NOTE

The Forced Choice of Dignified Disposal: Government Mandate of Interment or Cremation of Fetal Remains

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INTRODUCTION

It no longer rings true that one in three women in the United States will have an abortion during her lifetime. In fact, the reported rate of abortion among U.S. women has plummeted to an unprecedented low in recent years. To account for this significant decline, political adversaries posit wildly different explanations. Pro-choice advocates credit increased access to contraceptives and the consequent fact that women are experiencing fewer unintended pregnancies. At the other end of the spectrum, the pro-life movement applauds a shift in public opinion, indicated by a higher percentage of pregnant mothers “choosing life, rather than death, for their babies.” From this seemingly irreconcilable discord, one thing appears to be certain: abortion remains a highly politicized and divisive issue for most Americans.

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Recognizing that the constitutional right to privacy encompasses the right to an abortion,\textsuperscript{7} \textit{Roe v. Wade} affirmed that states have the power to regulate when and under what circumstances abortions are performed.\textsuperscript{8} In the forty years following \textit{Roe}, state lawmakers have enacted hundreds of abortion regulations under the guise of maternal protectionism and fetal preservation.\textsuperscript{9} These laws limit a woman’s right to terminate an unwanted pregnancy by discouraging women from utilizing abortion services as well as by erecting practical barriers to abortion access.\textsuperscript{10}

Looking to the future, there is little evidence to suggest that this regulatory barrage on reproductive health services will slow.\textsuperscript{11} In 2015, state legislatures proposed 514 provisions concerning abortion services.\textsuperscript{12} Of those measures passed, fifty-seven imposed restrictions on access to reproductive healthcare.\textsuperscript{13} In July of 2016, the Supreme Court of the United States affirmed that laws that restrict access to

\begin{footnotesize}
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\item \textsuperscript{7} \textit{Roe v. Wade}, 410 U.S. 113, 153 (1973).
\item \textsuperscript{8} \textit{See id. at} 163 (“[A] State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.”); \textit{see also} Jessica Arden Etinger, Note, \textit{Seeking Common Ground in the Abortion Regulation Debate}, 90 NOTRE DAME L. REV. 875, 878 (2014).
\item \textsuperscript{13} \textit{Id.}
\end{itemize}
\end{footnotesize}
abortion services must actually promote the government's interest in promoting health and safety.\textsuperscript{14} It appears unlikely, however, that the Court's decision in \textit{Whole Woman's Health v. Hellerstedt} will deter legislative efforts to regulate abortion moving forward.\textsuperscript{15} Just last year, eighteen states enacted fifty new abortion restrictions, raising the total number of abortion regulations passed since 2010 to 338.\textsuperscript{16}

Joining the entanglement of measures limiting access to reproductive healthcare in 2016 was a new and unusual mandate: fetal remains resulting from abortions and miscarriages must be interred or cremated to avoid criminal sanctions.\textsuperscript{17} Indeed, fetal tissue has been a strong point of contention in the abortion debate ever since the discovery of its efficacy in medical research.\textsuperscript{18} Yet, in 2015, the Center for Medical Progress released a series of sensationalized videos accusing Planned Parenthood of “selling baby body parts” and revived the controversy anew.\textsuperscript{19} In subsequent months, eleven states

\textsuperscript{14} Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2311, 2315-18 (2016).
scrutinized Planned Parenthood’s handling of aborted fetal matter, each coming up short of substantive evidence of wrongdoing but prompting public outcry for defunding nonetheless.20

Consequently, numerous states imposed stringent limitations on the use of fetal tissue during the 2016 legislative session.21 Fetal disposal laws were especially prevalent, with eleven states proposing laws concerning the final resting place of the unborn.22 Joining Arkansas and Georgia, which have restrictive fetal disposal laws on the books,23 Indiana, Louisiana, and Texas implemented the mandate of interment or cremation in 2016.24 Abortion providers and pro-choice advocates responded by challenging the constitutionality of these provisions in


federal court. Thus far, no fetal disposal provision enacted in 2016 has been enforced due to pending litigation.

This Note analyzes the constitutionality of government mandate of interment or cremation of fetal remains. Part I explores the regulatory landscape governing the disposal of medical waste and fetal matter. Part II presents three distinct ways in which the dignified disposal mandates enacted in 2016 violate the Due Process Clause of the Fourteenth Amendment. Part III concludes that current fetal disposal laws must be struck down, but proposes the undertaking of sensitive disposal guidelines through which states can respect the controversial nature of fetal disposal. This Note concludes by looking to the future, anticipating the extent to which the Trump Administration will affect the constitutionality of fetal disposal laws.

I. DISPOSAL OF MEDICAL WASTE

A. Origin and Modern Landscape

A series of environmental disasters is largely responsible for the statutory scheme governing medical waste disposal today. In an event known as the Syringe Tide, medical debris washed ashore in New Jersey, forming a mile-long “garbage slick” during the summer of 1988. Shortly thereafter, the unmanageable public health threat looming in the accumulation of medical waste forced ocean beaches on both coasts to close. Public outcry, namely a formidable fear of

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26 See, e.g., Whole Woman’s Health v. Hellerstedt, 231 F. Supp. 3d 218, 221-23 (W.D. Tex. 2017) (enjoining proposed amendments to the Texas administrative code); Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, 194 F. Supp. 3d 818, 822-23 (S.D. Ind. 2016) (enjoining fetal tissue disposition provisions pending resolution of litigation).
28 Wagner, supra note 27, at 811.
infectious disease, prompted federal regulation. Subsequently, Congress passed the Medical Waste Tracking Act (‘‘MWTA’’), thereby establishing a two-year program to study medical waste and determine the necessary contours of federal regulation. Additionally, the MWTA provided an expansive definition of medical waste and mandated its tracking from cradle to grave. Upon its expiration in 1992, however, the MWTA had largely proved ineffective in regulating medical waste. Nevertheless, federal regulation spurred states to implement their own regulatory frameworks for treatment and disposal of medical waste. Although numerous federal agencies have limited regulatory authority over medical waste today, the primary level of regulation remains among the states.

No uniform definition exists as to what constitutes medical waste. Several states adopted the MWTA’s definition of medical waste as “any solid waste which is generated in the diagnosis, treatment, or immunization of human beings or animals, [or] in research pertaining thereto.” Other states’ definitions differ greatly from this language and from each other. On a rudimentary level, medical waste is

32 See id.
34 See Coon & Gilberg, supra note 33, at 1110, 1114 (explaining that many states had enacted their own regulatory frameworks, and that state programs are an ‘‘indirect benefit[] of the MWTA demonstration program’’); Gilman, supra note 27 (“[T]he MWTA resulted in stricter laws and regulations for the disposal of medical wastes in state and local governments.”).
37 42 U.S.C. § 6903(40) (2012); see Jensen, supra note 31, at 22; see, e.g., N.Y. COMP. CODES R. & REGS. tit. 10 § 70-1.2 (2017) (“Regulated medical waste’ shall mean waste generated in diagnosis, treatment or immunization of humans or animals in research pertaining thereto . . . .”).
38 Compare 6 COLO. CODE REGS. § 1007-2-1.2 (2017) (defining medical waste as
potentially infectious waste material generated by healthcare facilities, including but not limited to: bloodied bandages, discarded surgical gloves, removed body organs, discarded needles, and cultures of infectious agents. Pathological waste, a subset of medical waste, consists of recognizable human or animal body parts. It is this wide variation in statutory definition that makes providing an estimate of the amount of medical waste generated annually in the United States nearly impossible.

Medical waste generators utilize several methods to dispense with hazardous material safely. Medical waste can be incinerated, converting the discarded material into ash, flue gas, and heat. Incineration is valued because it decreases the volume of medical waste deposited into landfills considerably. Autoclaving, in comparison, uses pressurized steam to eliminate the biohazard presented by medical waste, rendering it suitable for disposal in a landfill. Under certain circumstances, medical waste may even be discarded into sanitary landfills directly or discharged into the sewer system. Until the 1990s, incineration was a prevalent method of medical waste disposal. With rising public awareness of toxic

“any infectious, pharmaceutical or trace chemotherapy waste”), with ALASKA ADMIN. CODE tit. 18, § 60.990(78) (2017) (defining medical waste as “laboratory waste . . . pathological wastes . . . selected isolation waste”).


41 See Deliganis & Calandrillo, supra note 36, at 173; Young, supra note 29, at 86.

42 This paragraph outlines only the most prevalent methods utilized by medical healthcare facilities. See generally WORLD HEALTH ORG., SAFE MANAGEMENT OF WASTES FROM HEALTH-CARE ACTIVITIES 103-34 (Yves Chartier et al. eds., 2d ed. 2014) (describing the available treatment technologies for medical waste).


emissions, however, most healthcare facilities now use alternative methods of disposal or send medical waste to centralized private incinerators.  

B. Final Disposition of Fetal Remains

Abortions produce a significant amount of discarded biological matter. In 2011, U.S. healthcare providers performed an estimated 1.06 million abortions. The U.S. Centers for Disease Control and Prevention estimates that ninety-one percent of these abortions occurred within the first thirteen weeks of gestation, during which the embryo develops into a 0.81 ounce fetus nearly three inches in length. When a woman in the twelfth week of gestation undergoes an abortion, the abortion provider removes an average of sixty milliliters of fetal tissue, approximately the size of a 5-hour ENERGY Shot. Following the removal of the fetal matter, the abortion provider then transfers the tissue to third party researchers or disposes of it pursuant to state law.

While the regulatory frameworks governing fetal tissue disposal vary, many jurisdictions understand fetal tissue to be categorically the same as other forms of medical waste. Typically, healthcare facilities

48 See EPA, supra note 27.

49 GUTTMACHER INST., supra note 2, at 1.

50 See Average Fetal Length and Weight Chart, Babycenter, http://www.babycenter.com/my/a1004000/average-fetal-length-and-weight-chart (last visited July 15, 2017); Karen Pazol et al., Abortion Surveillance — United States, 2011, 63 MMRW Surveillance Summaries, no. 11, Nov. 28, 2014, at 1, https://www.cdc.gov/mmwr/pdf/ss/ss6311.pdf (“In 2011, most (64.5%) abortions were performed by ≤8 weeks' gestation, and nearly all (91.4%) were performed by ≤13 weeks' gestation.”).


contract with private medical waste services to dispose of discarded fetal matter. These services then treat the fetal tissue alongside other types of pathological waste in accordance with state law. For instance, prior to the passage of the new agency rule in 2016, Texas permitted fetal remains and other medical waste to be: (1) incinerated followed by deposition of the residue in a sanitary landfill; (2) grinded and discharged into a sanitary sewer system; (3) interred; (4) disinfected with steam followed by interment; (5) disinfected with moist heat followed by deposition in a sanitary landfill; (6) disinfected with chlorine, macerated, and deposited in a sanitary landfill; or (7) disposed by an approved alternate treatment process. This Texas provision, by no means representative of how all states regulate fetal tissue, demonstrates a broad range of permitted disposal practices.

In contrast, the majority of states regulate fetal tissue disposal more narrowly. For example, some states allow for cremation, interment, or incineration of fetal material. Others merely permit interment or incineration. Only three states, however, mandate the forced choice.


57 See, e.g., MICH. COMP. LAWS ANN. § 333.2836 (2017) (“All fetal remains resulting from abortions shall be disposed of by interment or cremation . . . or by incineration by a person other than a cemetery registered under the cemetery regulation act . . . .”); N.D. ADMIN. CODE 33-03-02-05 (2017) (“Disposal of a nonviable fetus in a humane fashion shall consist of incineration, burial, or cremation.”); S.D. CODIFIED LAWS §§ 34-25-32.4 (2017) (“Any hospital, clinic, or medical facility in which abortions are induced or occur spontaneously . . . shall arrange for the disposal of the remains by cremation, interment by burial, or by incineration . . . .”).

58 See, e.g., CAL. HEALTH & SAFETY CODE § 7054.3 (2017) (“[A] recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration.”); MONT. CODE ANN. § 75-10-1005 (2017) (“Fetal remains or recognizable body parts other than teeth must be disposed of by incineration or interment.”); N.M. CODE R. § 20.9.8.13 (2017) (“Human fetal remains, as defined by the state medical investigator, when measured to be 500 grams or greater, shall be disposed by incineration or interment.”); UTAH ADMIN. CODE r. 315-316-5 (2017) (“Infectious waste consisting of recognizable human anatomical remains
between interment and cremation, rendering incineration unavailable for fetal remains.\(^{59}\)

The difference between incineration and cremation is not facially apparent. According to the Cremation Association of North America, cremation is “the mechanical and/or thermal or other dissolution process that reduces human remains to bone fragments.”\(^{60}\) Similarly, the Environmental Protection Agency defines incineration as “the process of burning hazardous materials at temperatures high enough to destroy contaminants.”\(^{61}\) Evidenced by their respective definitions, both processes employ high temperatures to combust organic material. Cremation, however, often functions as a funeral or post-funeral rite, thereby implicating religious traditions and deeply held personal beliefs.\(^{62}\) During the cremation process, a corpse is placed in an individual container and burned for two to three hours with identification of the remains carefully monitored throughout.\(^{63}\) The resulting bones and fragments are pulverized in a cremulator and poured into a plastic container or urn.\(^{64}\) Conversely, medical waste management companies incinerate medical waste in large, indiscrete quantities.\(^{65}\) Medical incineration combustion rates vary from 75 to 6,500 pounds per hour.\(^{66}\)


\(^{64}\) Kim, supra note 63.

\(^{65}\) See Veilla E. Matee & Samwel V. Manyele, Performance of a Large-Scale Medical Waste Incinerator in a Referral Hospital, 7 ENGINEERING 676, 680 (2015) (“The total waste incinerated ranged between 823 and 1018 kg/day with an average of 945 kg/day or 118.1 kg/h for daily operation of 8 hours.”).

\(^{66}\) See ENVTL. PROT. AGENCY, AIR EMISSIONS FACTORS AND QUALIFICATIONS: MEDICAL WASTE INCINERATION 2.3-1 (1993), https://www3.epa.gov/tnn/chief/ap42/ch02/final/c02s03.pdf.
C. Humane and Sanitary Disposal: City of Akron

The Supreme Court has addressed the constitutionality of a fetal disposal law in only one instance to date: *City of Akron v. Akron Center for Reproductive Health, Inc.*\(^{67}\) There, three abortion clinics and a physician brought suit challenging the validity of a 1978 Akron abortion ordinance.\(^{68}\) The ordinance, in part, required abortion providers to guarantee that fetal remains were disposed of in a “humane and sanitary manner.”\(^{69}\) The ordinance gave no further instruction as to which disposition methods met this standard.\(^{70}\) In the lower proceedings, the physician plaintiff argued that the relevant section of the Akron ordinance was unconstitutionally vague in that it failed to give him fair notice of the criminally proscribed behavior.\(^{71}\)

Upon review, the Supreme Court affirmed the Sixth Circuit’s invalidation of the provision, finding the phrase “humane and sanitary” to be im-permissibly vague as to whether it mandated the burial of an aborted fetus.\(^{72}\) Accordingly, the Court held that the ordinance violated the Due Process Clause of the Fourteenth Amendment because it failed to give appropriate notice to abortion providers as to whether and when their actions triggered criminal liability.\(^{73}\) In so holding, the Court explicitly recognized a legitimate government interest in “proper disposal of fetal remains.”\(^{74}\) The Court gave no further insight as to the contours of the state interest in proper disposition beyond its existential legitimacy.

II. FETAL DISPOSAL LAWS VIOLATE THE DUE PROCESS CLAUSE

A. Fetal Disposal Laws Are Not Rationally Related to a Legitimate Government Interest

In 2016, Planned Parenthood of Indiana and Kentucky (“PPINK”) challenged the constitutionality of Indiana House Enrolled Act No. 1337 (“HEA 1337”) in the Southern District of Indiana.\(^{75}\) Prior to HEA

\(^{67}\) 462 U.S. 416 (1983).

\(^{68}\) See id. at 421-25.

\(^{69}\) Id. at 424.

\(^{70}\) See id. at 451-52.


\(^{72}\) City of Akron, 462 U.S. at 451.

\(^{73}\) Id. at 451-52.

\(^{74}\) See id. at 452 n.45.

\(^{75}\) Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, 194 F. Supp. 3d 818, 822
1337, Indiana women could personally dispose of the fetal material resulting from a pregnancy less than twenty weeks post-fertilization, or in the alternative, the medical facility could dispose of it as pathological waste. HEA 1337 requires fetal tissue to be categorized as distinct from other types of medical waste and consequently mandates healthcare facilities to dispose of fetal remains by way of interment or cremation exclusively. HEA 1337 also reserves the right for women to assume complete responsibility for final disposition. In its complaint, PPINK argued that by treating the fetal tissue “differently, for purposes of disposal, than other medical material,” HEA 1337 violated its right to due process under the Fourteenth Amendment. The Southern District of Indiana found the alleged violation to be a “close call” but ultimately awarded the preliminary injunction, finding PPINK likely to prevail on the merits of its due process claim.

The district court in Planned Parenthood v. Commissioner conducted rational basis review to determine the constitutionality of Indiana’s fetal disposal law under the Due Process Clause of the Fourteenth Amendment. Both PPINK and the State of Indiana conceded that fetal disposal laws do not impinge upon a fundamental right. State regulation of non-fundamental rights is not subject to the heightened standard of strict scrutiny; rather, these regulations need only pass muster under rational basis review, or be rationally related to a legitimate government interest.

The rhetoric put forth by proponents of fetal disposal laws sheds light on the likely government interest at stake. For example, upon

(S.D. Ind. 2016).


77 Compare IND. CODE § 16-41-16-5 (2015), with IND. CODE § 16-41-16-5 (2016) (inserting language explicitly excluding aborted or miscarried fetuses from the definition of “pathological waste”).


79 See id.


81 Planned Parenthood, 194 F. Supp. 3d at 823.

82 Id. at 831-34.

83 Id. at 831.

signing what he christened a “comprehensive pro-life measure,” former Indiana Governor Mike Pence praised HEA 1337 as “ensuring the dignified final treatment of the unborn.”

A spokeswoman on behalf of Texas Governor Greg Abbott struck a similar chord when stating that Texas’s “proposed rule changes affirm the value and dignity of all life.”

State Representative Robert McCollie introduced Ohio House Bill 417 as “ensuring that the lives of aborted infants are treated with dignity.” Similarly, in Planned Parenthood v. Commissioner, the State of Indiana articulated multiple formulations of its interest in mandating interment or cremation: (1) “to treat fetal remains with the same dignity as other human remains,” (2) “promoting respect for human life by ensuring proper disposal of fetal remains,” and (3) “ensuring that fetal remains be treated with humane dignity.”

These descriptive parallels reveal the common origin of U.S. fetal disposal laws: the Unborn Infants Dignity Act (“UIDA”). Americans United for Life, a preeminent pro-life public interest law firm and advocacy group, drafted the model legislation to “assist states in ensuring that every mother of a deceased unborn infant is given the opportunity to ensure that her infant is treated with dignity and respect.” Clearly at issue in the UIDA is honoring the passing of the unborn, whose innate worth necessitates that they should be treated like persons under the law. For champions of fetal disposal laws, interment or cremation are the only methods of humane disposal.


88 Planned Parenthood, 194 F. Supp. 3d at 832.


90 Id. at 2.

91 Cf. id. at 3, 8 (including model language expressing that only interment or cremation are viable options to afford deceased “unborn infants” the same respect and
Central to the abortion debate is the extent to which a fetus constitutes a person under the Fourteenth Amendment. Pro-choice advocates argue that categorizing the fetus as a person will lead to the prioritization of fetal rights over and against the mother’s constitutional right to privacy. Alternatively, fetal personhood, or the idea that zygotes and embryos are legal persons subject to the protections and benefits of the law, frequently serves as the ideological underpinning of anti-choice legislation. Fetal disposal laws appear to be predicated on this very concept.

Fourteenth Amendment jurisprudence indicates the extent to which treating the unborn as persons may constitute a legitimate governmental interest. In its prohibition against the deprivation of life, liberty, or property, without due process of law, the Fourteenth Amendment limits protection to “persons.” Yet, the Constitution sets forth no framework for defining personhood. Nevertheless, determining what exactly is meant by the term is important because...
this categorical designation delineates what entities and which of their activities are entitled to due process under the Constitution.98 There is ample evidence to suggest that the Framers intended “person” to, at a minimum, encompass all human beings.99 Various Supreme Court decisions confirm this understanding.100 In Yick Wo v. Hopkins,101 for example, the Supreme Court struck down a San Francisco ordinance that required laundries in wooden buildings to receive a permit from the city’s Board of Supervisors. Persons of Chinese descent owned over 200 laundries in the city, yet the Board of Supervisors had issued not one permit to a Chinese laundry owner.102 In reasoning that the protections of the Fourteenth Amendment “are universal in their application . . . without regard to any differences of race, of color, or of nationality,” the Court found Chinese nationals to be “persons” under the Equal Protection Clause.103 The Court’s Fourteenth Amendment jurisprudence has explicitly affirmed other groups within this constitutional designation: incompetent persons,104 nonmarital children,105 prisoners,106 and undocumented schoolchildren,107 to name a few.

Although all human beings likely qualify as constitutional persons, there is no jurisdiction in the United States that treats prenatal entities as persons for purposes of constitutional protection. Two states have enacted statutory language expressing that life begins at conception.108 These laws, however, contain a provision rendering them subject to


100 See Kelly J. Hollowell, Defining a Person Under the Fourteenth Amendment: A Constitutionally and Scientifically Based Analysis, 14 Regent U. L. Rev. 67, 74-77 (2002).

101 118 U.S. 356, 374 (1886).

102 Id. at 362.

103 Id. at 369.


the Constitution and Supreme Court precedent. Similarly, no federal act has defined a fetus as a constitutional person. Therefore, at this time, constitutional protection does not extend to the unborn.

Despite this, the pro-life movement points to various federal and state laws that appear to be premised on the notion of fetal personhood. Some states recognize a wrongful death claim where a tortfeasor’s acts cause the death of a fetus. Others criminally prohibit fetal homicide, thereby recognizing the unborn child as a potential victim. In 2016, Utah passed the first fetal pain bill, requiring doctors to administer anesthesia to a fetus aborted at twenty weeks of gestation. Many consider the Unborn Victims of Violence Act of 2004 to be the first step toward federal recognition of fetal personhood. To some extent, these laws afford fetuses the same privileges and protections as postnatal human beings. Mere analogous treatment under the law, however, does not in itself convey constitutional personhood onto fetuses.

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Under the Supremacy Clause, the Supreme Court has final say on the matter. In Roe v. Wade, the Supreme Court rejected Texas’s claim that a “fetus is a ‘person’ within the language and meaning of [the Constitution].” The Court acknowledged that although the Constitution provides no definition of personhood, in each of its appearances “person” denotes postnatal application. Additionally, the Court identified inconsistencies between the premise of fetal personhood and contemporaneous abortion statutes. In holding that the right to privacy afforded by the Due Process Clause encompasses the right to terminate a pregnancy prior to viability, the Roe Court declined to extend constitutional protections to the unborn.

As fetuses are not constitutional persons, states do not have a legitimate interest in affirming the human-like dignity of the unborn. The Southern District of Indiana in Planned Parenthood v. Commissioner arrived at this very conclusion when considering Indiana’s interest in mandating interment or cremation of fetal remains. The district court reasoned, “if the law does not recognize a fetus as a person, there can be no legitimate state interest in treating an aborted fetus the same as a deceased human.” Moreover, the court rejected Indiana’s other purported interest, showing respect for human life, because such an interest is only legitimate while the life of the fetus is still a potentiality.

These conclusions must be reconciled with City of Akron’s explicit affirmation of proper disposal of fetal remains as a legitimate governmental interest. Undoubtedly, the state’s ability to promote public health encompasses the ability to regulate fetal disposal akin to medical waste disposal. Human anatomical waste, comparable to

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115 See Cooper v. Aaron, 358 U.S. 1, 18-19 (1958) (affirming that the federal judiciary’s interpretation of the Constitution is the supreme law of the land and that governmental officials must defer to its interpretation).


117 Id. at 156-58.

118 See id.

119 Id. at 158.

120 Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, 194 F. Supp. 3d 818, 832 (S.D. Ind. 2016).

121 Id.

122 See id.


other forms of pathological waste, presents a risk of infection to those it may come into contact with during removal, transport, and disposal. Accordingly, the government’s interest lies in the minimization of this risk for patients, visitors, medical workers, transportation personnel, and the public at-large. The constitutional problem arises when fetal disposal laws single out fetal remains and regulate their disposal differently than general pathological waste.

Fetal disposal laws' treatment of aborted and miscarried fetal matter as distinct from other pathological waste products is irrational. The World Health Organization defines pathological waste as human tissues, organs or fluids, body parts, fetuses, and unused blood products. Similarly, the International Committee of the Red Cross enumerates fetuses as an example of pathological waste entailing risk of infection together with tissue, placentas, removed organs and limbs, and laboratory animals. These definitions illustrate how the medical community understands fetal remains not to be notably unique, but to be substantially similar to other forms of medical waste in terms of hazard and treatment.

In fact, the medical community understands fetal matter to pose the same risk of contamination as other forms of pathological waste. This shared risk is likely the reason why many states treat fetal remains as pathological or infectious waste.

Fetal disposal laws do not further the state interest in public health and safety. A disposal method “is effective if it inactivates or kills a...
significant number of the microorganisms that can cause infection." Apart from the cultural, ethical, and aesthetic factors influencing the disposal methods permitted by a particular state, it is clear that a wide variety of methods are effective for treating pathological matter and any subset thereof. Thus, disposal methods designated for pathological waste sufficiently eliminate the risk of infectious disease posed by fetal tissue. To the extent fetal remains pose no greater risk than general pathological waste, fetal disposal laws fail to reasonably relate to the government's interest in public health and thus violate the Due Process Clause of the Fourteenth Amendment.

Moreover, the irrationality of HEA 1337 goes beyond mere statutory discrimination of fetal remains. HEA 1337 allows abortion patients to assume complete responsibility for their fetal remains. Should a woman so choose, HEA 1337 does not mandate that she then dispose of the fetal matter by way of interment or cremation. Yet, fetal remains pose the same risk of infection regardless of whether they are within the possession of an individual woman or an abortion provider. Accordingly, any statutory distinction regarding fetal disposal in furtherance of public health must extend to whoever is providing for final disposition without exception. In carving out an exception to its mandate of interment or cremation for individual women, Indiana's fetal disposal law fails to promote public health.

B. Fetal Disposal Laws Constitute an Undue Burden on Abortion Access

The day after the Southern District of Indiana blocked enforcement of HEA 1337, abortion providers challenged Louisiana's fetal disposal


135 These methods include, but are not limited to the following: incineration, cremation, interment, steam treatment technologies, chemical disinfection, alkaline digestion, aerobic composting, promession, and anaerobic digestion. See Int'l. Comm. Red Cross, supra note 39, at 59; World Health Org., supra note 42, at 106-47.

136 Proponents of fetal disposal laws have not put forth any evidence suggesting disposal methods "used by abortion providers to dispose of fetal tissue . . . are less safe or not optimal for public health and safety." Alexa Ura, Sharp Disagreements at Fetal Remains Hearing, Tex. Trib. (Aug. 4, 2016, 2:41 PM), https://www.texastribune.org/2016/08/04/sharp-disagreements-fetal-remains-hearing/.


138 Id.
law in June Medical Services v. Gee.\textsuperscript{139} Prior, the Louisiana Department of Health and Hospitals (“DHH”) promulgated rules regarding final disposition, exempting “fetal remains” from the statute requiring interment or cremation for “human remains.”\textsuperscript{140} In practice, this exclusion permitted health facilities to dispense with the aborted material in the same manner as medical waste.\textsuperscript{141} Louisiana House Bill 815 (“HB 815”), however, requires “each physician who performs or induces an abortion which does not result in a live birth” to ensure that “the remains of the child are disposed by interment or cremation.”\textsuperscript{142} In their complaint, the abortion providers argued that Indiana’s mandate violates the Due Process Clause of the Fourteenth Amendment by imposing an undue burden on a woman’s right to terminate a pregnancy prior to viability.\textsuperscript{143}

In affirming the central tenets of Roe, Planned Parenthood v. Casey abandoned Roe’s rigid trimester framework in favor of an undue burden standard.\textsuperscript{144} Under Casey, a statute is unconstitutional if it places “a substantial obstacle in the path of a woman’s choice,” even if enacted in furtherance of a valid state interest.\textsuperscript{145} That is, an unnecessary health regulation that has “the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion” imposes an undue burden on a woman’s right to privacy.\textsuperscript{146} A finding of undue burden is shorthand for finding that the regulation violates the Due Process Clause of the Fourteenth Amendment.\textsuperscript{147}

The Supreme Court’s most recent abortion decision clarified the application of the undue burden framework.\textsuperscript{148} Whole Woman’s Health


\textsuperscript{140} See LA. STAT. ANN. § 8:562 (2017).


\textsuperscript{145} Id. at 877.

\textsuperscript{146} Id. at 878.

\textsuperscript{147} See id. at 877 (finding the spousal notification provision to impose an undue burden and thus violate the Due Process Clause of the Fourteenth Amendment).

v. *Hellerstedt* quashed the notion that traditional rational basis deference governs abortion regulations, instead interpreting the undue burden standard as necessitating a balancing test.\(^{149}\) Simply, when analyzing the purpose or effect of an abortion regulation, *Casey* requires the weighing of medical benefits guaranteed by the regulation against the burdens on access to abortion.\(^{150}\) The district court must closely examine the factual basis underlying the state’s interest to determine the extent to which the burden on access is contextually and empirically “undue.”\(^{151}\) Furthermore, when evaluating the benefits and burdens of a regulation, a district court need not merely defer to the factual findings of the legislature nor must it conclude its analysis with a finding of substantive medical benefits.\(^{152}\)

With regard to Louisiana’s HB 815, it is unlikely that a court will determine that its intended purpose is to impede abortion access. From the face of the statute, there is no indication that the Louisiana Legislature sought to make abortion any less accessible.\(^{153}\) Although HB 815 presents extensive findings relating to its prohibition of “post-abortion harvesting,” the statute as written renders these findings inapplicable to the fetal disposal provision.\(^{154}\) The legislative history of HB 815 is similarly unpersuasive of illicit legislative intent.\(^{155}\) Accordingly, since HB 815 provides no facially apparent purpose or illegitimate findings, “one is left to infer that the legislature sought to further a constitutionally acceptable objective.”\(^{156}\) Here, that objective is the promotion of public health and safety, as proper disposal of fetal matter minimizes the risk of infectious disease.\(^{157}\)

In contrast, a more fact-intensive inquiry is necessary to determine the effect of an abortion regulation. To illustrate, *Whole Woman’s Health* relied heavily on the factual findings of the district court, which ultimately informed the Court’s balancing of the benefits and burdens of HB 2, a 2013 Texas house bill that restricted abortion access by

\(^{149}\) See *Whole Woman’s Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2299, 2309 (2016); see also *Planned Parenthood v. *Abbott* (Abbott II)*, 748 F.3d 583, 590, 594 (5th Cir. 2014).  

\(^{150}\) *Whole Woman’s Health*, 136 S. Ct. at 2309.  


\(^{152}\) *Whole Woman’s Health*, 136 S. Ct. at 2310.  


\(^{154}\) See id.  

\(^{155}\) See id.  

\(^{156}\) *Whole Woman’s Health*, 136 S. Ct. at 2310.  

\(^{157}\) See supra notes 124–26 and accompanying text.
requiring clinics to meet hospital-like facility standards. Yet as of now, the practical consequences of the government mandate of interment or cremation remain unknown. Therefore, it is only possible to hypothesize about the effect of fetal disposal laws and determine if they will impermissibly limit women’s access to abortion.

Many predict that fetal disposal laws will lead to an increase in the cost of abortion, an already expensive procedure. At Hope Medical Group for Women, one of a few abortion clinics remaining in Louisiana, medical and surgical abortions start at $550. The price increases to $795 for a second term surgical abortion conducted sixteen weeks after the last menstrual period. These numbers fall relatively close to the national average. As a white Louisiana woman makes an average of $31,586 a year, an early term abortion costs nearly one-fourth of her monthly income, with a second term abortion costing thirty percent. In comparison, an African-American woman

158 See Whole Woman’s Health, 136 S. Ct. at 2311-13 (examining the record evidence giving support to the district court’s opinion that the admitting privileges requirement constituted an undue burden); id. at 2315-18 (examining the record evidence giving support to the district court’s opinion that the surgical center requirement constituted an undue burden).

159 In large part, this is because HEA 1337 and the Texas agency rule change have been temporarily enjoined. See supra note 26 and accompanying text. Additionally, parties to the suit challenging Louisiana’s fetal disposal law have agreed to temporarily postpone HB 815’s enforcement. See June Medical Services v. Gee, CTR. FOR REPROD. RIGHTS (June 13, 2017), http://www.reproductiverights.org/case/june-medical-services-v-gee.


in Louisiana makes an average of only $26,400 a year.165 Thus, an early term abortion costs over one-third of her monthly income, with a second term abortion costing forty percent.166

A rise in abortion price will undoubtedly make it more difficult for some women to obtain an abortion.167 In particular, low-income and minority patients will be vulnerable to price fluctuations.168 This is because many states restrict insurance coverage of abortion procedures in either private plans, plans offered through insurance exchanges, insurance plans for public employees, or some combination thereof.169 Additionally, Congress passed the Hyde Amendment in 1976, thereby excluding federal Medicaid funding for abortions except in the case of rape and incest, or when a pregnant woman’s life is threatened by a physical disorder, illness, or injury.170 Without insurance coverage for abortions, patients must cover the entire expense, with the financial strain presenting an insurmountable hurdle for many women.171

Interment and cremation are considerably more expensive procedures than contracting with third party waste disposal companies to dispense with fetal matter.172 Two companies who


166 Applying current national and state tax rates to the average income of an African-American Louisiana woman, I determined her yearly take-home pay to be $23,507, or $1,959 per month. See id.

167 See Erica Hellerstein & Tara Culp-Ressler, Pricing American Women out of Abortion, One Restriction at a Time, THINKPROGRESS (Feb. 25, 2015), https://thinkprogress.org/pricing-american-women-out-of-abortion-one-restriction-at-a-time-c545c546411f-5r8ld1njn (“And that doesn’t account for the fees that accumulate as a result of the legislative barriers to the procedure, which end up disproportionately burdening women of limited resources and economic means.”).

168 See id.


171 Researchers at the University of California, San Francisco determined that over 4,000 women were unable to obtain an abortion in 2008 because they could not afford the cost of travel or the procedure itself before the gestational age cutoff. See Ushma D. Upadhyay et al., Denial of Abortion Because of Provider Gestational Age Limits in the United States, 104 Am. J. Pub. Health 1687, 1692 (2014); see also Hellerstein & Culp-Ressler, supra note 167; Katie Klabusich, Louisiana Becomes Latest Front in National Battle over Abortion Rights, TRUTHOUT (July 20, 2016), http://www.truth-out.org/news/item/36897-louisiana-becomes-latest-front-in-national-battle-over-abortion-rights.

172 See DePillis, supra note 160.
operate along the Gulf Coast charge $50 to $100 for a weekly pick up of a twenty-eight gallon box of medical waste.\textsuperscript{173} In contrast, direct cremation, or cremation without a funeral or memorial service, starts at $695 per adult body in Louisiana but can go much higher.\textsuperscript{174} Interment is the pricier option of the two, with its price largely dependent on a number of factors: embalming and body preparation, grave space, cost to dig grave, headstone, funeral ceremony and viewing, and casket type.\textsuperscript{175} Nevertheless, an immediate burial, or interment without a ceremony, can run over $3,000, almost five times the price of direct cremation.\textsuperscript{176}

Someone will need to absorb the increased cost resulting from government mandate of interment or cremation. At a minimum, abortion providers will have to implement new administrative and logistical procedures while continuing to contract with medical treatment companies for the remaining medical waste.\textsuperscript{177} Medical facilities searching for crematory and funeral bids have found vendors unwilling to work with them, further driving up overhead expenses.\textsuperscript{178} As abortion clinics already operate under slim margins, providers will likely have to increase the cost of the procedure just to stay in business.\textsuperscript{179} Abortion patients paying out of pocket will experience the increase in price most dramatically.\textsuperscript{180}

\textsuperscript{173} See id.


\textsuperscript{177} Cf. Rebecca Grant, \textit{The Latest Anti-Abortion Trend? Mandatory Funerals for Fetuses}, \textit{Nation} (Oct. 11, 2016), https://www.thenation.com/article/the-latest-anti-abortion-trend-mandatory-funerals-for-fetuses/ (enumerating logistics and added expenses as issues arising from fetal disposal laws); Green, supra note 17 (“The financial burden is going to fall on somebody.”).

\textsuperscript{178} See Grant, supra note 177.

\textsuperscript{179} See Laylan Copelin, \textit{Abortion Debate: Will Bill Close Clinics?}, \textit{Austin Am.-
How much the price of an abortion must increase to constitute a substantial obstacle to abortion access remains unclear. The *Casey* Court concluded that Pennsylvania's twenty-four hour waiting period provision did not impose an undue burden on abortion access despite increased costs and delay of abortions.\textsuperscript{181} Although the Court left open the possibility that “at some point increased cost could become a substantial obstacle,” many jurisdictions have found an increase in cost alone insufficient.\textsuperscript{182} In *Planned Parenthood v. Miller*, for example, the District of South Dakota held that a price increase of sixty dollars per abortion did not impermissibly block access to abortion.\textsuperscript{183} Similarly, in *Cincinnati Women's Services, Inc. v. Taft*, the Southern District of Ohio found that a twenty-five percent increase in the cost of an abortion did not rise to the level of an undue burden.\textsuperscript{184} Few jurisdictions have come out the other way. In *Tucson Women's Clinic v. Eden*, the Ninth Circuit found that because the “individual providers [would] incur tens of thousands of dollars in expenses complying with the scheme,” the abortion regulation imposed a substantial obstacle by increasing the cost of an abortion.\textsuperscript{185}

Proponents of fetal disposal laws argue that any increase in abortion cost will be insignificant and thus easily absorbed by abortion providers.\textsuperscript{186} Admittedly, there is little information about whether the cost of abortion increased in Arkansas or Georgia as a result of their recent enactment of fetal disposal provisions. Whether and to what extent abortion costs will increase as a result of fetal disposal laws is


\textsuperscript{182} Id. at 901.


\textsuperscript{184} Cincinnati Women's Servs., Inc. v. Taft, 466 F. Supp. 2d 934, 946 (S.D. Ohio 2005).

\textsuperscript{185} Tucson Women's Servs., Inc. v. Taft, 379 F.3d 531, 542 (9th Cir. 2004).

unknown. Thus, without more empirical data, it seems unlikely that the abortion providers in June Medical Services will be able to carry their burden of proof with regard to the undue financial burden imposed by HB 815 in Louisiana.

Even if there is little increase in abortion cost resulting from fetal disposal laws, under Whole Woman’s Health, any burdening of abortion access must be weighed against the medical benefits guaranteed by the regulation.\(^{187}\) As demonstrated, government mandate of interment or cremation does not offer public health benefits.\(^{188}\) Because other, less costly disposal options effectively eliminate the possibility of the spread of infection, any burden imposed by fetal disposal laws is seemingly “undue” in light of less burdensome medical waste disposal practices.\(^{189}\) By increasing the cost of an abortion without providing any medical benefit, government mandate of interment or cremation violates the Due Process Clause of the Fourteenth Amendment.

Notably, the plaintiffs in June Medical Services did not concentrate on the undue burden of increased cost; rather, they argued that Louisiana’s fetal disposal law violates a woman’s right to an abortion prior to viability by banning first-trimester medical abortions.\(^{190}\) A medical abortion is a nonsurgical procedure used to terminate a pregnancy up to the first ten weeks of pregnancy.\(^{191}\) During a medical abortion, a patient is given a first dose of an abortion-inducing drug at the clinic but must take a second dose twenty-four to forty-eight hours later at home.\(^{192}\)

In June Medical Services, the plaintiffs maintained that abortion providers cannot comply with HB 815 when administering medical abortions because the “products of conception are passed at home” and then disposed of in a “similar manner as that used during menstruation.”\(^{193}\) The aborted material resulting from medical abortion is typically collected by a sanitary pad and is physically indistinguishable from menstruation at this early of a gestational


\(^{188}\) See supra Part II.A.

\(^{189}\) Id.


\(^{192}\) Id.

period.\textsuperscript{194} HB 815 requires the prescribing physician to then guarantee that the patient disposes of these soiled materials by way of interment or cremation.\textsuperscript{195} This is profoundly unworkable, as the doctor has no control over the disposition of the fetal remains when the patient aborts within the confines of her home. Therefore, by making proper disposal unattainable for women passing fetal material at home, HB 815 criminalizes medical abortion.

The unfeasibility of interment or cremation of medically aborted fetal remains presents another substantial obstacle to abortion access. Many women prefer medical abortion to its alternative as it is noninvasive, highly effective, and can occur within the privacy of one's own home.\textsuperscript{196} In fact, medical abortion accounted for forty-three percent of all abortions performed at Planned Parenthood in 2014.\textsuperscript{197} The advantages of first trimester medical abortions run deeper than mere convenience for some patients. Women with certain physical conditions complicating surgical abortion, as well as women living in highly volatile domestic violence situations, benefit from the choice of medical abortion.\textsuperscript{198} Thus, to the extent that medical abortions are nearly, if not just as effective as surgical abortions, banning medical abortions is an impermissible effect of government mandate of interment or cremation.\textsuperscript{199} In this way, Louisiana's fetal disposal law creates a substantial obstacle to pre-viability abortions in direct violation of the Due Process Clause of the Fourteenth Amendment.


\textsuperscript{199} Compare Mary Fjerstad et al., Effectiveness of Medical Abortion with Mifepristone and Buccal Misoprostol Through 59 Gestational Days, 80 CONTRACEPTION 282, 285 (2009) (finding buccal misoprostol-mifepristone regimen to be 98.3 percent effective for women with gestational ages below sixty days and oral misoprostol-mifepristone with a success rate of 96.8 percent), with Medical Versus Surgical Abortion, UCSF MED. CTR., https://www.ucsfhealth.org/education/medical-versus_surgical-abortion/ (last visited July 11, 2017) (presenting the effectiveness rate of surgical abortion as ninety-eight percent).
C. Fetal Disposal Laws Impinge on the Constitutional Right to Privacy

Bypassing the legislative process, the Texas Department of State Health Services (“DSHS”) quietly proposed new agency rules regarding fetal disposal in July of 2016.\(^{200}\) Prior, DSHS enumerated seven legal means of fetal disposal.\(^{201}\) Published without announcement in the Texas Register, the suggested change distinguishes between pathological waste and fetal tissue by mandating interment or cremation exclusively for the latter.\(^{202}\) After a highly contentious public comment period, DSHS made no substantive revisions to the proposed rule.\(^{203}\) Shortly before taking effect, a federal judge in the Eastern District of Texas temporarily enjoined its enforcement.\(^{204}\) Despite the block, Texas Governor Greg Abbott signed Senate Bill 8, a reformulation of the DSHS-suggested fetal burial rule, in June of 2017.\(^{205}\)

Fetal disposal laws raise a red flag for pro-choice advocates with regard to their potential applicability to miscarriages that occur in non-clinical settings.\(^{206}\) As written, Texas’s mandate of interment or cremation governs all “fetal tissue,” a subcategory of “the products of spontaneous or induced human abortion.”\(^{207}\) Thus, the rule appears to regulate both electively terminated fetal matter and spontaneously aborted fetal matter, or miscarriages.\(^{208}\) A joint letter penned to DSHS by the Texas Medical Association and Texas Hospital Association articulates the resultant anxiety most powerfully: “Would the rules, if adopted as proposed, require a woman who experiences spontaneous miscarriage to carry the fetal tissue to a physician’s office . . . for an

\(^{200}\) 41 Tex. Reg. 7659 (Sept. 30, 2016).

\(^{201}\) See supra note 56 and accompanying text.

\(^{202}\) 41 Tex. Reg. 7663-64 (Sept. 30, 2016). The proposed rule permits fetal remains to be disposed of by way of: “incineration followed by interment,” “steam disinfection followed by interment,” “interment,” or “cremation.” Id. at 7664.

\(^{203}\) See id.


\(^{207}\) 41 Tex. Reg. 7664 (Sept. 30, 2016).

\(^{208}\) See id.
For many, this reality constitutes an extreme invasion of privacy.\textsuperscript{210} During Texas’s first public comment period, DSHS spokeswoman Carrie Williams denied this potential absurdity,\textsuperscript{211} yet Supreme Court decisions indicate that the collective concern over fetal disposal laws’ applicability to miscarriages is valid. The Constitution provides no textual hook for a constitutional right to privacy.\textsuperscript{212} In \textit{Griswold v. Connecticut}, however, the Supreme Court invalidated a Connecticut statute banning contraception use by married couples on the basis of a “zone of privacy created by several fundamental constitutional guarantees.”\textsuperscript{213} The Court concluded that when the Fourteenth Amendment incorporated various provisions of the Bill of Rights against the States, it also incorporated specific penumbras, including the right to privacy within marital relations.\textsuperscript{214} Similarly, \textit{Lawrence v. Texas} struck down a Texas law criminalizing homosexual relations on the premise that “liberty protects the person from unwarranted government intrusions into a dwelling or other private places.”\textsuperscript{215}

The Supreme Court has found the constitutional right to privacy to encompass nearly all phases of reproduction and childrearing. Just as \textit{Griswold} concluded that the right to privacy protects contraception use by married couples, \textit{Roe} explicitly extended this to abortion.\textsuperscript{216} Similarly, \textit{Eisenstadt v. Baird} found the right to privacy to protect individual decisions about “whether to bear or beget a child.”\textsuperscript{217} In \textit{Meyer v. Nebraska}\textsuperscript{218} and \textit{Pierce v. Society of Sisters},\textsuperscript{219} the Supreme Court posited the right of privacy as including the parental right to


\textsuperscript{210} See Reagan, supra note 160.


\textsuperscript{212} See generally U.S. CONST.


\textsuperscript{214} See id. at 486.


\textsuperscript{218} 262 U.S. 390 (1923).

\textsuperscript{219} 268 U.S. 510 (1925).
direct the upbringing and education of children. Accordingly, miscarriage, an intermediate step between conception and childbirth, would seem to fall within the purview of the constitutional right to privacy.

Like contraception use or sexual intimacy, miscarriage is profoundly personal.220 According to a 2013 study by researchers at the Albert Einstein College of Medicine, the public believes that miscarriages occur in five percent or less of all pregnancies.221 In reality, miscarriage is the most common pregnancy complication, occurring in ten to twenty-five percent of all clinically recognized pregnancies.222 This widespread misconception about the prevalence of miscarriage may be due in part to the “shame and silence” shrouding miscarriage in the public eye.223 A misplaced sense of personal responsibility and guilt lead many women to carry the burden of pregnancy loss alone.224

For most women, it is not medically necessary that a miscarriage occur in a clinical setting.225 Many women choose to pass the fetal material at home and do so safely.226 Furthermore, a significant number of women miscarry before they even know they are pregnant, and some do not learn of their miscarriage until a subsequent prenatal visit.227 For these women, miscarrying in a clinical setting is not an option should they even want it. When a complication arises, like significant bleeding without effective passage of tissue or signs of

223 See Bardos et al., supra note 221, at 1313-15.
infection, doctors recommend seeking consultation.\textsuperscript{228} Otherwise, miscarriages do not require any medical treatment.\textsuperscript{229}

Were fetal disposal laws to apply to at-home miscarriages, a Texan woman could choose to self-inter or transfer the material to a medical provider, funeral home, or crematorium. Regardless of the choice, the woman will likely need to comply with state laws regarding final disposition of human remains. Hypothetically, she would need to file a Report of Death form with the local registrar of vital statistics within twenty-four hours.\textsuperscript{230} This form requires the name, sex, and date of birth of the deceased.\textsuperscript{231} Importantly, this information becomes public record after the twenty-fifth anniversary of the date of death.\textsuperscript{232} Until then, the record is only available to immediate family members with proper identification.\textsuperscript{233} This Report of Death would also serve as the transit permit for the miscarried fetus, allowing the woman to then transport the remains to a service provider or final disposition location of her choosing.\textsuperscript{234} Within ten days of the fetal death and before final disposition, the woman would also need to file a death certificate with the local registrar.\textsuperscript{235} Finally, if utilizing a funeral home for final disposition, the funeral home must keep a record of the decedent’s name, the place of death, and the date of interment or disposal.\textsuperscript{236}

State regulation of miscarried fetal remains offends notions of constitutional privacy as guaranteed by the Due Process Clause of the Fourteenth Amendment. By compelling women to undergo the aforementioned administrative procedures, fetal disposal laws force women to reveal this private incident to numerous state officials. This subjects women to public scrutiny as to the timing and cause of death.

\begin{itemize}
\item \textsuperscript{228} See Krissi Danielsson, Complications After a Miscarriage, \textsc{Verywell}, https://www.verywell.com/possible-complications-after-a-miscarriage-2371525 (last updated July 2, 2017).
\item \textsuperscript{230} See \textsc{25 Tex. Admin. Code} § 181.2 (2017); see also Jessica Gillespie, \textsc{Texas Home Funeral Laws}, \textsc{Nolo}, http://www.nolo.com/legal-encyclopedia/texas-home-funeral-laws.html (last visited July 13, 2017).
\item \textsuperscript{232} See \textsc{Death Registration Frequently Asked Questions}, \textsc{Tex. Dept. State Health Servs.}, http://www.dshs.texas.gov/vs/faq/death.shtm (last visited July 13, 2017).
\item \textsuperscript{233} Id.
\item \textsuperscript{234} See \textsc{25 Tex. Admin. Code} § 181.2 (2017).
\item \textsuperscript{235} See \textsc{Tex. Health & Safety Code Ann.} § 193.003 (2017).
\item \textsuperscript{236} See id. § 193.009.
\end{itemize}
of the fetus, although miscarriage is natural and unpreventable.\footnote{Cf. Miscarriage, MEDLINE PLUS, https://medlineplus.gov/ency/article/001488.htm (last visited July 13, 2017) (defining miscarriage as a “naturally occurring event” that causes spontaneous loss of a fetus before the twentieth week of pregnancy).} To avoid this stigmatization, women may avoid seeking out medical advice against their best interest.\footnote{Cf. Sian Ferguson, 6 Loving Ways to Practice Self-Care After a Miscarriage, EVERYDAY FEMINISM (Sept. 15, 2015), http://everydayfeminism.com/2015/09/self-care-after-miscarriage/ (“Plenty of people avoid medical care for fear of the stigma relating to miscarriage: They’re afraid they will be shamed or judged for having a miscarriage . . . .”).} Furthermore, after twenty-five years, any person may request information regarding the death of the fetus.\footnote{See supra notes 233–38 and accompanying text.} Allowing miscarriage records to become public record subjects women to prolonged shame and humiliation by leaving a permanent paper trail to personal hardship.

Arguably, the Due Process Clause of the Fourteenth Amendment should afford even greater protection against unwarranted governmental regulation of miscarriage. Unlike contraceptive use or abortion, miscarriage by definition is not a choice.\footnote{See Kristeen Moore & Jacquelyn Cafasso, Miscarriage, HEALTHLINE (Dec 22, 2016), http://www.healthline.com/health/miscarriage.} In light of the constitutional right to privacy protecting decisions about whether and how to have a child, the natural and unintended consequences of such decisions should warrant similar constitutional protection. By this logic, mandating interment or cremation for miscarried fetal remains is impermissible state regulation of private matters.

III. A CONSTITUTIONAL ALTERNATIVE: SENSITIVE DISPOSAL GUIDELINES

In failing the most forgiving level of constitutional review, government mandate of interment or cremation emerges irremediable. As demonstrated, states have no legitimate interest in regulating fetal disposal in furtherance of fetal dignity.\footnote{See supra pp. 13-14.} Furthermore, fetal disposal laws bear no rational relation to the advancement of public health.\footnote{See supra pp. 14-15.} Any statutory distinction between the disposal of fetal remains and other forms of pathological waste impinges on the constitutional protections provided by the Due Process Clause of the Fourteenth Amendment.\footnote{See supra pp. 14-23.} In light of these problematic conclusions, it is clear that current fetal disposal laws must be struck down.
It is important to note that this conclusion, without more, fails to meaningfully reflect the religious and personal beliefs held by community members that led to the enactment of fetal disposal laws. Many Americans sincerely believe that life begins at conception. Under this view, fetuses are no different than postnatal human beings. Accordingly, disposing of fetal remains alongside “trash” diminishes the value of human life. The pro-life movement finds current medical waste disposal practices deeply offensive. Such persons often believe that interment and cremation, practices endowed with extensive religious and cultural importance, are the only appropriate methods of final disposition for human beings. In acknowledging the sensitivity surrounding final disposition, some states already statutorily permit parental wishes to be reflected in the disposal of fetal remains.

Although the government cannot mandate interment or cremation in furtherance of fetal dignity, a more equitable solution may be state guidelines regarding sensitive disposal of fetal remains. Other

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244 See, e.g., Micaiah Bilger, Abortion Activists Oppose Dignified Burials of Babies Killed in Abortions, LIFE NEWS.COM (Oct. 11, 2016, 10:33 AM), http://www.lifenews.com/2016/10/11/abortion-activists-oppose-dignified-burials-of-babies-killed-in-abortions/ (positing abortion activists’ outrage at fetal disposal laws as a denial of the scientific fact that “unborn babies are unique, living human beings from the moment of conception”); Burial Shows Reverence for Miscarried Baby’s Body, ELIZABETH MINISTRY INTL. RETREAT & RES. CTR., http://www.elizabethministry.com/files/Burial_Show_Reverence_For_Miscarried_Baby.pdf (“The rituals, memorials, burial service and other support offered will provide families the opportunity to remember their child. Yet, few faith communities honor the unborn child, who died through miscarriage, with a proper Christian burial.”).


247 See Paprocki, supra note 186.


249 See, e.g., 210 ILL. COMP. STAT. 85/11.4 (2017) (requiring hospitals to inform mother that she has the right to arrange for burial or cremation); MO. REV. STAT. § 194.378 (2017) (allowing mother the right to determine method of final disposition); H.B. 635, 84th Leg., Reg. Sess. (Tex. 2015) (permitting parents to elect to bury stillborns).
countries recommend sensitive management of fetal tissue. For example, the Human Tissue Authority (“HTA”), an executive agency within the United Kingdom’s Department of Health, provides guidance as to the minimum standard expected for sensitive “disposal of pregnancy remains resulting from pregnancy loss or termination of pregnancy in a clinical setting.” These guidelines recognize that the disposal needs of patients vary and therefore recommend flexibility with regard to the performance of the patient’s individual disposal wishes. Furthermore, the HTA’s recommendations limit the imposition of significant administrative or logistic burdens on abortion providers as to not create an undue burden impeding abortion access. Sensitive disposal may take a variety of forms; however, the HTA’s guidelines illustrate several options that would allow states to affirm the dignity of the unborn without infringing on women’s constitutional rights.

Under the HTA’s recommendations, a woman who decides to electively terminate a pregnancy should know that she has the right to designate the disposal method of the remains within reasonable limit. At a minimum, a woman should be informed that there are legal options available for the final disposition of the fetus. Upon request, the abortion provider should provide information regarding how the facility will dispose of the remains under state law and that the woman may designate an alternative method that aligns with her cultural, religious, or personal beliefs. Nevertheless, many women do not care to be informed about available disposal methods and should be permitted to decline this offer of information. In this way, women who are interested in exercising their disposal rights are able to opt in without interfering with the rights of other women who prefer to refrain from making disposal decisions.

State law should always allow for interment and cremation in addition to the state-approved methods of pathological waste disposal. In doing so, state law will not impermissibly distinguish between fetal remains and pathological waste, but rather permit


253 See id. at 2-3.

254 See id.

255 See id. at 3.

256 See id.

257 See id. at 5-6.
additional disposal methods over the constitutional floor. Interment and cremation, however, must be available only at an additional cost to the individual patient, thereby alleviating the possibility of imposing an undue burden on abortion access by raising the provider’s overall disposal costs. Should a provider be unable to arrange for the requested disposition method, it should allow the woman the opportunity to make her own arrangements pursuant to state law.257

Another HTA recommendation is for “pregnancy remains [to] be subject to a different process from clinical waste.”258 To the extent that fetal remains are indistinguishable from pathological waste in terms of infectious risk, this assertion is irrational and its implementation would thus likely constitute an undue burden.259 Yet, separate storage of fetal remains until final disposition would recognize the legitimacy of conflicting points of view about the nature of fetal material without imposing substantial financial burden on abortion providers. In this way, separate storage could serve as a compromise that respects that statutory distinctions are impermissible but is also sympathetic to the concerns of many women. For abortion providers, separate storage would merely entail placing all aborted material in a single receptacle as is done now. On the other hand, hospitals would face a more substantial obstacle by having to sort general pathological matter and fetal remains into separate bags. This procedural burden would be optional, however, as the hospital has the ultimate choice as to whether or not to comply with the state recommendations of sensitive disposal.

Due to the private nature of non-clinical, spontaneous pregnancy loss, miscarriage is best understood as beyond government regulation.260 With the consult of her doctor, a woman experiencing a miscarriage should dispose of the fetal material practically and in accordance with her personal wishes. The state has no place extending its reach into her home to regulate this disposal, whether by way of sensitive disposal guidelines or by mandate.261 To do so is to violate a woman’s constitutional right to privacy regarding matters profoundly personal.262

257 See id. at 5.
258 Id. at 7.
260 See supra pp. 24-25.
261 See id.
262 See id.
CONCLUSION

In light of the current political climate, pro-choice advocates are preparing for the worst. Their fears are not completely unfounded; during his 2016 campaign, President Donald Trump swore to overturn Roe and return abortion regulation to the states. As Governor of Indiana, Vice President Mike Pence slashed funding for Planned Parenthood while banning women from obtaining an abortion because of the race, gender, or disability of the fetus. Thousands of women rushed to get intrauterine devices after Election Day, concerned that executive order would overturn the provision of the Affordable Care Act that requires insurers to provide contraceptive coverage within Trump’s first 100 days. Furthermore, historically anti-choice Republicans now control a record sixty-eight percent of the ninety-eight partisan state legislative chambers in the nation, in addition to holding the majority in both the House and the Senate. For these reasons, the future of access to low-cost reproductive healthcare is uncertain.


It is improbable, however, that the Trump administration will be able to overturn forty-three-year-old precedent hastily, if at all. While Roe remains in force, the Constitution guarantees practical access to abortion prior to viability. Without significant shifting of the political ideologies of the current Supreme Court justices, the lower courts will continue to apply Casey's undue burden framework when determining the constitutionality of abortion regulations. Moreover, pro-choice advocates stand ready to defend meaningful access to reproductive healthcare.

Pro-choice advocates can attack the fallibility of government mandate of interment or cremation on three distinct bases in the coming months. Without sufficient evidence that current disposal practices fail to eliminate the biohazard presented by fetal remains, the government cannot single out such material by legislating onerous disposal methods. Any imposition of additional costs and

272 See supra Part II.A.
administrative burdens is unjustified, as fetal disposal laws provide no demonstrated medical benefit to women. Furthermore, fetal disposal laws impermissibly reach into the home to police miscarried fetal remains and thus breach constitutional notions of privacy. Government mandate of interment or cremation will not survive judicial review.

273 See supra Part II.B.
274 See supra Part II.C.