

The First Amendment and the Politics of Reproductive Health Care

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More than forty years after *Roe v. Wade*¹ and more than fifty years after *Griswold v. Connecticut*,² nearly every aspect of reproductive rights remains intensely disputed. The courts continue to struggle with the scope of the constitutional right to abortion.³ Employers seek exemptions from generally applicable requirements to provide insurance coverage for contraception, re-opening questions about women's need for contraception that once seemed well settled.⁴ Indeed, the very nature of abortion and contraception is contested: some consider them to be essential health care, whereas others consider them controversial moral choices. Moreover, these two different ways of looking at reproductive health care operate not only in the social political realms but also often, in unacknowledged ways, in the judicial realm.

This Article examines these hidden assumptions about the place of reproductive health care—especially contraception and abortion—within health care more generally. Abortion and contraception are often perceived by courts and legislators as being something other than health care. Moreover, reproductive health is doctrinally, and

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1. 410 U.S. 113 (1973).

2. 381 U.S. 479 (1965).

3. As of this writing, the Supreme Court is preparing to revisit the meaning of the “undue burden” standard for abortion restrictions in *Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), cert. granted sub nom., *Whole Woman's Health v. Hellerstedt* __ S. Ct. __, 2015 WL 517636 (Nov. 13, 2015).

4. This Term, the Supreme Court will revisit the scope of the right of employees of religious organizations to access subsidized contraception in *Geneva College v. U.S. Dep't of Health & Hum. Servs.*, 778 F.3d 422 (3d Cir. 2015), and the related cases that were consolidated with it. *Zubik v. Burwell*, 136 S. Ct. 144 (Nov. 6, 2015).

often even physically or geographically, isolated from health care more generally—for example, abortions generally take place in freestanding clinics rather than hospitals or doctors’ offices.⁵ Arguably, this isolation has encouraged, if not enabled, differential regulation of reproductive health care,⁶ for example in the form of so-called TRAP (Targeted Regulation of Abortion Providers) laws.⁷ These include laws that require clinics offering abortions to meet certain standards—such as having physicians on staff who hold admitting privileges at a local hospital—that are not applicable to other medical procedures of similar risk level.⁸

If reproductive health care is not exactly health care, then what is it? In the views of some courts and commentators, abortion and contraception are not forms health care, but instead political, moral, or ideological choices. Of course, suggesting that abortion and contraception possess moral dimensions will not strike most people as outrageous or surprising. Indeed, many health care decisions have moral and political dimensions. But in many cases, the moral dimension of reproductive health care leads courts to construct it as primarily, or even exclusively, a moral (or political or ideological) choice and to obscure the private, medical dimensions altogether.

The Affordable Care Act (ACA) could counteract this view somewhat. For the first time, contraception was identified as an “essential health benefit.”⁹ Indeed, it is significant that the ACA

5. See David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 ALB. L. REV. 833, 837–40 (1999) (describing how most abortions came to be provided in free-standing clinics).

6. *Id.* at 839 (arguing that, by “concentrat[ing] abortion services in the free-standing clinics and in the hands of what quickly became a very small number of abortion providers,” pro-choice groups were telling “organized medicine, which had become an important participant in abortion liberalization efforts, [that it] no longer had to hold itself responsible for helping to provide actual abortion services”).

7. See, e.g., John A. Robertson, *Science Disputes in Abortion Law*, 93 TEX. L. REV. 1849, 1849–50 (2015) (defining “TRAP” laws).

8. See, e.g., *Whole Woman’s Health v. Cole*, 790 F.3d 563 (5th Cir. 2015) (adjudicating a constitutional challenge to TEX. HEALTH & SAFETY CODE ANN. § 171.0031 (West, Supp. 2014), which requires that abortion providers, but not other physicians, possess hospital admitting privileges); Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTET. GYNECOL. 175 (2015) (finding that the complication rate for abortion is extremely low).

9. 42 U.S.C.A. § 18022 (West 2014); 42 U.S.C. § 300gg–13(a)(4) (2012). Although the ACA requires provision of essential health benefits, and essential health benefits must include

affirms that contraception is not just health care, but it is actually *essential* health care. It is thus possible to see the Affordable Care Act's contraceptive coverage mandate as an initial attempt to break down the distinction between reproductive health care and the rest of health care. Put another way, the ACA may be breaking down the distinction between "therapeutic" health care—that which is designed to meet important medical needs—and "elective" health care such as contraception and abortion, which may be seen as the product of a moral choice.

The remainder of this Article proceeds as follows. First, Part I demonstrates how reproductive health care has been treated as second-class health care. In large part, the view of abortion and contraception as less-than-essential health care has been created and reinforced by the longstanding distinction between "elective" and "therapeutic" reproductive health care services. Part II then turns to the First Amendment. Drawing on recent controversies at the intersection of reproductive rights and First Amendment rights, this Part analyzes how the tendency to view reproductive health care as something other than "real" or "essential" health care has played out when courts are tasked with categorizing reproductive health-related speech for First Amendment purposes. Specifically, it demonstrates the schism that arises in the case law between judges that view reproductive health care as primarily medical and those that view it as something else—an elective procedure and thus a moral, political, or ideological choice. Finally, this Article concludes in Part III with an attempt to sketch a defense of the view that reproductive health care is essential, necessary, and therapeutic rather than merely the elective product of a moral choice.

I. REPRODUCTIVE HEALTH CARE: "THERAPEUTIC" OR "ELECTIVE"?

The distinction between therapeutic and non-therapeutic abortion and contraception has permeated case law and popular discourse for

preventive services for women, the statute itself does not specify that contraception constitutes such a service. Instead, that requirement is found in the implementing regulations. *See* 42 U.S.C. § 300gg-13(a)(4) (referencing guidelines promulgated by Health Resources and Services Administration, available at <http://hrsa.gov/womensguidelines/>).

decades. The distinction between therapeutic and non-therapeutic *health care* is thus important not only for its direct legal effect—that is, because some legal rules draw distinctions between therapeutic and elective interventions—but also because it shapes the way politicians, individuals, and voters think about reproductive health care, often on an unconscious level. This Part thus presents a handful of examples of how the therapeutic/elective distinction has been identified and remains entrenched in American legal and political discourse.

The Hyde Amendment, passed for the first time in 1976 and again every year thereafter, is an appropriations rider that forbids the use of federal Medicaid funds to pay for abortions except in certain narrow circumstances.¹⁰ The scope of the restriction on federal funds has varied over time—sometimes permitting federal payment for abortions only to save the life of the woman or if the pregnancy resulted from rape or incest, and at other points including the “health” of the woman as a permissible indication—but the focus on funding only “therapeutic” abortions remained throughout.¹¹ Indeed, the terms “therapeutic” and “elective” permeate the debates over the Hyde Amendment, particularly in its early years.¹² More recently enacted state statutes, as well, draw distinctions between therapeutic and non-therapeutic abortion, often defining “therapeutic” quite narrowly.¹³

10. Pub. L. No. 94-439, § 209, 90 Stat 1418 (1976) (first Hyde Amendment, enacted September 30, 1976); *see generally* Jon F. Merz et al., *A Review of Abortion Policy: Legality, Medicaid Funding, and Parental Involvement, 1967-1994*, 17 WOMEN’S RTS. L. REP. 1, 7-8 & n.44 (1995). In addition, the ACA and an executive order issued by President Barack Obama now reinforce the restrictions contained in the Hyde Amendment. Exec. Order No. 13,535 § 1, 75 Fed. Reg. 15,599 (Mar. 29, 2010); 42 U.S.C.A. § 18023(b)(1)(B) (West 2010).

11. Merz, *supra* note 10, at n.44.

12. *See, e.g.*, 122 Cong. Rec. 34828, 34829 (1976) (contrasting therapeutic and elective abortions for funding purposes).

13. *See, e.g.*, NEB. REV. STAT. ANN. § 28-3,106 (West 2010) (forbidding abortions after twenty weeks unless the woman “has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function”); Ohio Rev. Code Ann. § 9.04 (West 2011) (defining nontherapeutic abortion as “an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term or when the pregnancy of the mother was not the result of rape or incest reported to a law enforcement agency”).

Tracing the distinction back yet further, Professor Melissa Murray has written about the history of birth control litigation.¹⁴ Before *Griswold v. Connecticut*, Murray notes, there were two federal challenges to Connecticut's criminal ban on contraceptives that made it to the U.S. Supreme Court.¹⁵ One was the well-known case of *Poe v. Ullman*, in which the Supreme Court dismissed the challenge to the Connecticut birth control ban because of its supposed history of non-enforcement.¹⁶ The other was *Trubek v. Ullman*, which the Supreme Court dismissed without opinion on the same day as *Poe*, likely for the same reason.¹⁷ As Murray points out, *Poe* involved two traditional married couples, with breadwinner husbands and stay-at-home wives, both of whom needed to avoid pregnancy because of serious potential health consequences for the wife.¹⁸ *Trubek*, by contrast, involved a less traditional couple, both law students, who wished to use contraception solely for family planning purposes.¹⁹ Thus, it appears that the two cases revolved around two dichotomies: traditional versus egalitarian gender roles within marriage (gender equality), and therapeutic versus non-therapeutic uses of contraception (health).²⁰ *Poe* involved contraception that was medically necessary in a narrow sense, whereas *Trubek* involved contraception that was necessary only for family and career planning purposes. The fact that the litigation strategy proceeded on these two

14. Melissa Murray, *Overlooking Equality on the Road to Griswold*, 124 YALE L.J. FORUM 324 (2015), <http://www.yalelawjournal.org/forum/overlooking-equality-on-the-road-to-griswold>.

15. *Id.* at 324.

16. 367 U.S. 497, 508 (1961) (“The fact that Connecticut has not chosen to press the enforcement of this statute deprives these controversies of the immediacy which is an indispensable condition of constitutional adjudication. This Court cannot be umpire to debates concerning harmless, empty shadows.”).

17. 367 U.S. 907 (1961). Three of the dissenters in *Poe* also dissented from the dismissal of the appeal in *Trubek* because they were “of the opinion that probable jurisdiction should be noted.” *Id.*

18. Murray, *supra* note 14, at 325.

19. *Id.* (citing Louise G. Trubek, Op-Ed, *The Unfinished Fight over Contraception*, N.Y. TIMES (Mar. 1, 2012), <http://www.nytimes.com/2012/03/02/opinion/contraception-war-goes-on.html>).

20. Murray focuses on the fact that the *Trubek* case had the potential to bring the issue gender equality before the Court, but that issue was ultimately submerged in the *Griswold* litigation, in which the Court recognized a right to access contraception while invoking traditional concepts of marriage and marital privacy. Murray, *supra* note 14, at 327–29.

parallel paths suggests, then, that the therapeutic/non-therapeutic distinction was present from the very beginnings of the judicial recognition of constitutional reproductive rights.

Professor Mary Dudziak has also examined the history of early birth control litigation in Connecticut, noting that, despite pleas from litigants, the Connecticut Supreme Court declined to read an exception into the state prohibition allowing contraception when the woman's life would be at risk from a pregnancy.²¹ The solution in this situation, according to the court, was for the married couple in question simply to refrain from sex.²² Thus, in suggesting that pregnancy itself was always elective, in a sense, the Connecticut court firmly placed reproductive health care outside of the framework of necessary or therapeutic health care.²³

The distinction plays out in contemporary political discourse as well. In particular, the claims for religious and conscientious exemptions from providing certain health care services—culminating in the *Burwell v. Hobby Lobby*²⁴ litigation—tend to downplay the significance of contraceptives to women's health. Indeed, Justice Ginsburg's dissent in that case took the majority to task for failing to recognize the importance of contraceptives in the context of women's health care and for ignoring the harms to women arising from religious exemptions.²⁵

In fact, some religious doctrines distinguish between contraceptives used for therapeutic and contraceptive purposes.²⁶ An

21. Mary L. Dudziak, *Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut*, 75 IOWA L. REV. 915, 925 (1990) (discussing *Tileston v. Ullman*, 26 A.2d 582 (Conn. 1942), and *State v. Nelson*, 11 A.2d 856 (Conn. 1940)).

22. *Id.* at 925–26.

23. *Id.* Ironically, as Dudziak notes, Connecticut's abortion law *did* allow for abortions to save the life of the woman, thus making its abortion law more liberal than its contraceptives law. *Id.* at 926.

24. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

25. *Id.* at 2788–90 (Ginsburg, J., dissenting) (explaining the significance of contraceptive coverage to women's health and economic and social equality and noting that the religious exemption “would deny legions of women who do not hold their employers' beliefs access to contraceptive coverage that the ACA would otherwise secure.”).

26. Leonard J. Nelson, III, *God and Woman in the Catholic Hospital*, 31 J. LEGIS. 69, 103–04 (2004) (discussing the Catholic principle of “double effect”). The doctrine of double effect refers to the Catholic belief that certain forbidden actions, such as abortion or euthanasia, may be considered morally licit if they are done with the intention of achieving a permissible goal. For example, Leonard J. Nelson, III gives the example of a surgical sterilization, which is

Arizona law passed in 2012 (before *Hobby Lobby*) appeared to embrace that distinction, allowing religious employers to refuse to provide coverage for prescription contraception if it violated their beliefs to do so, except if the drug was required for “medical indications other than for contraceptive, abortifacient, abortion or sterilization purposes.”²⁷ Indeed, this distinction has permeated even medical discourse to some extent. For example, Professor Farr Curlin, who has written extensively (and supportively) about conscientious objections to the provision of health care, refers to reproductive health care services as “controversial clinical practices,” and “legal yet controversial treatments,” seemingly distinguishing them from other types of medical procedures and studiously avoiding any implication of therapeutic benefit.²⁸ Similarly, in an online article for an ethics journal, Professor Curlin and his co-author Rev. Russell Burck discuss a hypothetical example of a physician who is asked by his young, unmarried, adult female patient to prescribe contraception. The doctor’s choice whether to prescribe the drugs, according to Curlin, “is a moral choice which implicitly or explicitly expresses a moral judgment.”²⁹

To summarize, the distinction between health care that is “therapeutic” and reproductive health care—which is not—has

illicit if performed to prevent future pregnancies but permissible if sterilization occurs in the course of removing a diseased organ to cure the sterilized individual. *Id.* (citing CHARLES J. MCFADDEN, *MEDICAL ETHICS* 294–95 (3d ed. 1953)); *see also* CATECHISM OF THE CATHOLIC CHURCH 2271–74 (1994) (distinguishing between “direct abortion, that is to say, abortion willed either as an end or a means” and actions such as prenatal diagnosis that are taken without the intention of ending fetal or embryonic life but that may result in accidental termination of a pregnancy); *cf. id.* at 2279 (stating, with respect to euthanasia, that “[t]he use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable”).

27. ARIZ. REV. STAT. § 20-826(Z) (2014) (West).

28. Farr A. Curlin, M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 N. ENG. J. MED. 593, 595, 597 (2007).

29. Farr A. Curlin, M.D. & Rev. Russell Burck, Ph.D., *Clinical Case: Patient Counseling and Matters of Conscience*, VIRTUAL MENTOR: ETHICS JAMA 3 (May 2005) (Commentary 1 by Prof. Curlin), available at <http://journalofethics.ama-assn.org/2005/05/pdf/ccas3-0505.pdf>. Later in the article, Curlin minimizes the focus on reproductive health services as uniquely controversial, stating that “the pretense of neutrality cannot be sustained in any case where a physician is asked to make a judgment, and such judgments are implicit in all deliberate human actions, such as the decision to prescribe contraceptives, or, for that matter, to prescribe anti-hypertensives.” *Id.*

permeated legal, political, and even to some degree medical discourse since the use and legalization of contraception and abortion became widespread. While this Article does not argue that the distinction has always been firmly maintained in all contexts, it has been remarkably salient and persistent. The next Part considers some of the implications of this distinction for First Amendment issues that arise in the reproductive health care context.

II. FIRST AMENDMENT IMPLICATIONS

I have argued elsewhere that, in recent First Amendment cases arising in the reproductive health care context, many courts have tended to view abortion and contraception (albeit not explicitly) as something other than health care—primarily, as a moral or ideological choice.³⁰ This submerged understanding of reproductive health care as “not really health care,” I argue, has often driven the First Amendment analysis in ways that have gone largely unnoticed. This Part summarizes and extends that argument.

In a series of recent cases, courts have considered the extent to which the government can require entities known as Crisis Pregnancy Centers (CPCs) to disclose the limited nature of their services and to convey certain health-related messages.³¹ CPCs are generally non-profit organizations that are often set up to look like medical clinics, whose primary goal is to dissuade pregnant women from choosing abortion.³² These entities may be religiously affiliated and may have no licensed medical practitioners on-site, despite offering ultrasounds, pregnancy testing, and counseling, along with some forms of material and emotional support to pregnant women.³³

30. B. Jessie Hill, *Casey Meets the Crisis Pregnancy Centers*, 43 J.L. MED. & ETHICS 59 (2015).

31. *Centro Tepeyac v. Montgomery Cnty.*, 722 F.3d 184 (4th Cir. 2013); *Greater Balt. Ctr. for Pregnancy Concerns v. Mayor of Balt.*, 721 F.3d 264 (4th Cir. 2013); *O'Brien v. Mayor of Balt.*, 768 F. Supp. 2d 804 (D. Md. 2011), *vacated in part on other grounds in* *Greater Balt. Ctr. for Pregnancy Concerns, Inc.*, 721 F.3d 264; *Evergreen Ass'n v. City of New York*, 740 F.3d 233 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 435 (2014); *A Woman's Friend Pregnancy Res. Clinic v. Harris*, No. 2:15-CV-02122-KJM-AC, 2015 WL 9274116 (E.D. Cal. Dec. 21, 2015).

32. Alice X. Chen, *Crisis Pregnancy Centers: Impeding the Right to Informed Decision Making*, 19 CARDOZO J.L. & GENDER 933, 936–37 (2013).

33. *Id.* at 936; *New York, N.Y., Local Law 17 § 1* (Mar. 16, 2011) (findings) (stating that CPCs in New York City have been found to deceive clients about “the availability of licensed

Responding to documented incidents of deceptive conduct by CPCs that sought to trick women into believing they were medical establishments or abortion clinics (and in some instances trying to prevent women from accessing abortion altogether) some municipalities instituted disclosure requirements.³⁴ In particular, these municipalities required CPCs to make it known to clients that they do not have a licensed medical professional on staff; that they do not provide or refer for contraception or abortion; and/or that government recommends that pregnant women see a licensed health professional.³⁵ Courts have generally applied heightened scrutiny to these compelled speech requirements under the First Amendment, on the theory that they require mention of “controversial services” and are therefore “ideological.”³⁶ Indeed, the Second Circuit in *Evergreen Ass’n v. City of New York* suggested that abortion and contraception were a matter of “public concern” and that the recommendation that pregnant women should see licensed medical professionals is a “public issue subject to dispute.”³⁷

The framing of reproductive health care as a moral or ideological choice and a matter of public concern rather than as private health care is significant not just because it may shape the social meaning and public understanding of contraception and abortion, but also because this framing arguably affects the outcome in First Amendment disputes. Particularly in the CPC cases, the non-profit entities challenged the municipalities’ restrictions as compelled ideological speech. In accepting the CPCs’ framing of the required disclosures regarding the availability of certain services and medical personnel as “ideological” in the reproductive health care context, courts placed the case in a category that required heightened scrutiny

medical providers that provide or oversee services on-site”).

34. New York, N.Y., Local Law 17 § 1; *Tepeyac v. Montgomery Cty.*, 779 F. Supp. 2d 456, 459 (D. Md. 2011) *aff’d in part, rev’d in part*, 683 F.3d 591 (4th Cir. 2012), *aff’d on reh’g en banc sub nom. Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184 (4th Cir. 2013) (citing Montgomery County Res. No. 16–1252 (Feb. 2, 2010)).

35. See *Evergreen Ass’n*, 740 F.3d 233; *Centro Tepeyac*, 722 F.3d 184; *Greater Balt. Ctr.*, 721 F.3d 264.

36. See *infra* note 38.

37. *Evergreen Ass’n*, 740 F.3d at 250 (“It may be the case that most, if not all, pregnancy services centers would agree that pregnant women should see a doctor. That decision, however, as this litigation demonstrates, is a public issue subject to dispute.”).

according to First Amendment doctrine.³⁸ If the required disclosures had been viewed as dealing with primarily medical issues, the speech likely would have been understood to constitute professional speech, which receives a very low level of scrutiny (much like standard medical informed consent requirements).³⁹ Indeed, the required disclosures could be seen as speech that is essentially aimed at regulating a form of *conduct* that could constitute unlicensed practice of medicine, since CPCs sometimes intentionally adopt the appearance of medical clinics and offer diagnostic and related medical services.⁴⁰

By contrast, in cases dealing with ideologically-charged informed consent requirements for abortion, courts' framing of abortion as a moral or ideological choice rather than as health care leads them to uphold these forced disclosures under the First Amendment. This seemingly counter-intuitive result arises from the fact that the framing of abortion as a moral or ideological choice leads courts to

38. *Evergreen Ass'n*, 740 F.3d at 245 (holding that the challenged speech is subject to either strict or intermediate scrutiny); *Centro Tepeyac v. Montgomery Cnty.*, 779 F. Supp. 2d 456, 468 (D. Md. 2011), *aff'd in part, rev'd in part*, 683 F.3d 591 (4th Cir. 2012), *aff'd on reh'g en banc*, 722 F.3d 184 (4th Cir. 2013). Sitting *en banc*, the Fourth Circuit upheld the district court's application of strict scrutiny in *Centro Tepeyac* but emphasized that the district court agreed the speech was non-commercial and non-professional because "it could not determine otherwise *on the undeveloped record before it.*" *Centro Tepeyac*, 722 F.3d at 189 (emphasis added). *But see A Woman's Friend Pregnancy Res. Clinic v. Harris*, No. 2:15-CV-02122-KJM-AC, 2015 WL 9274116, at *19-23 (E.D. Cal. Dec. 21, 2015) (holding that CPC speech should be categorized as professional speech and therefore that CPC disclosure requirements are subject either to intermediate scrutiny or to a "reasonableness" test).

39. *See generally Hill*, *supra* note 30, at 60-62 (explaining that the Supreme Court has not directly addressed the category of professional speech in its First Amendment jurisprudence but that rational basis review is generally applied to speech restrictions in the professional-speech context); *see also A Woman's Friend*, 2015 WL 9274116, at *19-23 (applying a lower level of scrutiny to a law requiring certain disclosures for CPCs after identifying CPC speech as professional speech and identifying the relevant government interest as "ensur[ing] that California residents know their rights and the *health care* resources available to them when they make their personal reproductive *health care* decisions") (emphasis added).

40. Jennifer Keighley offers the analogy of a "Sickle Cell Anemia Treatments Options Center" that looks like a clinic but does not employ licensed medical professionals and counsels against blood transfusions (based on religious belief). Jennifer M. Keighley, *Can You Handle the Truth? Compelled Commercial Speech and the First Amendment*, 15 U. PA. J. CONST. L. 539, 604 (2012); *see generally* Kirsten Gallacher, *Protecting Women from Deception: The Constitutionality of Disclosure Requirements in Pregnancy Centers*, 33 WOMEN'S RTS. L. REP. 113, 125 (2011) ("Some pregnancy centers . . . locate near abortion or medical clinics and try to look like them.").

view a wider range of propositions—not just medical facts, but also metaphysical or ideological statements—as relevant to the abortion decision. For example, the State of South Dakota requires physicians to inform women seeking abortions that they are about to terminate the life of “a whole, separate, unique, living human being.”⁴¹ In *Planned Parenthood v. Rounds*, the Eighth Circuit considered whether that required disclosure violated physicians’ First Amendment rights.⁴² To answer that question, the court looked to *Planned Parenthood v. Casey*, which briefly stated that informed consent requirements are constitutionally acceptable if they are *relevant*, truthful, and non-misleading.⁴³ Because it framed abortion as moral rather than medical, the Eighth Circuit upheld the disclosures in *Rounds*, finding that informed consent requirements that extend beyond an explanation of the “medical risks” of the procedure were nonetheless “relevant,” because “abortion requires a difficult and painful *moral* decision.”⁴⁴ In this way, the court suggested that abortion is different from other medical procedures, in which the informed consent process is limited to medical risks, benefits, and alternatives.⁴⁵

Thus, in cases like *Rounds*, courts rely on the medical aspects of abortion to frame abortion informed-consent requirements as compelled professional speech, which, according to *Casey*, is subject to a much lower level of scrutiny than compelled ideological speech. But then, by also framing abortion as predominantly (or at least substantially) a moral decision rather than a medical one, courts expand the concept of “relevance” beyond its traditional boundaries in the informed-consent context. In this way, government-mandated statements about the transcendental nature of the fetus or embryo can be justified as relevant to the medical decision.

41. *Planned Parenthood v. Rounds*, 530 F.3d 724, 726 (8th Cir. 2008) (citing S.D. CODIFIED LAWS § 34-23A-10.1 (2008)).

42. *Id.* at 724.

43. *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992) (plurality op.).

44. *Rounds*, 530 F.3d at 734 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007)) (emphasis added).

45. See Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 CORNELL J.L. & PUB. POL’Y 1, 31–32 (2011).

Unfortunately, this manipulation of the notion of relevance conflicts with the justifications for subjecting compelled professional speech like informed consent to a lower standard of scrutiny. In particular, the idea that the government should have some leeway to require disclosures in the informed-consent context derives in large part from the notion that professionals such as physicians have superior knowledge and therefore superior power over the patient that requires special protection of the patient.⁴⁶ Once the informed-consent requirements no longer relate to medical issues within the physician's domain of expertise, however, this patient-protection rationale fades away.⁴⁷

Interestingly, some of the earliest cases extending First Amendment protection to commercial speech also dealt with reproductive health care. In those cases, too, the understanding of reproductive health care as not being primarily *medical* influenced the doctrinal framework that was applied to the free-speech claims. For example, in *Bolger v. Youngs Drug Products Corp.*, the Supreme Court considered the constitutionality of a ban on mailing unsolicited advertisements for condoms.⁴⁸ Although some of the brochures contained factual discussions of sexually transmitted infections, others were simply advertisements.⁴⁹ Treating all of these items the same for First Amendment purposes, the Court noted that the flyers "contain[ed] discussions of important public issues" and struck down the ban.⁵⁰ Thus, the framing of reproductive health care as having a non-medical, political dimension arguably contributed to the protection of speech about reproductive health care. A similar analysis affected the Court's approach in another early case, *Bigelow v. Virginia*, in which the Court found that an advertisement for

46. See, e.g., *Lowe v. SEC*, 472 U.S. 181, 229–32 (1985); see generally Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 47 U. PA. L. REV. 771 (1999).

47. Sawicki, *supra* note 45, at 32.

48. 463 U.S. 60, 60 (1983).

49. *Id.*

50. *Id.* at 67.

abortion services was protected commercial speech.⁵¹ In so holding, the Court noted that the advertisement discussed issues of “clear ‘public interest,’” such as the legal status of abortion in New York, which was “not unnewsworthy.”⁵² By contrast, the Virginia Supreme Court had upheld the newspaper’s conviction for violating Virginia’s law against advertising abortion services, on the ground that the law pertained to medical care and was clearly within the state’s police power to pass.⁵³ Placing abortion in a broader political context allowed the Supreme Court to afford expansive protection to the advertisement, whereas pure commercial speech would likely have received a lower level of protection.

In a different area of the First Amendment—abortion protests—the framing of reproductive health care could also be seen as affecting the approach to the free-speech questions. In the recent case of *McCullen v. Coakley*, Justice Scalia sparred with counsel over whether to refer to picketers outside an abortion clinic as “protestors” or “counselors.”⁵⁴ Similarly, Chief Justice Roberts’s opinion for the

51. 421 U.S. 809 (1975). The advertisement, which was published in 1971, stated:

UNWANTED PREGNANCY
LET US HELP YOU
Abortions are now legal in New York.
There are no residency requirements.
FOR IMMEDIATE PLACEMENT IN ACCREDITED
HOSPITALS AND CLINICS AT LOW COST
Contact
WOMEN’S PAVILION
515 Madison Avenue
New York, N.Y. 10022
or call any time
(212) 371-6670 or (212) 371-6650
AVAILABLE 7 DAYS A WEEK
STRICTLY CONFIDENTIAL. We will make
all arrangements for you and help you
with information and counseling.

Id. at 812.

52. *Id.* at 823.

53. *Bigelow v. Comm’r*, 191 S.E.2d 173, 176 (Va. 1972), *rev’d*, 413 U.S. 909 (1973).

54. Transcript of Oral Argument at 29, 43, *McCullen v. Coakley*, 134 S. Ct. 2518 (2014) (No. 12-1168) (“I — I object to you calling these people protestors, which you’ve been doing here during the whole presentation. That is not how they present themselves. They do not say they want to make protests. They say they want to talk quietly to the women who are going into

majority insisted that the picketers were engaged in “counseling” and were “not protestors.”⁵⁵ By rejecting the “protestor” label in favor of the “counseling” label, the majority analogized the activity to what takes place in an intimate (mental or physical) health-care setting.⁵⁶ This framing of the picketers’ activity is part of what led the Court to see the buffer zone surrounding the clinic as overbroad and insufficiently tailored, since it was aimed at limiting loud, intrusive protests.⁵⁷ At the same time, however, the notion that women ought to be open to “counseling” and quiet suggestion from complete strangers on the street is somewhat incongruous with an understanding of the abortion decision as private. Perhaps Justices Scalia and Roberts could see this notion as unexceptional only because they understood the woman’s abortion decision as somehow of interest and relevance to other people, or to the public at large—not, in other words, as fundamentally private.

Finally, though it is not a First Amendment case, the majority’s opinion *Burwell v. Hobby Lobby*, dealing with protection of religious freedom under the Religious Freedom Restoration Act (RFRA), arguably minimizes the therapeutic aspects of contraception in foregrounding the individual claims of conscience.⁵⁸ In the majority’s consideration of whether the Affordable Care Act’s contraceptive coverage mandate violates the rights of certain religious employers, the health dimension of contraception is almost entirely lost. Indeed, by simply “assuming” the Government’s interest “in guaranteeing cost-free access to the four challenged contraceptive methods,”⁵⁹ without even mentioning the word “health,” the majority minimized

these facilities. Now how does that make them protestors?”); *Id.* at 24 (referring to “abortion counselors”).

55. *McCullen v. Coakley*, 134 S. Ct. 2518, 2527, 2536 (2014).

56. *Id.* at 2536 (“Petitioners are not protestors. They seek not merely to express their opposition to abortion, but to inform women of various alternatives and to provide help in pursuing them. Petitioners believe that they can accomplish this objective only through personal, caring, consensual conversations.”).

57. *Id.* at 2535–37.

58. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

59. *Hobby Lobby*, 134 S. Ct. at 2780; cf. Neil S. Siegel & Reva B. Siegel, *Compelling Interests and Contraception*, 47 *CONN. L. REV.* 1025, 1031 (2015) (noting the ways in which the majority’s opinion and the Government’s brief were both “incomplete” in their descriptions of the interests at stake in *Hobby Lobby*).

the public-health and individual health benefits of contraceptives coverage; the women affected by the decision are nearly invisible.⁶⁰

Ultimately, the characterization of reproductive health care as something other than health care can cut either way. It can lead to greater protection for reproductive-health related speech; it can also protect speech intended to mislead women who may wish to seek an abortion. Either way, unacknowledged assumptions about the place of reproductive health care within health care more generally often drives the doctrinal First Amendment analysis.

III. IS ALL REPRODUCTIVE HEALTH CARE “THERAPEUTIC”?

This Article concludes with some reflections on whether reproductive health care—particularly abortion and contraception—can and should be understood as “essential” or “therapeutic” health care. Feminists and reproductive rights advocates have long rejected the notion that there is such a thing as “non-therapeutic” reproductive health care,⁶¹ but this idea has not been sufficiently developed in the legal literature. Indeed, even within this distinction, the definition of “therapeutic” has been remarkably fuzzy.⁶²

In the vast majority of cases, contraception and abortion are used for purposes of “family planning,” rather than to avoid physical ailments or injury.⁶³ But the concept of family planning—itself rather

60. Justice Ginsburg’s dissent, by contrast, partially supplied this missing rationale. *Hobby Lobby*, 134 S. Ct. at 2788–90 (Ginsburg, J., dissenting) (noting that, with the contraceptive coverage requirement, “Congress left health care decisions—including the choice among contraceptive methods—in the hands of women, with the aid of their health care providers”).

61. See, e.g., Susan Randall, *Health Care Reform and Abortion*, 9 BERKELEY WOMEN’S L.J. 58, 76 n.46 (1994); Suzanna Sherry, *Women’s Virtue*, 63 TUL. L. REV. 1591, 1598 n.6 (1989); cf. Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV. 957, 982 (2010) (describing the “right to health” model for protecting reproductive health rights under international law).

62. See, e.g., B. Jessie Hill, *What Is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 459 (2012) (discussing the Hyde Amendment debates); Sherry, *supra* note 61, at 1598 n.6 (discussing the incoherence of considering abortions for pregnancies resulting from rape or incest to be “therapeutic” while not taking seriously the mental health costs of carrying other unwanted pregnancies to term).

63. Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL AND REPROD. HEALTH 110 (2005).

amorphous—does not fit obviously or easily into most understandings of health care or medical treatments, which often center on avoidance or treatment of disease.⁶⁴ Indeed, pregnancy, which seems eminently “natural,” can be a healthy, wanted state. It is unlike many other physical conditions in that the identical condition may be perfectly desirable and thus “healthy” or, in a sense, pathological, depending on the subjective desires of the individual woman.

At same time, it seems relevant that pregnancy itself is a state for which medical attention is generally sought (the Second Circuit’s skepticism about that proposition in *Evergreen* notwithstanding).⁶⁵ Moreover, even in common usage “therapeutic” treatments are not just those that heal the patient or rid her of “disease.” They also include those that rid the individual of unwanted, undesirable health conditions and health risks, as well as negative social and emotional effects.⁶⁶ Medical treatments to correct a disfiguring deformity, such as breast implants after a mastectomy, are one example of therapeutic and widely accepted health care that corrects primarily for negative social and emotional effects. According to this wider understanding of necessary health care, unwanted pregnancy is not just a social emergency for the individual—it is an undesirable medical state. Indeed, pregnancy certainly includes physical risks and sometimes illness, at least temporarily, and it is a physical state that can reduce normal functioning in some respects. As one court has put it, avoiding unwanted pregnancy allows woman to “prevent a litany of physical, emotional, economic, and social consequences.”⁶⁷ Unintended pregnancies and births are associated with a wide range

64. See, e.g., Janet L. Dolgin, *Unhealthy Determinations: Controlling “Medical Necessity”*, 22 VA. J. SOC. POL’Y & L. 435, 440 (2015) (citing, among other things, the American Medical Association description of “a ‘prudent’ physician’s provision of medical care [as being] aimed at ‘preventing, diagnosing[,] or treating an illness, injury, disease or its symptoms.’”).

65. *Evergreen Ass’n v. City of New York*, 740 F.3d 233, 250 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 435 (2014).

66. See, e.g., Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1468 (1994) (discussing Professor Norman Daniels’s theory that necessary health care is health care aimed at providing a “normal opportunity range” to individuals).

67. *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001).

of physical and mental health problems for the mother and the child.⁶⁸

Nonetheless, it remains difficult for many people to recognize that an abortion of an unwanted pregnancy that occurs simply because the pregnancy is unplanned constitutes a “therapeutic” abortion. Indeed, emphasizing the physical and mental health risks of pregnancy may operate to rhetorically re-inscribe the distinction between the therapeutic and the non-therapeutic. The narrowly medical account of the risks of unintended pregnancy feels incomplete and not quite right; something more is needed to demonstrate that all reproductive health care wanted and needed by a woman is, in fact, necessary health care.

That “something more” may be the equality framework for reproductive rights. The notion that the need to avoid or end a pregnancy for career and family planning reasons makes it just as therapeutic as avoiding it for more narrowly physical, medical reasons only makes sense in light of a perspective that recognizes equality of opportunity and autonomy over one’s life path as an aspect of full human flourishing. It is only by rejecting pregnancy as natural, as part of the inevitable duty and destiny of all women, and therefore in all circumstances a positive good (or at least by refusing to see forced childbearing as a relatively minor harm, as being not as bad as going through life with a deformity, for example), that we can see how avoiding or ending unwanted pregnancy is inherently “therapeutic.”⁶⁹

Indeed, the equality framework sheds light on another area in which courts have drawn a distinction between “therapeutic” and “non-therapeutic” reproductive health care—namely, in the availability of condoms to prevent the spread of disease. As Professors Neil S. Siegel and Reva B. Siegel explain, the nineteenth-

68. See, e.g., Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 365 & n.8 (1998); ALAN GUTTMACHER INST., FACT SHEET: UNINTENDED PREGNANCY IN THE U.S. (July 2015), available at <https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>.

69. Cf. Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 291–92 (1992) (discussing nineteenth-century views of pregnancy as natural and an inherent part of women’s destiny).

and early twentieth-century history of enforcing bans on contraception was a highly gendered one.⁷⁰ Yet the gendered nature of the enforcement was also tied to the understanding of various forms of birth control as therapeutic or non-therapeutic. In the twentieth century, Connecticut and Massachusetts—states that outlawed contraception in most instances—made explicit exceptions for the use of condoms to prevent sexually transmitted diseases.⁷¹ Thus, protection against disease, which was possible through a form of birth control used only by men, was a therapeutic purpose; avoidance of unwanted pregnancy, which could be achieved through forms of birth control available to women, was not. Indeed, even avoidance of dangerous pregnancies was not seen as medically necessary in the same way as avoidance of venereal disease; courts refused to read exceptions into the states' birth control statutes even for women who would suffer substantial health risks from pregnancy.⁷² They, unlike men, were advised simply to abstain from sex.⁷³

This example from the early state regulation of birth control demonstrates how gender has played into traditional concepts of what is therapeutic and what is not. In the first half of the twentieth century, states like Massachusetts and Connecticut treated the use of a prophylactic, which does not even require a physician's prescription or recommendation, as a medically necessary form of health care, whereas use of birth control pills to avoid pregnancy was not.⁷⁴ As a consequence, women and men have different degrees of control over their reproductive lives. Men are able to avoid unwanted diseases and pregnancy, but unwanted pregnancy for women is not even conceived as medically cognizable harm. As Siegel and Siegel explain, this

70. Neil S. Siegel & Reva B. Siegel, *Contraception as a Sex Equality Right*, 124 *YALE L.J.* F. 349, 351–52 (2015), <http://www.yalelawjournal.org/forum/contraception-as-a-sex-equality-right>.

71. *Id.* at 352–53.

72. *Id.* at 352.

73. *Id.* at 352 & n.24.

74. *Id.* (citing *Commonwealth v. Corbett*, 307 Mass. 7, 8 (1940)). Relatedly, the Connecticut Supreme Court delineated a distinction between contraception for the “‘general health’ of the patient,” and contraception to alleviate “‘a specific disease or condition,’” although it ultimately held that both uses of contraception were forbidden. *Tileston v. Ullman*, 129 Conn. 84, 86, 26 A.2d 582, 584 (1942) (citing *State v. Nelson*, 11 A.2d 856 (1940)).

“disparate treatment” both “reflected and reinforced traditional gender roles in sex and parenting.”⁷⁵

At the same time, it is important to acknowledge that the equality framework also has the potential to undermine the view of reproductive health care as therapeutic. It is arguably the politicization of reproductive health care as an aspect of women’s equality that has led to the construction of abortion and contraception as political rather than personal and medical.⁷⁶ If access to reproductive health care is intimately tied to women’s political, social, and economic equality, then reproductive health care itself is more easily framed as a political or ideological choice. As demonstrated above in Part II, the political construction of reproductive health care has persisted, shaping courts’ doctrinal approaches in First Amendment cases dealing with reproductive health care, both for better and for worse. The equality framework is also incomplete without the therapeutic health-care framework.

CONCLUSION

Though reproductive health care undoubtedly possesses moral and even spiritual dimensions that may differentiate it from some other forms of health care, the tendency to view reproductive health as inherently and primarily political has shaped the legal approach to contraception and abortion. Both recent and more venerable First Amendment cases arising in the reproductive health context reflect an underlying tension between framing reproductive health care as simply health care and framing it as primarily something else.

In some cases, constructing reproductive health care as political has led to greater protection for speech related to abortion and contraception; in other instances, it has allowed legislatures to require doctors to promote ideological state messages and has prevented them from enforcing measures intended to protect pregnant women seeking access to unbiased information regarding their options.

75. Siegel & Siegel, *supra* note 70, at 355.

76. See generally Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions About Backlash*, 120 YALE L.J. 2028, 2052 (2011) (discussing the politicization of abortion in the 1970s and its association with the feminist movement).

Whether this understanding of reproductive health care is helpful or harmful in the First Amendment context, it is important to recognize that it often drives the legal analysis. Moreover, it is useful to recognize that these First Amendment cases, by validating the view of reproductive health care as non-medical, reinforce the distinction between therapeutic and non-therapeutic reproductive health care.

If all reproductive health care were seen as therapeutic and necessary, several positive consequences would follow. First, it would mean that reproductive health care is taken seriously as a government interest and an individual need; it might weigh more heavily against companies' claims to religious exemptions, for example. Second, it would be more difficult to engage in differential regulation of abortion and contraception if they were viewed as forms of medically necessary care. Broad conscience-based exemptions to provision of reproductive health care services would be harder to justify, as would so-called TRAP laws. Abortion and contraception could not be so easily isolated from other forms of health care, in statutory law or in constitutional doctrine.

Ultimately, to arrive at this result, a new rhetorical framework is required—one that merges both equality and health. As demonstrated in Part III, the medical framework for reproductive health care is incomplete unless it builds upon an assumption that women are entitled to equality of opportunity and control over their futures. Yet, the equality framework, which sees access to abortion and contraception as essential to women's political and social equality, is incomplete without an understanding of abortion and contraception as fundamentally private medical matters rather than political and ideological choices.