheme of criminalization is inimical to true choice and autonomy.

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[173] *See* Purvaja S. Kavattur et al., *The Rise of Pregnancy Criminalization: A Pregnancy Justice Report*, PREGNANCY JUST. (Sept. 2023), https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/9-2023-Criminalization-report.pdf [https://perma.cc/KW9A-466Q].

A. The Abortion Act 1967

Before the groundbreaking Abortion Act 1967 passed in Parliament, abortion in Britain was a crime with few exceptions,[174] only for extreme circumstances defined by common law.[175] Reformers concerned with the public health consequences of unsafe abortion sparked debates in Parliament by the 1950s,[176] and a young Member of Parliament (MP), David Steel, took up the cause to "'stamp out from the country the scourge of criminal abortion,' with all the public health benefits that would entail."[177] The major activist organization, the Abortion Law Reform Association (ALRA), determined that advocating for abortion on demand would be going "a bit too far," so from its earliest drafts the Abortion Act "provided that abortion would be lawful only under conditions of strict medical control."[178] Accordingly, much of the debate over the bill centered around the role of the medical profession and the impact that the Abortion Act would have on their practice and conscience.[179] Opponents argued that it "threatened the independence of the medical profession, placing any doctor who opposed an abortion in an invidious position" by requiring doctors to provide abortions against their conscience.[180] Meanwhile, the British Medical Association (BMA) "constantly emphasized the importance of leaving the individual doctor free and unfettered to exercise his independent judgment," so much so that "[i]t seemed to some reformers that the clinical freedom of the doctor was a more important

[174] Abortion law in Britain contains variations by jurisdiction and is a devolved matter, with authority to legislate on abortion dedicated to the Scottish and Northern Irish legislatures. In Scotland, abortion is a crime by common law, whereas in England and Wales it is a crime by statute. The Abortion Act applies in England, Wales, and Scotland but did not affect the law in Northern Ireland, where abortion remained more restrictively criminalized until 2019. When I refer to the abortion law in Britain, I generally refer to England, Wales, and Scotland, though Scotland's criminal law backdrop is different from that in England and Wales. For an overview of the legal framework, *see* BRITISH MED. ASSOC., THE LAW AND ETHICS OF ABORTION (March 2023), at 5–7, https://www.bma.org.uk/media/3307/bma-the-law-and-ethics-of-abortion-report-march-2023-final-web.pdf [https://perma.cc/ML7X-273U]; BRITISH PREGNANCY ADVISORY SERV., BRITAIN'S ABORTION LAW: WHAT IT SAYS, AND WHY (May 2013), https://web.archive.org/web/20131023033829/http://www.reproductivereview.org/images/uploads/Britains_abortion_law.pdf.

[175] Madeleine Simms, *Abortion Law and Medical Freedom*, 14 BRIT. J. CRIMINOLOGY 118 (1974).

[176] SALLY SHELDON ET AL., THE ABORTION ACT 1967: A BIOGRAPHY OF A UK LAW 3 (2023).

[177] *Id*. at 6 (quoting Steel's remarks in the House of Commons).

[178] *Id*. at 8.

[179] *Id*. at 9.

[180] *Id*.

issue to the BMA than the welfare of the patient."[181] Others who opposed the bill, like MP Jill Knight, considered it "so wide and so loose than any woman who felt that her coming baby was an inconvenience would be able to get rid of it."[182] Supporters and opponents of the Abortion Act alike promoted stereotypical views about the kind of woman who would use it: opponents feared it would "permit selfish, irresponsible, and promiscuous women to end pregnancies for reasons of mere convenience," while supporters emphasized "the need to help women in serious and extreme circumstances, such as the 'distracted multi-child mother, often the wife of a drunken husband.'"[183] In the end, the bill passed with "enormous compromises," most notably by excluding Northern Ireland, and requiring two doctors to approve every abortion.[184] In the words of ALRA activist Diane Munday:

> How could, or should, somebody who's probably never seen the woman before, and is never going to see her afterwards, make such an important decision for that woman's life and future? We had to accept it. It was also appalling to exclude Northern Irish women. But if we hadn't done it, we wouldn't have got anything at all. It was by the skin of our teeth getting that through.[185]

The Abortion Act carved out specific medical circumstances where abortion would be legal, and thus it "offer[ed] relief in limited, deserving cases."[186] The Act modified preexisting criminal law by creating exceptions, but it notably maintained the abortion ban in the Offences Against Persons Act 1861, which criminalizes in England and Wales all attempted abortion via the administration of "any poison or noxious thing" or the use of "any instrument or other means" with "intent to procure the miscarriage of any woman," whether pregnant or not.[187] In relevant part, the Abortion Act reads,

> (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered

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[181] Simms, *supra* note 175, at 124.

[182] SHELDON ET AL., *supra* note 176, at 11.

[183] *Id*.

[184] *Id*. at 16.

[185] *Id*.

[186] *Id*. at 9.

[187] Offences against the Person Act 1861, 24 & 25 Vict. c. 100, § 58 (Eng., Wales, & N. Ir.).

> medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
>
> (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
>
> (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
>
> (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
>
> (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
>
> (2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.[188]

The Act also requires that abortions be carried out in an approved hospital setting and explicitly provides for conscientious objection.[189] The Abortion Act therefore "explicitly allows for a broad exercise of clinical discretion"[190]—unlike today's abortion bans in the United States, it poses few specific restrictions on medical judgment. Courts generally read "good faith" to mean "adherence to accepted norms of clinical practice," evincing a broad "judicial deference to doctors' professional morality as well as their technical skill."[191] Judicial scrutiny "extend[ed] only to ensuring that proper processes had been followed and an 'authentic clinical evaluation' made."[192] In other words, the law trusts doctors to serve as arbiters of abortion access, and courts provide oversight only to the extent necessary to ensure doctors make these

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[188] Abortion Act 1967, c. 87 (Gr. Brit.), § 1. A second opinion is not required where a registered medical practitioner "is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman." *Id*. at § 1(4).

[189] *Id*. at § 1(3), 4.

[190] Sally Sheldon, *The Decriminalisation of Abortion: An Argument for Modernisation*, 36 OXFORD J. LEGAL STUD. 334, 343 (2016).

[191] SHELDON ET AL., *supra* note 176, at 165.

[192] *Id*.

decisions by professional process norms.[193] The vague wording of the Abortion Act (such as "serious" and "substantial"), rather than create confusion as it has in the United States, "deliberately left broad scope for the exercise of clinical discretion, subject to professional norms of good practice."[194] Unlike in the United States, where existing medical exceptions are narrow and unmoored from medical norms in order to deny care, the British law was designed to defer to prevailing standards for medical judgment within the medical community itself.[195]

In practice, the Abortion Act has made abortion widely accessible—though its early years included uncertainty about its interpretation and greater disparities in access, as I discuss below. Today, "[t]he overwhelming majority of legal terminations are performed on the basis of [Abortion Act 1967 section] 1(1)(a),"[196] enabling abortion where two doctors determine in good faith that "the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family."[197] This is because "[m]odern abortion procedures are very considerably safer than carrying a pregnancy to term and thus in all cases there will be a basis for a doctor to reach a good faith determination that termination is indicated."[198] In other words, because carrying a pregnancy to term is virtually always more dangerous than having an abortion, the law permits an abortion to mitigate these risks in almost any pregnancy. Compare this regime with *Zurawski*, which concluded that "[w]hile merely being pregnant may increase a mother's risk of death or injury, pregnancy itself is not a 'life-threatening physical

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[193] Anti-abortion judges have been exceptions to this generally minimal oversight and have sometimes been eager to sentence both doctors and women under the Offences Against Persons Act. Consider the case of Eva, who:

> [H]ad the misfortune to appear before a judge who had made no secret of his opposition to abortion: he had reasoned that a maximum term of life imprisonment was appropriate given that her crime of procuring a miscarriage very late in her pregnancy was one that "all right thinking people" would consider more serious than "any offence on the calendar other than murder" (but would "generously" reduce her sentence by one-third in light of her guilty plea).

Sally Sheldon & Jonathan Lord, *Guest Editorial: Care Not Criminalization; Reform of British Abortion Law is Long Overdue*, 49 J. MED. ETHICS 523 (2023).

[194] Sheldon et al., *supra* note 176, at 266.

[195] Elizabeth Chloe Romanis, *Abortion Access and the Benefits and Limitations of Abortion-Permissive Legal Frameworks: Lessons from the United Kingdom*, 32 CAMBRIDGE Q. HEALTHCARE ETHICS 378, 381 (2023).

[196] Sheldon, *supra* note 190.

[197] Abortion Act 1967, c. 87 (Gr. Brit.), § 1(1)(a).

[198] Sheldon, *supra* note 190.

condition' under the law."[199] And because the Abortion Act explicitly includes mental health, fetal abnormality, and environmental factors,[200] it allows abortion in practically all cases where someone wants or needs to terminate a pregnancy before the gestational limit. Sally Sheldon et al. summarize the permissive state of abortion access today:

> Fifty years on, while a lawyer might quibble that no medical procedure is available "on demand," abortion is now widely available on request within early pregnancy: professional codes of practice emphasise the importance of respecting women's own decisions and services are largely funded by the NHS. Assessment can take place via webcam or telephone, certifying doctors may choose to rely on information gathered from nurses or counsellors in forming an opinion, and legal formalities are likely to be completed quickly behind the scenes.[201]

Indeed, abortion is so accessible that few Britons can describe the terms of the law or realize abortion remains a criminal offense.[202] These effects of increasing medical freedom began immediately: the National Health Service (NHS) performed nine times as many abortions in 1971 as in 1966, suggesting that "gynaecologists holding liberal views on abortion [were] at last [able] to practice medicine accordingly."[203] The country's main abortion provider, the British Pregnancy Advisory Service (BPAS), asserts that "[w]omen in Britain cannot obtain abortions 'just because' they want them—doctors have to agree that they are warranted," and thus "there is no right to abortion on demand."[204] Nonetheless, abortion is "the most common gynecological procedure" performed in Britain, with one in three women having an abortion at some point in her life, and mortality from unsafe abortion "virtually unknown."[205]

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[199] Texas v. Zurawski, 690 S.W.3d 644, 665 (Tex. 2024).

[200] Abortion Act 1967, c. 87 (Gr. Brit.).

[201] SHELDON ET AL., *supra* note 176, at 265.

[202] *See id*. at 266, 282. In one study, twenty percent of health care workers and a third of women interviewed "were unaware that abortion is still a criminal offence without doctor authorisation." Matthew Limb, *The Two Doctors Rule for Authorising Abortion Should be Scrapped, Recommends Review*, BRIT. MED. J. (Mar. 8, 2023), https://www.bmj.com/content/380/bmj.p563.

[203] Simms, *supra* note 175, at 130.

[204] *Abortion Law in Great Britain*, BRIT. PREGNANCY ADVISORY SERV. (2024), https://www.bpas.org/our-cause/campaigns/briefings/abortion-law-in-great-britain [https://perma.cc/6P7W-YHNF].

[205] Sheldon, *supra* note 190, at 344.

The meaning of good faith is therefore incredibly deferential to medical norms, embracing abortion as a normal medical procedure and generally prioritizing the wishes of the pregnant person, as well as the decisions of individual doctors. In essence, good faith requires doctors to provide an individualized assessment; in a rare case where doctors violated the law, it was because they had pre-signed approval forms before meeting with patients.[206] BPAS explains that the good faith standard means "simply that the doctor has not been dishonest or negligent in forming [an] opinion. What makes an abortion lawful is the doctor's opinion that there are lawful grounds for the procedure, rather than the fact that these grounds exist."[207] As the Abortion Act granted broad discretion to doctors and courts took a hands-off approach to oversight, the Abortion Act developed its meaning through "daily acts of interpretation by individual doctors," which were in turn molded by medical associations, professional codes, and supervising doctors who shaped policy at their hospitals.[208] These interpretations were also "developed in meetings with real women who described concrete problems, anxieties and aspirations."[209] While interpretation of the law has not been static over time, the Abortion Act's trust in doctors has allowed them to provide abortions according to their clinical judgment and evolving norms of professional practice.[210]

In sum, the Abortion Act's broad good faith medical exceptions defer to doctors to make individualized assessments with little scrutiny, and abortion is widely accessible as a result. By affording broad discretion to the medical community, then, medical exceptions can work to enable genuine access to care. However, the Abortion Act's journey to today's status quo has not been smooth, with persistent barriers and inequities. Below, I describe what additional lessons we can glean from the British experience, including challenges to implementing a similar good faith standard in the United States.

B. Good Faith's Consequences

First, because a good faith standard defers to individual doctors' subjective judgment, access can be variable, and doctors' personal biases

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[206] Miranda Prynne, *Pre-Signing Abortion Forms is Illegal, General Medical Council Admits*, TELEGRAPH (May 5, 2014), https://www.telegraph.co.uk/news/uknews/law-and-order/10807990/Pre-signing-abortion-forms-is-illegal-General-Medical-Council-admits.html [https://perma.cc/E5Y6-XYJS].

[207] BRIT. PREGNANCY ADVISORY SERV., *supra* note 204.

[208] SHELDON ET AL., *supra* note 176, at 266–67.

[209] *Id.* at 267.

[210] *See generally* SHELDON ET AL., *supra* note 176 (describing the evolution of the Abortion Act from its introduction in Parliament through 2023).

can impact care. In the early years of the Abortion Act, "medical opinion was initially sharply divided," and the President of the Royal College of Obstetricians and Gynaecologists described the meaning of the Act as "largely depend[ent] on what you want it to mean."[211] Doctors who believed a woman was seeking an abortion out of "mere inconvenience" might discourage her and refuse to refer her elsewhere.[212] Doctors might also impose a policy according to "covert ethical, religious, and personal motives" hidden behind "an ostensible medical rationale."[213] For example, a senior gynecologist could limit the services that his hospital offered by instituting a policy against terminating pregnancies believed to be "just inconvenient," resulting in one consultant telling a woman that she needed a greater "medical or psychological reason" for an abortion because "we try to preserve the lives of our babies and not deliberately destroy them."[214] These subjectivities led to significant regional disparities in abortion access.[215] Cities with greater Catholic populations and more senior anti-abortion doctors setting hospital policy, including Birmingham and Glasgow, became "some of the most difficult places in Britain in which to obtain NHS abortion services," while other cities saw abortion access virtually upon request.[216] Over two-thirds of Scottish women who went to BPAS, the non-NHS provider, for an abortion "originated from within a 20-mile radius of Glasgow."[217] Women in rural areas, women with lower social classes and poorer education, and women of color suffered the most under this unpredictable regime, with doctors' racial, economic, and religious biases influencing whether they thought abortion was necessary or advisable.[218] Doctors also regularly required women to be sterilized before agreeing to perform an abortion, especially Black and working-class women,[219] with sterilization rates the highest in the geographic areas where abortion was most restricted.[220] Meanwhile, given "a lack of robust enforcement under the Act," other doctors were willing to accept bribes to sign off on abortions no matter the circumstances.[221] As a result, an

[211] *Id*. at 31.
[212] *Id*.
[213] *Id*. at 30.
[214] *Id*. at 33.
[215] *Id.* at 35.
[216] *Id*. at 33.
[217] *Id*.
[218] *Id*. at 40–41.
[219] *Id*. at 40–43.
[220] *Id.* at 33.
[221] *Id*. at 37.

individual's ability to access abortion often depended on resources, race, geography, and luck.[222]

These early trends illustrate how abortion's legal availability alone does not guarantee access, especially when that availability is subject to doctors' discretion rather than the needs or desires of the pregnant person. This reality is plain in the United States, where abortion has become increasingly difficult to access—especially on the basis of geography, class, and race—even when abortion before viability was a constitutional right under *Roe*.[223] Northern Ireland also provides an instructive example, where abortion was decriminalized in 2019 but access remains piecemeal, as the government has yet to affirmatively commission adequate abortion services and Northern Irish citizens "are still forced, at personal and financial cost, to travel to Great Britain for care."[224] The potential for a subjective standard to lead to disparities in access in the United States is particularly stark. Abortion seekers in America have long been forced to travel to access care,[225] abortion services generally do not receive federal funding—unlike in Britain's nationalized health care system[226]—and abortion access is marked by profound economic and racial disparities.[227] Any medical exception in the United States necessarily exists against this unequal backdrop. And if state governments are concerned not with abortions wrongfully denied, but only with abortions illegally provided, a lack of oversight could allow anti-abortion doctors or hospitals to deny abortions with impunity as they often did in the Abortion Act's early years.[228] A medical exception that makes abortion legal in certain

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[222] *Id*. at 39.

[223] Liza Fuentes, *Inequity in U.S. Abortion Rights and Access: The End of Roe is Deepening Existing Divides*, GUTTMACHER INST. (Jan. 17, 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides [https://perma.cc/X9UE-RDL2].

[224] Elizabeth Nelson, *Abortion was Legalised in Northern Ireland in 2019—So Why are We Still Waiting For It?*, GUARDIAN (Oct. 29, 2021), https://www.theguardian.com/commentisfree/2021/oct/29/abortion-legalised-2019-northern-ireland-human-rights [https://perma.cc/PZ99-M9ZA]; *see also Barriers to Abortion Access in Northern Ireland*, AMNESTY INT'L UK (2024), https://www.amnesty.org.uk/barriers-abortion-access-northern-ireland-0 [https://perma.cc/PZ99-M9ZA].

[225] Kimya Forouzan et al., *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, GUTTMACHER INST. (Dec. 7, 2023), https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care [https://perma.cc/4MM3-5JFB].

[226] *State Funding of Abortion Under Medicaid*, GUTTMACHER INST. (Aug. 31, 2023), https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid [https://perma.cc/SKU2-EZFH].

[227] *See* Fuentes, *supra* note 223.

[228] The prevalence of Catholic hospitals, which control an estimated one in seven hospital beds in the United States, already impairs access to reproductive health care. Frances Stead

circumstances is far from enough to ensure that medically necessary abortions will actually be available.

Gender bias has particularly influenced doctors' subjective judgments under Britain's good faith standard. While doctors were initially divided on how to interpret the Abortion Act, there was consensus that "the final decision as to whether it was appropriate was a medical one: women's views were important but not determinative," because "there were doubts in the doctors' minds as to whether a woman in such a predicament would know what was in her best interests."[229] Abortion rights activist Eileen Cook described this "very condescending attitude to women, that women somehow can't . . . be trusted to make their own decisions about whether they want children or not. And the less educated you are, or the poorer you are . . . the more likely that needs to be the case."[230] In particular, doctors might interview the woman's husband in the decision-making process or conduct a psychiatric evaluation.[231] Such medical paternalism has declined over time, as medical standards have evolved to further emphasize evidence-based decision-making and patient autonomy, and abortion providers are increasingly motivated by powerful pro-choice beliefs.[232] The medical profession has undergone a similar evolution in the United States, where medical standards embrace patient-centered care[233] and the vast majority of new OBGYNs are women.[234] Yet medicine in both countries has long suffered from profound racial and gender biases that continue to impact patient experiences.[235] For example, women's pain is often "dismissed or misdiagnosed by doctors," and research indicates that women are less likely than men to receive treatment for their pain and more likely to be diagnosed with mental illness.[236]

Sellers & Meena Venkataramanan, *Spread of Catholic Hospitals Limits Reproductive Care Across the U.S.*, WASH. POST (Oct. 10, 2022), https://www.washingtonpost.com/health/2022/10/10/abortion-catholic-hospitals-birth-control [https://perma.cc/8X7X-XLRZ].

[229] SHELDON ET AL., *supra* note 176, at 30.

[230] *Id*. at 42.

[231] *Id*. at 30–31.

[232] *Id*. at 282.

[233] *See* AM. MED. ASSOC., *supra* note 63.

[234] Soumya Karlamangla, *Male Doctors are Disappearing From Gynecology. Not Everybody is Thrilled About It*, L.A. TIMES (March 7, 2018), https://www.latimes.com/health/la-me-male-gynos-20180307-htmlstory.html [https://perma.cc/P363-XT5D].

[235] Hannah Devlin, *Misogyny and Racial Bias Routinely Putting Patients at Risk, Warns NHS England Safety Chief*, GUARDIAN (Feb. 4, 2024), https://www.theguardian.com/society/2024/feb/04/misogyny-and-racial-bias-routinely-putting-patients-at-risk-in-england-warns-nhs-safety-chief [https://perma.cc/874X-8SYF].

[236] Lindsey Bever, *From Heart Disease to IUDs: How Doctors Dismiss Women's Pain*, WASH. POST (Dec. 13, 2023), https://www.washingtonpost.com/wellness/interactive/2022/women-pain-gender-bias-doctors [https://perma.cc/EM94-NFSB].

Studies also show that clinician biases and institutionalized inequities contribute to worse health outcomes among Black women, especially in maternal health care.[237] We should therefore be alert to the likelihood that centering doctors' subjective judgments in the application of medical exceptions will lead to mistakes and inequities, which have long been a feature of reproductive medicine.[238]

Today, the role of personal beliefs in the application of the good faith standard in Britain is more limited, yet differences from the United States may lead to further inconsistencies here. Conscientious objection is guaranteed by the text of the Abortion Act but available only in narrow circumstances;[239] the UK Supreme Court clarified in 2014 that health care workers may conscientiously object to "hands-on" participation in the termination of pregnancy, but not to "the host of ancillary, administrative and managerial tasks that might be associated with those acts."[240] Moreover, the conscientious objector must refer the patient to someone else who will provide the necessary care.[241] By contrast, clinicians in the United States "can almost always deny medical care they're qualified to provide," can "decline to treat patients for any reason that civil rights laws don't forbid," and can refuse to "refer or counsel them, or to disclose that their objection is based on reasons that are more moral than medical."[242] While the effects of conscientious objection on the use of medical exceptions remain to be seen, anti-choice claims of conscience have long affected abortion care, contributing to restrictions on the use of government funds and protections for objectors.[243] The broad ability to refuse care on grounds of conscience in the United States could therefore pose a more major problem than in Britain. Other scholars have proposed detailed solutions to the problem of conscientious objection after *Dobbs*: Dov Fox argues for a system honoring conscience without excusing malpractice and abandonment.[244] Professional organizations have an important role in setting standards for the exercise of medical judgment,

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[237] Brittany D. Chambers et al., *Clinicians' Perspectives on Racism and Black Women's Maternal Health*, 3.1 WOMEN'S HEALTH REPS. 476, 477 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9148644/pdf/whr.2021.0148.pdf [https://perma.cc/QCY8-4KER].

[238] *See generally* DOROTHY ROBERTS, KILLING THE BLACK BODY (1997) (describing the historic and modern reproductive and sexual control of Black women).

[239] Abortion Act 1967, c. 87 (Gr. Brit.), § 4.

[240] Greater Glasgow Health Board v. Doogan & Anor [2014] UKSC 68, [38]–[39].

[241] *Id*. at [40].

[242] Dov Fox, *Medical Disobedience*, 136 HARV. L. REV. 1030, 1048 (2023).

[243] Mary Ziegler, *Disobedience, Medicine, and the Rule of Law*, 136 HARV. L. REV. F. 319, 322–29 (2023).

[244] *See generally* Fox, *supra* note 242 (providing an overview of America's system of conscientious objection in medicine and proposing a new framework).

so that good faith judgment comports with medical norms and not merely personal beliefs. To ensure personal beliefs alone cannot determine patient outcomes, the General Medical Council (GMC), the organization that registers and licenses doctors to practice in the UK, sets guidelines on the use of personal beliefs that doctors must follow.[245] Except those who properly assert a conscientious objection, the GMC instructs doctors not to "[allow] your personal views to affect your professional relationships or the treatment you provide or arrange," and "[t]he investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgment about the likely effectiveness of the treatment options."[246] To ensure that doctors' discretion in applying medical exceptions remains within clinical bounds, licensing organizations in the United States might consider strengthening similar guidelines.

Second, while Britain's good faith regime vests authority in doctors, it continues to criminalize people who seek abortions outside approved medical settings, including those who self-manage their abortions. When strict medical control defines abortion access, abortions outside the norm may be punished, as illustrated by a recent uptick in criminalization of British women. Between the enactment of the Offences Against Persons Act criminalizing abortion in 1861 and November 2022, only three women in Britain were convicted for illegal abortions.[247] But since 2022, six people have been charged, one woman has been convicted, and "[s]cores of women have found themselves criminally investigated after losing a late pregnancy" under the Abortion Act's twenty-four week limit.[248] In 2023, Carla Foster was sentenced to twenty-eight months in prison after she obtained abortion pills from BPAS by mail during the COVID-19 pandemic, when rules for telehealth administration of abortion services were relaxed.[249] Prosecutors argued that she "had knowingly misled [BPAS] by saying she was below the 10-week cutoff point, when she

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[245] *Personal Beliefs and Medical Practice*, GEN. MED. COUNCIL (March 25, 2013), https://www.gmc-uk.org/-/media/documents/personal-beliefs-and-medical-practice-20200217_pdf-58833376.pdf [https://perma.cc/ZCA3-D7WY].

[246] *Id*.

[247] Zoe Williams, *The Women Being Prosecuted in Great Britain for Abortions: 'Her Confidentiality Was Completely Destroyed,'* GUARDIAN (Nov. 10, 2023), https://www.theguardian.com/world/2023/nov/10/the-women-being-prosecuted-in-great-britain-for-abortions-her-confidentiality-was-completely-destroyed [https://perma.cc/J86X-VXMV].

[248] *Id*.

[249] Alexandra Topping, *Woman Jailed for Taking Abortion Pills After Time Limit to be Freed From Prison*, GUARDIAN (July 18, 2023), https://www.theguardian.com/uk-news/2023/jul/18/carla-foster-woman-jailed-obtaining-tablets-pregnancy-freed-appeal [https://perma.cc/Q36J-STN9].

believed she was about 28 weeks pregnant," in order to obtain mifepristone that caused a stillbirth.[250] As Charlotte Proudman describes, "Women [today] are being shackled by a 160-year-old law made at a time when we were not even allowed to set foot in the House of Commons."[251] Not only intentionally late abortions may be criminalized, but also mistakes and pregnancy loss:

> We know that it is overwhelmingly vulnerable women who are investigated and prosecuted for having abortions. One woman collapsed in the dock when she was sentenced to two and a half years in 2015 for taking tablets she had bought online to induce a miscarriage after the 24-week period of gestation. The court heard that she had "a history of emotional and psychological problems." Another woman, a mother of one, ordered pills online to induce an abortion in 2019 after her abusive boyfriend had told her not to go to the doctor. She had believed she was eight to 10 weeks pregnant but after a traumatic miscarriage in her bath tub, where she described sitting in an inch of blood, she realised her pregnancy had been much further along. She was arrested in her hospital bed and served two years in prison.[252]

With the rise of pregnancy criminalization in the United States[253] and some prosecutors' thirst to go after self-managed abortion,[254] any abortion law retaining criminal penalties will continue to be used against the most vulnerable here as well.

Third, as the continued criminalization of abortions outside medical norms indicates, Britain's good faith regime transforms doctors into gatekeepers, denying pregnant individuals true choice and autonomy. As

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[250] *Id.*

[251] Charlotte Proudman, *Think Abortion is Legal in Great Britain? Ask the Two Women Currently Facing Life Sentences*, GUARDIAN (Aug. 19, 2022), https://www.theguardian.com/commentisfree/2022/aug/19/abortion-legal-great-britain-women-life-sentences-roe-v-wade [https://perma.cc/ZD3E-U2RP].

[252] *Id.*

[253] *E.g.*, Laura Huss & Goleen Samari, *Self-Care, Criminalized: The Criminalization of Self-Managed Abortion from 2000 to 2020*, IF/WHEN/HOW (2023), https://ifwhenhow.org/wp-content/uploads/2023/10/Self-Care-Criminalized-2023-Report.pdf [https://perma.cc/3CSV-NWRH].

[254] *See, e.g.*, Margery A. Beck, *Nebraska Mother Sentenced to 2 Years in Prison for Giving Abortion Pills to Pregnant Daughter*, AP (Sept. 22, 2023), https://apnews.com/article/abortion-charges-nebraska-sentence-36b3dcaadd6b705ca2315bc95b99bdc1 [https://perma.cc/ERP5-5LQT].

Sally Sheldon writes in *Beyond Control*, her foundational work on medical power and abortion law:

> The Abortion Act accords clear moral authority to the doctor . . . who has the final decision regarding abortion . . . . The woman's whole lifestyle, her home, finances and relationships are opened up to the doctor's scrutiny, so that he may judge whether or not the patient is a deserving case for relief.[255]

Bestowing authority to doctors in this way has its political advantages: medical authority can make abortion seem "logical and neutral," as "[s]cientific knowledges can legitimate and depoliticise, providing grounds for making what might otherwise be seen as an inherently political decision seem neutral or commonsensical."[256] We see the same dynamic in American discourse around abortion today, with pro-choice advocates and medical organizations proclaiming that "Abortion Is Healthcare" to make it seem "factual" and beyond politics.[257] Yet while the Abortion Act "clearly aims to protect medical autonomy and discretion," it does so instead of "grant[ing] substantive rights to the woman, even where she is in the most extreme circumstances envisaged by the reformers."[258] The same is true in medical exceptions to abortion bans across the United States: while they may provide (if only in name) some protection for the provision of abortions deemed medically necessary, they grant no substantive right to obtain one, even in deadly situations.[259] Medical exceptions therefore establish doctors as gatekeepers to abortion access rather than entrusting women to make their own decisions, creating a gendered dynamic in which a "female subject . . . who cannot take decisions for herself" is subject to the decision-making of the "reassuringly mature and responsible (male) figure of the doctor."[260] As the medical establishment has gained increasing control over reproduction, and "reproductive knowledge has become increasingly privatised, available only to the medically trained," medical norms "have provided the rationale for all sorts of reproductive decisions traditionally made by women (regarding pregnancy, contraception, infertility and

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[255] SALLY SHELDON, BEYOND CONTROL: MEDICAL POWER AND ABORTION LAW 25 (1997).

[256] *Id*.

[257] *See, e.g.*, *Facts Are Important: Abortion Is Healthcare*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (2024), https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare [https://perma.cc/F2KX-UJ2E].

[258] SHELDON, *supra* note 255, at 27.

[259] *See supra* Part III.

[260] SHELDON, *supra* note 255, at 44.

abortion) to be made instead by—or at best in conjunction with—doctors."[261] In this regime of centralized medical control, it is the "women who know their way around the system" who are "likely to fare better" at having their needs met within it, while poor and minority women are left especially vulnerable in a medical system that has historically harmed or ignored them.[262] Medical exceptions therefore create a paradox: it is political and "judicial respect for medical discretion" that enables abortion to be meaningfully available despite its general criminalization, but this medicalized access comes at the price of "a significant encroachment into female bodily autonomy."[263] To access abortion in a world where abortion is a crime, it is essential for the law to trust doctors to use their best medical judgment. But even with a usable exception, abortion is still criminalized, and there is no substantive right for individuals to make reproductive decisions for themselves.

A final problem with a good faith standard is an obvious one: to make abortion meaningfully available, even if only in limited medical circumstances, would contradict the essence of the bans that the rabidly anti-choice have worked so hard to make possible. As Britain's example suggests, a medical exception that is broad enough to really work must make access so straightforward that, in most ordinary citizens' minds, abortion hardly seems criminal at all. In the United States, where abortion is criminalized in half the states but very few people (and, as yet, no doctors) have been prosecuted,[264] it seems that signaling moral disapproval and instilling fear around abortion is the bans' whole point. Anti-choice activists and legislators view workable medical exceptions as "loopholes," while existing opaque and restrictive exceptions "do nothing but make abortion bans appear more reasonable than they really are."[265] Anti-choice activists fear that providing doctors with real discretion will clear the way for more and more abortions, and Britain's example proves them right. A medical exception that really works is therefore incompatible with the basic anti-choice aspiration of fewer abortions, and this is why proposals to expand medical exceptions have failed.[266]

But anti-choice obstinance is no reason to give up. While broader exceptions have failed thus far, many legislators who identify as

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[261] *Id.* at 52.

[262] *Id.* at 53.

[263] *Id.* at 78.

[264] Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few are Granted.*, N.Y. TIMES (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html [https://perma.cc/5JX3-W7G8].

[265] *Id.*

[266] *See* Surana, *supra* note 57.

conservative or pro-life are open to them, with some conservative legislators even leading the efforts in their respective states to pass broader medical exceptions.[267] And medical exceptions are overwhelmingly popular; the vast majority of Americans support abortion access where necessary to preserve the pregnant person's life or health.[268] Wider exceptions could thus help make abortion bans more politically palatable, ironically helping the pro-life movement quiet pro-choice dissent. In states where overturning the bans is politically unthinkable today, broadening medical exceptions could still be on the table with buy-in from conservatives who want to appear pro-life but who lack the diehard spirit. Grimly, the needless deaths of their constituents in the coming months and years may help to persuade some legislators that absurdly restrictive bans must be softened.

Time will tell whether workable medical exceptions will be politically possible. But as prominent pro-choice advocates embrace medical exceptions as a means of expanding access in the near term,[269] we must consider what would make such exceptions real. Changing the standard for medical judgment to "good faith" while leaving the rest of a draconian regime intact will likely make no difference. Medical exceptions need to be broad and highly deferential to doctors to enable genuine access to care. Britain's example shows one way that this can be done, but it also reveals a warning: we cannot afford to fool ourselves into believing that medical exceptions are good enough.

CONCLUSION: THE MANIPULATION OF MEDICINE

In the new era of abortion criminalization, where many states have banned abortion in nearly all circumstances, good faith medical exceptions represent the only real scenarios where abortion can be legal. It is therefore no surprise that prominent reproductive rights advocates have focused on medical exceptions as a venue for clarifying and expanding the law, hoping to broaden exceptions and adopt a good faith standard to make abortion more accessible in the near term. While others are thinking about how to clarify the laws and recruit various actors to shape their meaning,[270]

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[267] *Id.*; *see also* Walker, *supra* note 264 (quoting an "anti-abortion Republican who was unable to persuade colleagues this fall to broaden the exceptions in a proposed ban").

[268] *See* MARIST POLL, *supra* note 116.

[269] *See, e.g.*, *Medical Exceptions to State Abortion Bans*, CTR. FOR REPROD. RTS. (2024), https://reproductiverights.org/case/state-abortion-bans-medical-exceptions [https://perma.cc/8QVX-AJV4] ("the Center's cases seek to clarify medical exceptions to U.S. state laws that have outlawed abortion and put health, lives and fertility at risk.").

[270] *See, e.g.*, Carmel Shachar et al., *Whose Responsibility Is It to Define Exceptions in Abortion Bans?*, 331(7) JAMA 559, 559--60 (Jan. 22, 2024), https://doi.org/10.1001/jama.202

this Article's contribution is to consider the discretion that the laws give to doctors and what adjusting that discretion could mean.

Granting discretion to doctors to regulate abortion access is a double-edged sword. A reasonable medical judgment standard is designed to restrict doctors' authority, instilling fear that the law will second-guess their medical judgment, thereby chilling the provision of care. By contrast, a good faith standard can give doctors the discretion they need to provide medically necessary abortions, but only if the terms of the exceptions are broad and largely unrestricted. In a world where abortion is criminalized, only a broad good-faith exception like Britain's can meaningfully enable access to care. But even then, abortions outside the medical establishment are punished, access is far from guaranteed, and abortion is not a substantive right that individuals can choose to exercise for themselves.

As this Article has explored, both subjective and objective standards for medical judgment are flawed. Both standards are vulnerable to gender bias; both may lead to inequities and leave access to care spotty and uncertain; and both position doctors as gatekeepers to abortion access at the expense of individual autonomy. No standard for medical judgment can fully address these problems, elucidating the inherent shortcomings in vesting decision-making authority outside the pregnant individual. Why, then, have doctors become the central figures in debates over the new abortion bans?

Doctors have become pawns, useful symbols in both pro- and anti-choice efforts to construct a new political reality. Pro-choice advocates rely on doctors as proof that abortion is normal and necessary,[271] even as many would prefer a world in which people who want abortions don't necessarily need doctors at all.[272] In Britain, the "medicalization of abortion was a mechanism that enabled the practice to be somewhat depoliticized and more palatable to politicians, making room for

4.0001; Olivia Goldhill, *Texas Medical Board Under Pressure to Define Emergency Exception to Abortion Ban*, STAT (Feb. 2, 2024), https://www.statnews.com/2024/02/02/texas-abortion-law-standard-of-emergency-care [https://perma.cc/Q62F-VJSR]; Sam McCann, *The Prosecutors Refusing to Criminalize Abortion*, VERA (Sept. 19, 2022), https://www.vera.org/news/the-prosecutors-refusing-to-criminalize-abortion [https://perma.cc/G3VX-DLX5].

[271] *See, e.g.*, *Abortion Is Essential Health Care, Even With Wanted Pregnancies*, CTR. FOR REPROD. RTS. (Aug. 1, 2023), https://reproductiverights.org/abortion-health-care-wanted-pregnancies [https://perma.cc/JF3K-P6HB].

[272] *See, e.g.*, Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, GUTTMACHER INST. (Oct. 17. 2018), https://www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care [https://perma.cc/3SCL-ZKZZ]; *Let's Talk About Self-Managed Abortion*, PLANNED PARENTHOOD (July 11, 2023), https://www.plannedparenthood.org/blog/lets-talk-about-self-managed-abortion [https://perma.cc/6RYU-F8GF].

legislation that enabled access."[273] But scholars have explored the dangerous consequences of such pro-choice reliance on science and medicine; in 2015, Aziza Ahmed argued that reliance on medical evidence "is no longer a reliable or stable strategy for pro-choice lawyering" given the growth of skewed anti-choice evidence and increasing judicial credence to it.[274] Likewise, Ruth Colker argues that "overmedicalization," or the "unnecessary reliance on medical categories to determine how people should be treated in society," simplistically classifies people as sick or impaired instead of pursuing "claims to equality, dignity, and respect."[275] Abortion is a primary arena for this phenomenon, and it similarly pervades political discussions on transgender and disability rights.[276] By framing abortion as primarily a medical procedure, then, we miss an opportunity to pursue a more substantive vision of abortion as a matter of equality and autonomy. As this Article has explored, this is essentially the message that medical exceptions perpetuate. Yet pro-choice activists may debate whether framing abortion as a medical decision to expand exceptions and increase access today is worth these costs. As Jordan Parsons and Chloe Romanis argue, "Framing matters, but access matters more."[277]

Meanwhile, anti-choice activists have worked hard to manipulate medicine to their own ends. Anti-choice organizations have long churned out reports that abortion is dangerous, unhealthy, or unnecessary, "tak[ing] advantage of the fact that the general public and most policymakers do not know what constitutes 'good science.'"[278] Over time, federal abortion jurisprudence "rewrote the boundaries of 'reliable' and 'objective' medical evidence by legitimizing conservative medical expertise and evidence . . . pro-life and pro-choice medical testimony and expertise could legitimately be treated as equal."[279] This shift explains why anti-choice advocates prefer a reasonable medical judgment standard: it would enable them to present their fringe evidence as though it is on equal footing with mainstream medical authority. Anti-choice advocates know that medical authority doesn't support them, so they've sought the appearance

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[273] Romanis, *supra* note 195, at 381.

[274] Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J.L. & MED. 85, 86–87 (2015).

[275] Ruth Colker, *Overmedicalization?*, 46 HARV. J. L. & GENDER 206, 207–08 (2023). I oversaw the publication of this excellent article as Managing Editor of the *Harvard Journal of Law & Gender*.

[276] *Id*.

[277] Romanis, *supra* note 195, at 383.

[278] *See* Cohen, *supra* note 160.

[279] Ahmed, *supra* note 274, at 102.

of legitimacy by creating their own.[280] This anti-choice strategy has conscripted doctors to carry out laws they mostly don't believe in.[281] While abortion bans hope to give the impression that they defer to doctors, it is doctors who the laws will punish and control. It's clear that medical exceptions to abortion bans aren't genuinely based on medical evidence or medical expertise; if they were, abortion wouldn't be banned at all.

Doctors feel left with an untenable choice: deny patients care or break the law. Whether doctors should be expected or encouraged to break the law as a matter of justice is debatable, not least because of the life-altering penalties they could face.[282] But perhaps there is another path, one in which doctors comply with the law but accept that they have a role in defining it, even if that role is not risk-free. This is what Katie Watson suggests is possible:

> I encourage physicians, hospital lawyers, and hospital risk managers to follow the advice women are given when we have to walk down a dark alley: Don't act like a victim. Head up. Look around. Then walk with confidence even when you're trembling inside, and the scary people in the shadows are more likely to leave you alone . . . . Physicians and hospitals have choices, and the moment calls for clinicians and institutions that have not previously assumed risk to deliver abortion care to pick up the baton and lead.[283]

If nothing else, doctors can resist being reduced to political pawns. They can refuse to accede quietly to the anti-choice effort to use them as tools and scapegoats. They can advocate for their own professional autonomy while keeping the needs and desires of their patients front and center.

Medical exceptions represent an opportunity, one that pro-choice advocates have a responsibility to seize. Expanding exceptions to be genuinely usable, as this Article has described, would be a lifesaving improvement to the status quo. In advocating for greater access, we also have an obligation to talk about medical exceptions for what they are:

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[280] Anti-choice activists also invoke medical terminology to hide religious motivations. *See, e.g.*, Pam Lowe & Sarah-Jane Page, *Rights-based Claims Made by UK Anti-Abortion Activists*, 21 HEALTH & HUM. RTS. J. 133, 142 (2019).

[281] *See* Simmons-Duffin & Feibel, *supra* note 82; Nadine El-Bawab, *Women, Doctors Announce Legal Action Against Abortion Bans in 3 States*, ABC NEWS (Sept. 12, 2023), https://abcnews.go.com/US/women-doctors-announce-legal-action-abortion-bans-3/story?id=103055654 [https://perma.cc/NZ26-FPBQ].

[282] Simmons-Duffin, *supra* note 27.

[283] Watson, *supra* note 62, at 1240, 1244.

partial and imperfect. It's true that abortion is health care and that doctors need authority to provide it; at the same time, it's true that abortion is much more than that. Abortion is multifaceted and messy, the devastating result of medical necessity for some, and for others the easiest decision in the world. Pro-choice advocates and doctors will need to work together to speak honestly about medical exceptions, their potential as an incremental strategy and their limits when autonomy and equality are our goals. We can hold all these truths at once: that abortion is complicated, that abortion is simple, that doctors sometimes know best, that women know themselves even better, that medical exceptions can help, and that medical exceptions will never be enough. No matter which truth resonates with us most, we need access to abortion on our own terms.