Disabling Abortion Bans

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In the aftermath of the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization*, states have rushed to enact restrictive abortion bans, often with vague and narrow health exceptions that disproportionately endanger the lives and well-being of people with disabilities. This Article argues that focusing on the disproportionate impact of these laws on disabled people is a critical strategy for dismantling the broader attack on reproductive freedom. It examines the deficiencies of current health exceptions, critiquing their subjective language, inconsistent application, and failure to account for the complexities of medical emergencies, particularly in the context of disability. This Article highlights the omission of mental health considerations and the clashes between state and federal laws. Furthermore, it explores how these bans exacerbate existing barriers disabled people face when seeking healthcare while ignoring the disproportionately high risks of pregnancy-related complications and maternal mortality among the disability community. Drawing on constitutional arguments, this Article contends that even under rational basis review, these bans lack a legitimate governmental interest and instead perpetuate discrimination by contradicting core disability rights principles of bodily autonomy and self-determination. It explores potential avenues for challenging these laws, including leveraging state constitutional provisions, expanding health exceptions, and protecting abortion providers through statutory presumptions and burden-shifting provisions. This Article emphasizes the importance of moving beyond a purely medicalized framing of abortion rights and toward a more holistic,*

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intersectional vision of reproductive justice that fully includes and empowers the disability community. It concludes with a call for robust coalition-building between the disability rights and reproductive justice movements to drive incremental change and ensure that reproductive autonomy is respected and protected for all.

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INTRODUCTION

For Jenni Miller, a woman in her mid-thirties in Ohio who has rheumatoid arthritis, managing her disability requires taking Methotrexate to reduce inflammation and chronic joint pain.[1] However, the medication carries significant risks if Jenni were to get pregnant.[2] Her doctors not only advised using two forms of contraception while on Methotrexate, which she did, but they also warned her of the potential for grave complications if she accidentally conceived.[3] Ultimately, Jenni decided that she would get an abortion in such a scenario given the likelihood of severe pregnancy issues or even a nonviable fetus.[4]

This challenging but necessary personal decision became clouded by uncertainty when Ohio's legislature implemented a highly restrictive six-week abortion ban[5] in the aftermath of the Supreme Court overturning the constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*.[6] Although the law included a health exception, it provided little reassurance for Jenni since it relied on demonstrating that an abortion was necessary "to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function," an extremely narrow definition that would likely not encompass the health complications she could face with her disability and medication.[7] Faced

[1] NPR Staff, *New Abortion Laws Changed Their Lives. 8 Very Personal Stories,* NPR (June 23, 2023), https://www.npr.org/sections/health-shots/2023/06/23/1183878942/abortion-bans-personal-stories-dobbs-anniversary [https://perma.cc/NU7R-52FY] [hereinafter NPR Staff].

[2] *See id.*

[3] *Id.*

[4] *Id.*

[5] Susan Tebben, *Ohio Abortion Bans on the Way Following Death of Roe,* OHIO CAP. J. (June 24, 2022), https://ohiocapitaljournal.com/2022/06/24/ohio-abortion-bans-on-the-way-following-death-of-roe/ [https://perma.cc/V7ED-4C2R]. The six-week abortion ban in Ohio faced court challenges and ultimately became unenforceable after voters passed a constitutional amendment in November 2023 that allows abortion up to fetal viability. Susan Tebben, *Abortion is Now a Constitutional Right in Ohio. But the Work isn't Done.*, OHIO CAP. J. (Nov. 8, 2023), https://ohiocapitaljournal.com/2023/11/08/abortion-is-now-a-constitutional-right-in-ohio-but-the-work-isnt-done/ [https://perma.cc/YZ2L-CEUV].

[6] Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 231 (2022).

[7] OHIO REV. CODE § 2919.16(F) (2011).

with the stark reality of losing all access to abortion — even if she faced a pregnancy that would endanger her health — Jenni agonized over the terrible predicament she now confronted.[8] Not wanting the government to force her into a dangerous pregnancy against her will, she made the excruciating choice to undergo permanent sterilization through surgical removal of her fallopian tubes.[9] Now forever unable to conceive, this procedure felt to Jenni the sole remaining option to retain some control and agency over her own body and future amidst the rapid erosion of abortion rights in her state.[10]

Tragically, Jenni is far from the only disabled person[11] endangered by abortion bans, especially those who lack meaningful health exceptions. In North Carolina, psychiatrist Dr. Samantha Meltzer-Brody treated a patient with postpartum psychosis, a mental health condition related to bipolar disorder.[12] Postpartum psychosis is often characterized by delusions focused on the infant and, in severe cases, has been linked to infanticide.[13] The symptoms are often excruciating for both the patient and other family members, and there is a strong association between postpartum psychosis and maternal suicide.[14] Eventually, the patient's most acute psychotic symptoms were remitted, but she continued to

[8] NPR Staff, *supra* note 1.

[9] *Id.*

[10] *Id.*

[11] This Article acknowledges the important role language plays in shaping our understanding and perception of disability. It recognizes that ableism can be embedded in language, potentially reinforcing and perpetuating oppression against disabled people. Lydia X. Z. Brown, *Ableism/Language*, AUTISTIC HOYA, https://www.autistichoya.com/p/ableist-words-and-terms-to-avoid.html (last updated Sept. 14, 2022) [https://perma.cc/V23R-DBZP]. Given the diverse language preferences within the disability community, I use both person-first (e.g., "people with disabilities") and identity-first language (e.g., "disabled people") interchangeably throughout the Article. *See generally* Erin E. Andrews, Robyn M. Powell & Kara Ayers, *The Evolution of Disability Language: Choosing Terms to Describe Disability*, 15 DISAB. & HEALTH J. 101328 (2022) (exploring the evolving language preferences among people with disabilities).

[12] Affidavit of Samantha Meltzer-Brody, M.D. at ¶¶ 40–44, SisterSong Women of Color Reprod. Just. Collective v. Georgia (No. 2022CV367796), 2022 WL 3335938 (Ga. Super. Ct. July 23, 2022).

[13] *Id.*

[14] *Id.*

receive ongoing care for bipolar disorder.[15] She then unexpectedly became pregnant again and descended into terrified distress, fearful of relapsing into the same suicidal and infanticidal psychosis that could severely endanger both herself and her new baby.[16] She was further concerned about either stopping her medication during pregnancy and experiencing a worsening of her bipolar disorder or continuing her medication and exposing the fetus to serious risks.[17] Therefore, after carefully weighing the risks, the patient and her husband decided to terminate the pregnancy.[18] Her mental health improved dramatically afterward.[19]

Notably, these events unfolded in North Carolina before the *Dobbs* decision. At that time, abortion was legal in the state up to twenty weeks' gestation, permitting this patient to receive life-preserving care.[20] However, in *Dobbs*' aftermath, North Carolina has instituted radical new restrictions prohibiting abortions entirely after twelve weeks without exceptions for mental health conditions — similar to other states enacting near-total abortion bans.[21] Under this draconian policy, the patient would be denied access to a procedure necessary to save her from the recurrence of months-long postpartum psychosis. Her situation spotlights the failure of lawmakers to account for people's mental health needs in crafting abortion legislation — an unconscionable oversight that will needlessly devastate the lives of many.

These stories spotlight the harsh reality of how ambiguous and narrow exceptions in abortion bans disproportionately jeopardize

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] N.C. GEN. STAT. §§ 90-21.81A, 21.81B (2023).

people[22] with disabilities, including chronic conditions,[23] by limiting access to necessary healthcare. By eliminating abortion rights, these laws stripped away Jenni and Dr. Meltzer-Brody's patient's autonomy to make deeply personal health decisions. Faced with restrictive policies, Jenni was left with no option but to undergo permanent sterilization to avoid an extremely high-risk pregnancy that could seriously endanger her health. Dr. Meltzer-Brody's patient, on the other hand, would be cruelly denied access to a necessary procedure that could save her from relapsing into months-long postpartum psychosis. These outcomes demonstrate the devastating consequences that arise when abortion laws fail to account for complex individual circumstances.

[22] It is important to recognize that while abortion services are often framed as being primarily important for women, transgender, nonbinary, and gender non-conforming people also require comprehensive reproductive health services and information, including access to abortion. *See ACOG Committee Opinion Number 815*, THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS e108 (Dec. 2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf [https://perma.cc/A7HQ-CQXT] (recognizing "[p]eople of all genders have sexual and reproductive health needs, including women, transgender people, nonbinary people, and those who are otherwise gender-diverse"). In light of this, the Article strives to use gender-neutral language whenever possible; however, in some instances, the terms "woman" or "women" are used when they are specific to the statutes, research, or cited source.

[23] While not all chronic conditions are considered disabilities, many fall under the broad definition of disability provided by the Americans with Disabilities Act ("ADA"), which includes impairments that "substantially limit[] one or more major life activities." 42 U.S.C. § 12102(1)(A). Chronic conditions, also known as "chronic diseases" or "chronic illnesses," are generally defined as "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both." *About Chronic Diseases*, CDC (May 15, 2024), https://www.cdc.gov/chronic-disease/about/index.html [https://perma.cc/RYH4-2J4N]. This Article includes chronic conditions under the broader term "disability" to recognize the significant overlap between these categories and to highlight the unique challenges faced by people with chronic conditions in the context of restricted abortion access. Asha Hassan, Lindsey Yates, Anna K. Hing, Alanna E. Hirz & Rachel Hardeman, *Dobbs and Disability: Implications Of Abortion Restrictions For People With Chronic Health Conditions*, 58 HEALTH SERVS. RSCH. 197, 197 (2023). The term "chronic condition" is used instead of "illness" or "disease" to acknowledge the problematic aspects of equating disability solely with sickness. Susan Wendell, *Unhealthy Disabled: Treating Chronic Illnesses as Disabilities*, 16 HYPATIA 17, 17 (2001). By including chronic conditions within the scope of disability, this Article aims to shed light on the substantial impact of the *Dobbs* decision on this often-overlooked subset of the disability community.

The ambiguity surrounding narrow health exceptions deters healthcare providers from offering services to avoid prosecution in the wake of *Dobbs*. As a result, even people technically eligible for the procedure face barriers to accessing timely abortions.[24] This lack of access leaves people with disabilities seeking abortions only when reaching crisis points of complications, organ failure, or imminent loss of life. The confusing and narrow exceptions thus exacerbate existing healthcare barriers disabled people face without providing any health benefits or furthering any legitimate state aim.

Instead, by disproportionately endangering disabled people through the erosion of their rights, these abortion bans perpetuate the troubling view of marginalized groups as secondary citizens devoid of autonomy over their bodies and decision-making power regarding deeply personal medical choices. In response, state legislatures must clarify and expand health exceptions to enable healthcare providers to perform appropriate procedures without risk of criminal or civil liability. Protecting equal rights and self-determination for people with disabilities necessitates reliable access to reproductive healthcare free from ambiguity or overbearing restrictions.

Accordingly, this Article argues that the unclear health exceptions in abortion laws disproportionately harm people with disabilities by restricting their access to vital reproductive care. In the wake of the *Dobbs* decision, inconsistent state laws have created confusion surrounding narrow health exceptions, leading to barriers to accessing timely abortions. By exacerbating existing hurdles people with disabilities face, these bans erode rights without furthering any legitimate aim. The ambiguous and narrow statutory provisions warrant immediate clarification to prevent further erosion of rights for millions of disabled people.

This Article proceeds in four Parts. Part I sets the stage by examining the devastating impact of the *Dobbs* decision on abortion rights and access, particularly for people with disabilities.[25] It delves into the legal deficiencies of current health exceptions in state abortion bans, critiquing their vague language, inconsistent application, and failure to

[24] *See infra* Part I.

[25] *See infra* Part I.A.

account for the complexities of medical emergencies.[26] This Part also addresses the chilling effect on healthcare providers who face severe penalties and ethical dilemmas when navigating these ambiguous exceptions.[27] Additionally, it highlights the glaring omission of mental health considerations in most abortion bans and the clashes between state laws and federal requirements under the Emergency Medical Treatment and Active Labor Act. [28] Lastly, this Part illuminates the real-world consequences of these restrictive laws, documenting the delays, denials, and dangers faced by pregnant people seeking necessary abortions. [29]

Part II examines how abortion bans with vague and narrow health exceptions disproportionately harm people with disabilities, jeopardizing their health and well-being.[30] It explores the existing barriers that disabled people face when seeking healthcare, including systemic ableism, inaccessible facilities and equipment, and provider bias.[31] This Part then highlights the disproportionately high risks of pregnancy-related complications and maternal mortality among the disability community, underscoring the urgent need for clear and comprehensive health exceptions. [32] It also critiques the absence of mental health considerations in most abortion laws and examines how vague exceptions erode trust in patient-physician relationships.[33]

Shifting to a normative assessment, Part III argues that abortion bans with ill-defined health exceptions fail to advance any legitimate government interest and instead perpetuate discrimination against people with disabilities.[34] It contends that these laws endanger the lives and well-being of disabled individuals by obstructing access to necessary reproductive healthcare and contradicting the fundamental disability

[26] *See infra* Part I.B.

[27] *See infra* Part I.C.

[28] *See infra* Parts I.D, II.E.

[29] *See infra* Part I.F.

[30] *See infra* Part II.

[31] *See infra* Part II.

[32] *See infra* Part II.

[33] *See infra* Part II.

[34] *See infra* Part III.

rights principles of bodily autonomy and self-determination.[35] This Part asserts that even under the lenient rational basis standard of review, these bans lack a rational justification and serve only to entrench ableism in reproductive healthcare.[36]

Finally, Part IV explores legal strategies and proposed reforms to protect the rights of people with disabilities in the face of increasingly restrictive abortion laws.[37] It examines potential constitutional avenues for challenging these bans, such as leveraging state right-to-life provisions, equal protection clauses, and due process guarantees.[38] This Part also proposes incremental advocacy efforts aimed at expanding and clarifying health exceptions, including guidelines for documenting medical necessity.[39] It emphasizes the importance of protecting abortion providers through statutory presumptions and burden-shifting provisions.[40] Additionally, this Part grapples with the need to move beyond a purely medicalized framing of abortion rights and towards a more holistic, intersectional vision of reproductive justice that fully includes and empowers the disability community.[41] The Article concludes by calling for robust coalition-building between the disability rights and reproductive justice movements to drive incremental change and lay the groundwork for a future in which the bodily autonomy and self-determination of all people are respected and protected.[42]

I. THE POST-*DOBBS* LANDSCAPE: A RAPID EROSION OF ABORTION RIGHTS

The Supreme Court's decision in *Dobbs* marked a seismic shift in abortion rights, overturning nearly five decades of precedent and catalyzing a reproductive health crisis across the United States. As states rushed to enforce dormant pre-*Roe* bans and enact new restrictions, the legal landscape transformed overnight, leaving millions

[35] *See infra* Part III.

[36] *See infra* Part III.

[37] *See infra* Part IV.

[38] *See infra* Part IV.A.

[39] *See infra* Part IV.

[40] *See infra* Part IV.D.

[41] *See infra* Part IV.

[42] *See infra* Part IV.E.

without access to vital care. Particularly concerning are the vague and narrow health exceptions within these laws that fail to adequately protect the well-being of pregnant people, especially those with disabilities.

This Part provides the foundation for understanding the impact of health exceptions on people with disabilities. It explores the monumental effect of the *Dobbs* decision, highlighting the rapid erosion of abortion access and the disproportionate harm inflicted upon marginalized communities. This Part delves into the deficiencies of current health exceptions, critiquing their subjective language, inconsistent application, and failure to account for the complexities of medical emergencies. It discusses the legal and professional implications for healthcare providers who face severe penalties and ethical dilemmas when navigating these murky exceptions, and it addresses the glaring omission of mental health considerations in most abortion bans. This Part also examines the clashes between state abortion laws and federal requirements, underscoring the confusion and legal battles surrounding emergency care. Finally, it illuminates the devastating impact on pregnant people who face delays, denials, and life-threatening risks when seeking necessary abortions under these restrictive regimes. By exposing the inadequacies of current health exceptions, this Part demonstrates the urgent need for reform to prioritize patient well-being over political ideology and advocate for clear, comprehensive exceptions that protect the health and autonomy of pregnant people, particularly those with disabilities who face unique challenges and barriers in accessing reproductive healthcare.

A. The Devastating Impact of Dobbs

The 2022 ruling in *Dobbs*[43] represented the culmination of conservative efforts to undo decades of settled abortion rights law. Despite nearly fifty years of precedent, starting with *Roe v. Wade*'s 1973 protections,[44] Mississippi asked the newly solidified 6–3 conservative

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

[44] *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973) (establishing a constitutional right to abortion based on the right to privacy found in the Fourteenth Amendment's liberty interest); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992) (upholding the

Supreme Court majority to uphold a fifteen-week abortion ban that violated the constitutional right to pre-viability abortion access repeatedly affirmed under *Roe* and *Planned Parenthood v. Casey*.[45] Empowered by fresh ideological control of the Court, the conservative supermajority willfully obliged. *Dobbs* brazenly discarded protections grounded in Fourteenth Amendment liberty principles, issuing an outright proclamation: "[T]he Constitution does not confer a right to abortion."[46] Instead, the Court declared that only "the people and their elected representatives" may determine abortion's legality, eliminating strict scrutiny review of pre-viability bans.[47] With that single stroke, *Dobbs* thoroughly erased nearly five decades of precedent safeguarding reproductive autonomy. *Dobbs* catalyzed a monumental change practically overnight by wholly eliminating the vital federal guardrails that had blocked excessive state-level restrictions on abortion access for nearly fifty years.

Within mere hours of the ruling being issued, "trigger bans" and other dormant pre-*Roe* statutes in about a dozen Republican-controlled states suddenly sprang into effect.[48] Having waited patiently for decades, these highly restrictive laws banned nearly all abortions from the very moment longstanding precedents fell. In the twenty months since, the landscape has continued to shift as more states rush to enforce near-

right to abortion while rejecting the trimester framework outlined in *Roe* and instead adopting the "undue burden" standard); Whole Woman's Health v. Hellerstedt, 579 U.S. 582 (2016) (finding that a Texas law that required abortion providers to have admitting privileges at a hospital within thirty miles and abortion facilities to meet the same standards as surgical-centers created an undue burden for people seeking abortion services); June Med. Servs. L.L.C. v. Russo, 91 U.S. 299 (2020) (holding that a Louisiana law that required abortion providers to have admitting privileges at a hospital within thirty miles of the clinic imposed an undue burden on people seeking abortion services).

[45] Petition for a Writ of Certiorari at 15, Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (No. 19-1392), 2020 WL 3317135, at *i; *see also* Adam Liptak, *Mississippi Asks the Supreme Court to Overrule Roe v. Wade*, N.Y. TIMES (July 22, 2021), https://www.nytimes.com/2021/07/22/us/politics/mississippi-supreme-court-abortion.html.

[46] *Dobbs*, 597 U.S. at 292.

[47] *Id.* at 231, 292.

[48] Elizabeth Nash & Isabel Guarnieri, *13 States Have Abortion Trigger Bans — Here's What Happens When Roe Is Overturned*, GUTTMACHER INST. (June 6, 2022), https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned [https://perma.cc/3LLP-AG4Y].

total abortion bans, even while facing court challenges.[49] As of January 2024, twenty-one states across the country have imposed stringent abortion restrictions.[50] Specifically, sixteen states currently enforce bans on abortions at the earliest stages of pregnancy — from conception up to six weeks.[51] Additionally, four states have enacted pre-viability abortion bans beginning at twelve, fifteen, and eighteen weeks of pregnancy.[52]

As abortion clinics nationwide continue closing in the wake of eliminated protections, the *Dobbs* decision has sparked an "unprecedented human rights crisis," according to Human Rights Watch.[53] Practically overnight, approximately thirty-six million women of reproductive age across twenty states now live under functionally total abortion bans or medically excessive restrictions.[54] Especially troubling, among this population are nearly three million women with disabilities and millions more transgender, nonbinary, and other marginalized groups facing compounded barriers to accessing reproductive healthcare, including abortion care.[55]

However, the dangerous, far-reaching fallout of *Dobbs* is only intensifying. Deficiencies within vaguely worded health exceptions ostensibly carved out to preserve limited abortion access carry profound, life-altering stakes for those navigating pregnancy. As explored in the next Section, inconsistent health exceptions and

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[49] Nadine El-Bawab, *Where Do Legal Challenges to Abortion Bans Stand 2 Years After Roe v. Wade Was Overturned?*, ABC NEWS (June 24, 2024, 2:13 AM), https://abcnews.go.com/US/legal-challenges-abortion-bans-stand/story?id=111329119 [https://perma.cc/PG4G-2QFA].

[50] Allison McCann & Amy Schoenfeld Walker, *Tracking Abortion Bans Across the Country*, N.Y. TIMES, https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (last updated Jan. 8, 2024).

[51] *Id.*

[52] *Id.*

[53] *Human Rights Crisis: Abortion in the United States After Dobbs,* HUM. RTS. WATCH (Apr. 18, 2023), https://www.hrw.org/node/384623/printable/print [https://perma.cc/Q8AU-G296].

[54] Katherine Gallagher Robbins, Shaina Goodman & Josia Klein, *State Abortion Bans Harm More Than 15 Million Women of Color,* NAT'L P'SHIP FOR WOMEN & FAMS. 1 (June 2023), https://nationalpartnership.org/wp-content/uploads/2023/02/state-abortion-bans-harm-woc.pdf [https://perma.cc/3WKC-JWFZ].

[55] *Id.*

subjectively interpreted language have resulted in significant confusion, delays, and outright denials of abortion care. Consequently, a growing number of pregnant people are forced to face heightened, medically unwarranted risks to their health, future fertility, liberty, and basic dignity.

B. The Legal Deficiencies of Current Health Exceptions

The majority opinion in *Dobbs* demonstrated callous indifference to the lives and well-being of pregnant people by failing to even consider whether abortion restrictions should include health exceptions. Legislators are now rushing dangerously flawed bans and restrictions and forcing physicians into impossible situations: either face severe penalties for helping patients or helplessly watch their patients suffer.[56] As described throughout this Article, by prioritizing ideology over sound medical ethics, these statutes treat pregnant people as instruments of state policy rather than as autonomous persons entitled to compassionate care.

Critically, typical health exceptions utilize vague, subjective language prone to inconsistent interpretation and application. Over a dozen states, for example, have incorporated health exceptions permitting abortion only when there is a "serious risk of substantial and irreversible impairment" to a "major bodily function."[57] However, terms like "serious" and "substantial" lack clinical definition, thereby making consistent application difficult.[58] Additionally, health exceptions routinely reference "major bodily functions" but do not delineate the

[56] Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services,* KAISER FAM. FOUND. (June 6, 2024), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/T29A-THBF] [hereinafter *A Review of Exceptions in State Abortion Bans*].

[57] *See, e.g.*, ALA. CODE § 26-22-2 (2024); LA. STAT. § 14:87.1(18) (2024); TENN. CODE § 39-15-213(c)(2) (2024); W. VA. CODE § 16-2R-2 (2024); *see also A Review of Exceptions in State Abortion Bans*, *supra* note 56.

[58] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

qualifying functions.[59] In fact, Arizona is the only state whose law defines "major bodily functions."[60]

The result, as seen in Georgia[61] and other states, is that pregnant people will be denied necessary procedures and forced to needlessly suffer preventable health consequences. For instance, what if a patient faces "substantial" but reversible bodily harm without an abortion? What if the impairment is less than "substantial," yet still permanent? What if the harm is declared "substantial and irreversible" but impacts a bodily function not considered "major?" In each of these scenarios, pregnant people in Georgia and numerous other states may be denied access to vital care and needlessly forced to endure health risks that could otherwise be mitigated. Laws like Georgia's establish strict, inflexible criteria for health exceptions to abortion bans that fail to comprehend the complexity of pregnancy-related health conditions afflicting people nationwide.

In Texas, physicians must determine whether an abortion is necessary based on their "reasonable medical judgment."[62] The ambiguous criteria put physicians at legal risk, understandably making them hesitant to confirm that a pregnancy meets the requirements for a life- or health-related exemption.[63] Specifically, doctors are concerned that even if they believe an exception applies, a court could later second-guess their judgment and find them guilty of violating the law by relying on contrasting testimony from other medical experts about meeting the "reasonable judgment" requirement.[64] Conversely, Arizona only

[59] Mabel Felix, Laurie Sobel & Alina Salganicoff, *Who Decides When a Patient Qualifies for an Abortion Ban Exception? Doctors vs. the Courts,* KAISER FAM. FOUND. (Dec. 14, 2023), https://www.kff.org/policy-watch/who-decides-when-patient-qualifies-for-abortion-ban-exception/ [https://perma.cc/5FG5-4RLU] [hereinafter *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*].

[60] ARIZ. REV. STAT. ANN. § 36-2321(6) (2022) ("'Major bodily function' includes functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.").

[61] GA. CODE ANN. § 16-12-141 (2024). *See generally, Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59 (describing how vague exceptions in Georgia and elsewhere harm pregnant people).

[62] TEX. HEALTH & SAFETY CODE § 170A.002 (2021).

[63] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59.

[64] *Id.*

requires doctors to make this determination based on their "good faith clinical judgment" — a lower and likely less legally perilous bar that grants them some deference.[65] However, some states also have different physician judgment standards across multiple abortion restrictions and bans, further muddying compliance requirements.[66]

Problems related to the ambiguity of "reasonable medical judgment" played out in the high-profile Texas lawsuits of Kate Cox and Amanda Zurawski.[67] Due to concern over a court later questioning her judgment, Ms. Cox's physician requested a court order allowing her to perform the abortion based on a "good faith" belief the patient met the exception.[68] Her physician also felt uncertainty around how close to death Ms. Cox needed to be to legally perform the abortion under Texas law and sought clarification from the court on that issue.[69] The District Court agreed with the plaintiffs that the case qualified for an exception, but the Texas Supreme Court disagreed.[70] Specifically, the court found a physician's "good faith belief" alone insufficient to meet Texas's exception, which requires that abortions be certified as "necessary" under "reasonable medical judgment."[71] Tragically, situations like Ms. Cox's will inevitably repeat themselves in states that criminalize abortion.[72] Indeed, similar legal challenges involving health exceptions are unfolding in states like Idaho, Tennessee, North Dakota, and Oklahoma.[73] The fractured outcomes so far underscore the likelihood of patchwork and conflicting standards across jurisdictions regarding when doctors can legally terminate pregnancies for patients experiencing health crises.

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[65] ARIZ. REV. STAT. ANN. § 36-2321(7) (2022).

[66] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59.

[67] Dahlia Lithwick, *What It's Really Like to Challenge Texas' Absurd Abortion Laws*, SLATE (Dec. 18, 2023, 2:53 PM), https://slate.com/news-and-politics/2023/12/amanda-zurawski-on-challenging-texas-abortion-law.html [https://perma.cc/85GZ-N2FW].

[68] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59.

[69] *Id.*

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Center Expands Work on Behalf of Patients Denied Abortion Care Despite Grave Pregnancy Complications*, CTR. FOR REPROD. RTS. (Sept. 12, 2023), https://reproductiverights.org/exceptions-complaints-idaho-tennessee-oklahoma/ [https://perma.cc/2FR7-F4Q7].

Critically, while some abortion bans contain health exceptions, all bans contain narrower exceptions to "prevent"[74] or "avert"[75] the death of the pregnant person or to "preserve"[76] their life.[77] However, most life exception statutes fail to specify how much mortality risk or proximity to death qualifies the affected individual to receive an emergency abortion. Instead, they rely on vague standards like "reasonable medical judgment," leaving physicians unsure of when abortion is legally permissible to save a life.[78] Moreover, analysis by the Kaiser Family Foundation indicates that five states —Arkansas, Idaho, Mississippi, Oklahoma, and South Dakota — provide no health exceptions at all, only to preserve life.[79] Notably, in Oklahoma, the ban's exception allows for abortion to "preserve [the pregnant person's] life."[80] Nonetheless, the Oklahoma Supreme Court held that the state constitution's inherent rights and due process clauses protect a right to abortion more broadly so as to preserve both life and health.[81] Overall, the lack of clarity and overly narrow application of life exceptions in abortion bans fail to adequately protect pregnant people's well-being.

Undoubtedly, health exceptions fail on multiple fronts. Fundamentally, they utilize unclear terms with no standardized medical definitions.[82] As Professor Teneille Brown explains, this forces

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[74] *See, e.g.*, IDAHO CODE § 18-622(2)(a)(i) (2023).

[75] *See, e.g.*, KY. REV. STAT. ANN. § 311.720(9) (2017).

[76] *See, e.g.*, ARK. CODE ANN. § 5-61-303(3) (2019).

[77] *See A Review of Exceptions in State Abortion Bans*, *supra* note 56.

[78] *Id.*

[79] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59; *see* ARK. CODE ANN. § 5-61-303(3) (2019); ARK. CODE ANN. § 304(a) (2019); IDAHO CODE § 18-622(2)(a) (2023); MISS. CODE ANN. § 97-3-3(1)(a) (1997); OKLA. STAT. tit. 21, § 861 (1999); OKLA. STAT. tit. 21, § 863 (1910); S.D. CODIFIED LAWS § 22-17-5.1 (2005).

[80] OKLA. STAT. tit. 21, § 861 (1999).

[81] Okla. Call for Reprod. Just. v. Drummond, 526 P.3d 1123, 1130 (Okla. 2023) ("[I]f at any point in the pregnancy, the woman's physician has determined to a reasonable degree of medical certainty or probability that the continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer from during the pregnancy.").

[82] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 59.

physicians to interpret statutes instead of employing their expertise.[83] Moreover, no statutes delineate how proximate the threat of death or organ failure must be to warrant an abortion.[84] Exacerbating this issue, the exceptions reflect a misleading binary view of emergencies as either present or absent. However, as Brown elaborates, "medical emergencies during pregnancy are not so simple," often materializing "slowly, then all at once.[85]" Beyond misunderstanding medical complexity, these kinds of abortion regulations also ignore that physicians' ethical duties involve more than just preventing patient deaths. The exceptions undermine physicians' training and discretion by framing complex judgment calls as simple yes or no questions.

The practical barriers caused by such legally ambiguous exceptions are immense. A survey found a staggering 70% of doctors were confused about defining a legally "life-threatening" emergency necessary for an abortion.[86] This stems from the exceptions demanding definitive diagnoses despite the practice of medicine dealing in probabilities. Additionally, their nonspecific language misaligns with clinical terminology. Consequently, physicians must waste time "tracking down hospital attorneys" to ask if a "30% chance of maternal death" qualifies as "life-threatening" instead of providing evidence-based care.[87] These issues disproportionately endanger those with high-risk pregnancies. As Dr. Jessica Rubino predicts, in Texas, if "you're sick, you're medically complicated, [and] you just will die from your pregnancy."[88]

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[83] *See* Teneille R. Brown, *Abortion and the Extremism of Bright Line Rules*, 119 NW. U. L. REV. ONLINE 1, 9, 24 (2024).

[84] Sonia M. Suter, *Alito is Wrong: We Can Assess the Impact of* Dobbs*, and It Is Bad for Women's Health*, 53 SETON HALL L. REV. 1477, 1499-1501 (2023).

[85] Brown, *supra* note 83, at 13.

[86] Annie Burky, *Most Physicians Unclear on 'Life-Threatening Emergencies' Under Abortion Bans: Survey*, FIERCE HEALTHCARE (Sept. 13, 2022, 7:30 AM), https://www.fiercehealthcare.com/providers/most-physicians-unclear-what-are-life-threatening-emergencies-under-abortion-bans-survey [https://perma.cc/XCD5-865Y].

[87] Selena Simmons-Duffin, *Doctors who Want to Defy Abortion Laws Say It's Too Risky*, NPR (Nov. 23, 2022, 5:01 AM), https://www.npr.org/sections/healthshots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky [https://perma.cc/9S5U-3JSA].

[88] Aria Bendix, *How Life-Threatening Must a Pregnancy Be to End it Legally?*, NBC NEWS (June 30, 2022, 10:57 AM), https://www.nbcnews.com/health/health-news/abortion-ban-exceptions-life-threatening-pregnancy-rcna36026.

C. Healthcare Providers in Legal Jeopardy

State abortion bans create an environment of harsh penalties and opaque rules surrounding health exceptions that chill medically necessary care. These laws impose severe criminal penalties against physicians — including prison terms ranging from one to twenty years — for terminating pregnancies contrary to strict statutory limits.[89] Strikingly, Alabama[90] and Texas[91] laws permit life imprisonment as the maximum sentence. On top of incarceration, some states impose additional fines ranging from $1,000 to $100,000 per violation.[92] Bans in several states include provisions that allow for the revocation of medical licenses for violating abortion restrictions.[93] A few states have also enacted civil fines and damages, Texas being a prime example, where penalties can total over $100,000 per abortion procedure

[89] Becca Damante & Kierra B. Jones, *A Year After the Supreme Court Overturned Roe v. Wade, Trends in State Abortion Laws Have Emerged*, CTR. FOR AM. PROGRESS (June 15, 2023), https://www.americanprogress.org/article/a-year-after-the-supreme-court-overturned-roe-v-wade-trends-in-state-abortion-laws-have-emerged/ [https://perma.cc/V4PK-78XM].

[90] *See* ALA. CODE § 26-23H-6(a) (2019) ("An abortion performed in violation of this chapter is a Class A felony."); ALA. CODE § 13A-5-6(a)(1) (2023) ("For a Class A felony, for life or not more than 99 years or less than 10 years.").

[91] *See* TEX. HEALTH & SAFETY CODE § 170A.004(b) (2021) ("An offense under this section is a felony of the second degree, except that the offense is a felony of the first degree if an unborn child dies as a result of the offense."); TEX. PENAL CODE § 12.32(a) (2009)("An individual adjudged guilty of a felony of the first degree shall be punished by imprisonment in the Texas Department of Criminal Justice for life or for any term of not more than 99 years or less than 5 years.").

[92] Becca Damante & Kierra B. Jones, *A Year After the Supreme Court Overturned Roe v. Wade, Trends in State Abortion Laws Have Emerged*, CTR. FOR AM. PROGRESS (June 15, 2023), https://www.americanprogress.org/article/a-year-after-the-supreme-court-overturned-roe-v-wade-trends-in-state-abortion-laws-have-emerged/ [https://perma.cc/V4PK-78XM].

[93] *See, e.g.*, ARIZ. REV. STAT. ANN § 36-2325(A) (2022) ("A physician who intentionally or knowingly violates the prohibition in section 36-2322, subsection B commits an act of unprofessional conduct and the physician's license to practice medicine in this state shall be suspended or revoked . . . ."); IDAHO CODE § 18-622(1) (2023) ("The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.").

performed illegally in violation of the ban.[94] Many abortion bans include health exceptions that lack clear definitions. As a result, physicians must interpret ambiguous language, risking prosecution or license sanctions if authorities later dispute their medical judgment.

Making matters worse, some states have adopted "bounty hunter" laws allowing ordinary citizens to sue anyone assisting abortions contrary to the strict terms of the bans.[95] These vigilante provisions provide monetary incentives to challenge doctors retroactively on the appropriateness of health exceptions, further imperiling physicians' professional judgment. For example, Idaho permits such suits against doctors for violating its strict six-week ban.[96] While Oklahoma's Supreme Court struck down a similar bounty hunter provision in 2023,[97] other states continue to introduce copycat proposals.[98] However necessary to preserve a patient's health, any abortion risks attracting ex

[94] TEX. HEALTH & SAFETY CODE § 170A.005 (2021).

[95] For example, Texas's pre-*Roe* abortion ban explicitly included accomplice liability ("Whoever furnishes the means for procuring an abortion knowing the purpose intended is guilty as an accomplice"). TEX. PENAL CODE art. 1192. Other states, in defining abortion as a felony, have imported generally applicable aiding and abetting provisions. *See, e.g.*, Memorandum from Okla. Att'y Gen. to All Okla. Law Enf't Agencies, Guidance for Okla. L. Enf't Following Dobbs v. Jackson Women's Health Org., (Aug. 31, 2022), https://content.govdelivery.com/attachments/OKAG/2022/08/31/file_attachments/2258126/Memo%20to%20Law%20Enforcement%20Following%20Dobbs%20%288.31.22%29.pdf [https://perma.cc/PK57-9NMV] (citing Oklahoma definitions of principal and accessory criminal liability, and opining, "Oklahoma law prohibits aiding and abetting the commission of an unlawful abortion, which may include advising a pregnant woman to obtain an unlawful abortion"). Meanwhile, Alabama, Arizona, Arkansas, Florida, and Ohio have considered such a provision. *See* H.B. 23, 2022 Leg., Reg. Sess. (Ala. 2022); H.B. 2483, 55th Leg., 2nd Reg. Sess. (Ariz. 2022); H.B. 4327, 2022 Leg., Reg. Sess. (Okla. 2022); S.B. 13, 93rd Gen. Assemb., 2nd Extraordinary Sess. (Ark. 2021); H.B. 167, 124th Leg., Reg. Sess. (Fla. 2022); H.B. 480, 134th Gen. Assemb., Reg. Sess. (Ohio 2021); *see also* Jia Tolentino, *We're Not Going Back to the Time Before Roe. We're Going Somewhere Worse*, THE NEW YORKER (June 24, 2022), https://www.newyorker.com/magazine/2022/07/04/we-are-not-going-back-to-the-time-before-roe-we-are-going-somewhere-worse/amp [https://perma.cc/W2HB-DJFM].

[96] IDAHO CODE § 18-8807(1)(b) (2023).

[97] *See Oklahoma Supreme Court Ruling Affirms Right to Life-Saving Abortion Care*, CTR. FOR REPROD. RTS. (June 1, 2023), https://reproductiverights.org/oklahoma-supreme-court-overturns-abortion-bans/ [https://perma.cc/W67X-5SBU].

[98] Damante & Jones, *supra* note 89.

post facto civil suits from private litigants questioning the procedure's necessity.

Alarmingly, some states are also attempting to enforce their stringent bans across state lines.[99] Although the legality is dubious, lawmakers have proposed letting private citizens sue anyone out-of-state who helps a resident end a pregnancy — from the doctor performing the procedure to the driver transporting the patient across state lines.[100] While not yet adopted, these efforts threaten prosecution beyond just providers in restrictive states, infringing on freedoms of movement and creating uncertainty even where abortion remains legal.[101]

Ultimately, state abortion bans impose a toxic mixture of harsh penalties and uncertainty that curtails healthcare. The threat of imprisonment, steep fines, loss of one's medical license, and vigilante lawsuits penalize doctors for practicing necessary medicine as doctors hesitate, delay, or refuse treatment amid statutory ambiguity. Yet without clear standards protecting medical judgment, providers also risk sanctions even if aiming to exercise good-faith discretion around health exceptions. This legal limbo infringes on physicians' rights while encouraging denial of care that imperils patient health and welfare.

D. The Glaring Omission of Mental Health

As states increasingly move to ban abortion, few provide exceptions for mental health conditions or emergencies, ultimately treating mental health differently than physical health.[102] This divergence reveals a troubling inconsistency between growing efforts to achieve mental health parity and the unbalanced approach being taken in crafting

[99] Rachel M. Cohen, *The Coming Legal Battles of Post-Roe America*, VOX (June 27, 2022, 4:30 AM), https://www.vox.com/2022/6/27/23183835/roe-wade-abortion-pregnant-criminalize [https://perma.cc/49RK-ZJ4P].

[100] *Id.*

[101] Terry Gross, *The U.S. Faces 'Unprecedented Uncertainty' Regarding Abortion Law, Legal Scholar Says*, NPR (Jan. 18, 2023, 2:53 PM), https://www.npr.org/sections/health-shots/2023/01/17/1149509246/the-u-s-faces-unprecedented-uncertainty-regarding-abortion-law-legal-scholar-sa [https://perma.cc/S5HB-K4NZ].

[102] Sandhya Raman, *State Abortion Bans Bar Exceptions for Suicide, Mental Health*, ROLL CALL (Dec. 7, 2023, 7:00 AM), https://rollcall.com/2023/12/07/state-abortion-bans-bar-exceptions-for-suicide-mental-health/ [https://perma.cc/YL9W-XRMH].

abortion policy. Recently, reducing stigma and gaining bipartisan support for mental health have been legislative priorities.[103] For example, bipartisan laws in 1996 and 2008 mandated equal insurance coverage for mental and physical health, recognizing their inextricable link.[104] However, the lack of mental health exceptions in most abortion bans encompasses the flawed mindset that mental health is distinct from physical health. It dismisses urgent mental health factors as invalid reasons for receiving an abortion despite the understanding that mental health is equally important to physical health. Though progress has been made toward destigmatizing mental health conditions and achieving parity, abortion policy risks regression by deprioritizing mental health.

This dismissive stance also counters extensive data. At least one in five pregnant people experience mental health challenges during the perinatal period, either exacerbating a pre-existing condition or newly developing one while pregnant or postpartum.[105] Moreover, mental health conditions are a leading cause of pregnancy-related deaths in the United States.[106] According to the Centers for Disease Control and Prevention ("CDC"), nearly 23% of pregnancy-related deaths are linked to mental health conditions.[107] By excluding mental health conditions as a permissible reason for abortion, these states fail to recognize the significant mental health toll that pregnancy and childbirth can take on pregnant people.

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[103] *Id.*

[104] *See* MENTAL HEALTH PARITY ACT of 1996, Pub. L. No. 104-204, §§ 701–703, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)); PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, IN EMERGENCY ECONOMIC STABILIZATION ACT OF 2008, Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765, 3881-93 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

[105] AMERICAN PSYCHIATRIC ASSOCIATION, PERINATAL MENTAL AND SUBSTANCE USE DISORDERS 29 (2023); *see also infra* Part II (describing the pregnancy-related complications experienced by people with mental health disabilities).

[106] Susanna Trost, Fanny Nijie, Alyssa Harvey, Jasmine Berry, Jennifer Beauregard, Gyan Chandra & David Goodman, *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019*, CDC (May 28, 2024), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html [https://perma.cc/DD62-3GN5].

[107] *Id.*

Commonly, abortion bans specifically exclude exceptions based on mental or emotional health.[108] For example, the health exception to Florida's abortion ban requires two physicians to certify that an abortion is necessary to save the pregnant person's life or avoid a "serious risk" of substantial impairment to a "major bodily function of the pregnant woman *other than a psychological condition*."[109] Likewise, Tennessee's ban reads: "No abortion shall be deemed authorized . . . on the basis of a claim or a diagnosis that the woman will engage in conduct that would result in her death or substantial and irreversible impairment of a major bodily function or for *any reason relating to her mental health*."[110]

Several other states take a prohibitive stance toward mental health consideration in their abortion restrictions by explicitly limiting health exceptions to physical conditions.[111] For instance, Oklahoma's statutory definition of a medical emergency overly emphasizes physical threats, stating:

> "Medical emergency" means a condition which cannot be remedied by delivery of the child[,] in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a *physical* disorder, *physical* illness or *physical* injury including a life-endangering *physical* condition caused by or arising from the pregnancy itself.[112]

The four-fold repetition of "physical" reflects outdated beliefs that mental health conditions lack physical causes, ultimately leaving many deprived of necessary care.[113] Indeed, the lack of exceptions considering mental health across numerous states with abortion bans in effect prevents physicians from providing appropriate care to their patients

[108] *A Review of Exceptions in State Abortion Bans*, *supra* note 56 (Georgia, Kentucky, Louisiana, Ohio, Tennessee, Idaho, Florida, Iowa, West Virginia, and Wyoming).

[109] FLA. STAT. § 390.01112 (2023) (emphasis added).

[110] TENN. CODE ANN. § 39-15-211 (2017) (emphasis added).

[111] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

[112] OKLA. STAT. ANN. tit. 63 § 1-731.4(A)(2) (West 2022) (emphasis added).

[113] Katherine L. Wisner & Paul S. Appelbaum, *Abortion Restriction and Mental Health*, 80 JAMA PSYCHIATRY 285, 286 (2023).

and puts those with mental health conditions in a dangerous position by denying them care.[114]

The few existing mental health exceptions in state abortion bans set unreasonably high barriers to access. For example, Alabama's near-total abortion ban contains a provision allowing limited emergency mental health exceptions if strict criteria are met.[115] Specifically, an Alabama-licensed psychiatrist with at least three years of clinical experience must certify that the pregnant person has a mental health condition that could result in death or loss of pregnancy if an abortion is not performed.[116] By establishing such narrow qualifications even for its limited exception, Alabama's law indicates a reluctance to fully recognize mental health as equal grounds for abortion.[117] Moreover, the stringent requirements are often impossible to meet for marginalized patients due to barriers like income, geography, and provider shortages.[118]

The push to exclude mental health as grounds for abortion exceptions in state laws can be traced back to federal legislative efforts between 2005 and 2006.[119] At that time, Congress considered bills aimed at limiting the ability of non-custodial adults to assist minors in obtaining out-of-state abortions.[120] One such 2005 bill included exception language for cases where delaying an abortion would cause "substantial and irreversible impairment of a major bodily function" for the pregnant minor.[121] However, it specified this did not apply to "psychological or emotional conditions."[122] Though the federal bill ultimately failed, the

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[114] *Who Decides When a Patient Qualifies for an Abortion Ban Exception?*, *supra* note 56.

[115] ALA. CODE § 26-23H-3 (2019).

[116] *Id.*

[117] Raman, *supra* note 102.

[118] Christine Fernando, *Mental Health Emerges as a Dividing Line in Abortion Rights Initiatives Planned for State Ballots*, ASSOCIATED PRESS (Feb. 13, 2024), https://apnews.com/article/abortion-mental-health-ballot-maryland-missouri-arizona-6268ec88d1638009128b55fc56e3610c [https://perma.cc/4AKH-3FGU] ("Medical experts say even states that do allow mental health exceptions require patients to jump through hoops that may be inaccessible to some people, especially those with low incomes.").

[119] Raman, *supra* note 102.

[120] *Id.*

[121] *Id.*

[122] *Id.*

wording excluding mental health laid the groundwork for exclusionary provisions that would be adopted in various states' abortion laws after the *Dobbs* decision.[123] In June 2022, the National Right to Life Committee issued model legislation for post-*Dobbs* state abortion bans, reaffirming that mental health should not qualify as an exception.[124] Hence, federal debates in the mid-2000s helped plant the early seeds of distinguishing between physical and mental health that eventually blossomed into recent state policies.

Notably, the United States is not alone in grappling with what constitutes a mental health emergency that justifies abortion access. Ireland previously permitted exceptions for suicide risk following a landmark 1992 Irish Supreme Court ruling, setting an important legal precedent followed by many other countries.[125] In addition, Australia's state of Victoria amended its abortion law in 2008 to allow for abortion procedures when a pregnant person's physical or mental health is at risk.[126] Similarly, in Canada, abortion is legal at any point if continuing the pregnancy would put the pregnant person's life or health at risk — including mental health.[127] The United Kingdom's Abortion Act of 1967 also permits abortion to prevent grave permanent injury to physical or mental health.[128]

Thus, as states now move to prohibit abortions even when severe mental health implications are present, they diverge from the standards set by many other developed countries. These nations recognize that certain mental health emergencies should supersede general abortion restrictions. The United States risks becoming an outlier in dismissing mental health as a valid medical criterion for allowing the procedure — out of step with legal precedents and policies around the world.

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[123] *Id.*

[124] *Id.*

[125] *Id.*

[126] *Abortion Law Reform Act 2008* (Vict.) pt 2 (Austl.).

[127] Criminal Law Amendment Act S.C. 1968-69 c 38, s 18 (Can.).

[128] Abortion Act 1967, c. 87 (UK).

E. Clashes with EMTALA Requirements

Following the *Dobbs* decision, confusion emerged around providing abortions in medical emergencies, spawning lawsuits with fractured rulings. One fundamental dispute is whether federal law like the Emergency Medical Treatment and Active Labor Act ("EMTALA")[129] can compel health exceptions in state abortion restrictions lacking them. Congress enacted EMTALA in 1986 to mandate that patients with life-threatening medical emergencies receive stabilizing treatment.[130] EMTALA covers all emergency room patients but was partly inspired by several highly-publicized cases where poor pregnant patients were denied care by hospitals — including horrifying examples of women in active childbirth being turned away rather than treating their fatal fetal distress.[131] Under the law, EMTALA requires hospital emergency rooms to screen any patients who arrive seeking care to determine if an "emergency medical condition" exists.[132] EMTALA also mandates stabilizing treatment if such emergency conditions exist.[133] EMTALA defines an "emergency medical condition" as a medical condition showing itself through acute symptoms so severe that lack of immediate medical care could reasonably risk serious danger to an individual's health or, for a pregnant woman, her or her unborn child's health.[134] An "emergency medical condition" also includes serious impairment to bodily functions or organs.[135] For pregnant people having contractions, an "emergency medical condition" exists if there is not enough time to safely move them to another hospital before delivery or if moving them

[129] 42 U.S.C. § 1395dd.

[130] *Id.*

[131] *See* 131 CONG. REC. E5520-02 (daily ed. Dec. 10, 1985) (statement of Rep. Stark); David U. Himmelstein, Steffie Woolhandler, Martha Harnly, Michael B. Bader, Ralph Silber, Howard D. Backer & Alice A. Jones, *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 496 (1984); Julie Lasson, *Despite Federal Law, Some Rural Hospitals Still Turn Away Women in Labor*, PROPUBLICA (Mar. 3, 2017, 7:00 AM), https://www.propublica.org/article/despite-federal-law-some-rural-hospitals-still-turn-away-women-in-labor [https://perma.cc/3ELV-ZTF8].

[132] 42 U.S.C. § 1395dd(a).

[133] *Id.* § 1395dd(b).

[134] *Id.* § 1395dd(e).

[135] *Id.*

could dangerously impact them or the unborn child's health or safety.[136] Treatment must continue until doctors determine the emergency has passed, regardless of ability of the patient to pay.[137]

In July 2022, the U.S. Department of Health and Human Services ("HHS") issued guidance clearly stating that EMTALA preempts state laws, so abortion services must be provided if necessary for emergency stabilization — even in states that have abortion bans.[138] Specifically, the guidance states:

> If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — that state law is preempted.[139]

Thus, HHS contends that EMTALA's requirement to provide emergency stabilizing medical treatment, including abortions deemed necessary by medical professionals, overrides state laws banning abortion that lack adequate exceptions to protect patient health and life.

Shortly after the guidance was issued, two federal courts weighed in on whether EMTALA's requirements superseded conflicting state laws.[140] Citing the Supremacy Clause, a federal court in Idaho ruled that EMTALA preempts the state's abortion ban and barred enforcement of the ban as it pertains to EMTALA's requirements.[141] Idaho's recently

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[136] *Id.*

[137] *Id.* § 1395dd(h).

[138] Memorandum from the Dirs. of the Quality, Safety & Oversight Grp. and Survey & Operations Grp. to the State Surv. Agency Dirs., Ctr for Medicare & Medicaid Servs. 1 (July 11, 2022) (on file with author).

[139] *Id.*

[140] Greer Donley, Kimi Chernoby & Skye Perryman, *Two Courts Ruled on Abortion in Emergency Situations. One Got It Right*, TIME (Aug. 26, 2022, 9:21 AM), https://time.com/6208656/abortion-emtala-texas-idaho-emergency-situations/ [https://perma.cc/L2Z5-H4YP].

[141] United States v. Idaho, 623 F. Supp. 3d 1096, 1102 (D. Idaho 2022).

enacted abortion ban contained only a narrow exception that permitted abortions strictly to prevent the death of the pregnant person; no allowance was provided for procedures deemed necessary to preserve health.[142] Finding this restriction conflicted with EMTALA's requirement to perform emergency abortions when pregnancy jeopardizes a patient's health, the Court issued an injunction against the abortion ban.[143] Following a series of appeals, the Ninth Circuit Court of Appeals upheld this interpretation of EMTALA's requirements.[144] However, in January 2024, the Supreme Court announced that it would hear this case later in the year and, in the process, lifted the injunction.[145] A 5–4 majority agreed the Court should not have taken the case, while a 6–3 majority held that the preliminary injunction blocking enforcement of the Idaho ban where it conflicts with EMTALA should be reinstated.[146] This decision effectively returns the case to lower courts for further proceedings without ruling on the merits of whether EMTALA preempts state abortion bans.

Separately, in Texas, a federal judge issued a nationwide injunction temporarily blocking the HHS guidance on EMTALA requirements concerning abortion, finding the Biden administration exceeded its authority in enacting the EMTALA abortion protections.[147] On appeal, the Fifth Circuit upheld this injunction, allowing state abortion bans to supersede EMTALA protections.[148] The Supreme Court's dismissal of the Idaho case leaves open the possibility that the EMTALA preemption issue may return to the Court in the future, either through this case after further lower court proceedings or through similar cases from other jurisdictions.

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[142] IDAHO CODE ANN. § 18-622(2) (2023).

[143] *United States v. Idaho*, 623 F. Supp. 3d at 1117.

[144] United States v. Idaho, 83 F.4th 1130, 1133 (9th Cir. 2023), *reh'g en banc*, *vacated*, 82 F.4th 1296 (9th Cir. 2023).

[145] United States v. Idaho, 82 F.4th 1296, 1296 (9th Cir. 2023), *cert. granted,* 2024 WL 61829 (U.S. Jan. 5, 2024) (No. 23-726).

[146] Moyle v. United States, 603 U.S. 2016, 2026 (2024).

[147] Texas v. Becerra, 623 F. Supp. 3d 696, 739 (N.D. Tex. 2022).

[148] Texas v. Becerra, 89 F.4th 529, 546 (5th Cir. 2024).

F. Delays, Denials, and Dangers for Pregnant People

The *Dobbs* decision catalyzed a reproductive health crisis where abortion bans endanger the lives of people nationwide. Abortion bans and pre-viability restrictions have severely limited abortion access even when a patient's life is endangered.[149] These laws also delay treatment for miscarriages, emergency care, and ectopic pregnancies while deterring doctors from offering complete medical information due to fears of legal repercussions.[150] The availability of contraception and other reproductive services faces reduction as well.[151] People denied abortions endure psychological trauma while the laws heighten safety risks for pregnant domestic violence survivors and discourage vital prenatal care.[152] Together, these far-reaching effects of abortion bans pose grave dangers to people's health and lives nationwide.

Robust public health research reveals the adverse outcomes abortion denial causes. Tracking outcomes between women denied access to abortions versus those who received care, the Turnaway Study has shown how forced childbirth severely threatens people's health, economic security, and personal goals for themselves and their families — with persistent impacts long after denial of care.[153] Women forced to carry unwanted pregnancies to term suffered ongoing health challenges, including two deaths from post-childbirth complications.[154] Nascent research also lays bare how abortion barriers unevenly punish low-income and marginalized communities.[155]

Emerging data underscores *Dobbs*' detrimental impacts. A recent study analyzed fifty cases between September 2022 and March 2023 where state-level abortion restrictions negatively impacted patient

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[149] *Human Rights Crisis: Abortion in the United States After Dobbs*, *supra* note 53.

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] *The Turnaway Study*, ANSIRH: ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/research/ongoing/turnaway-study.

[154] Lauren J. Ralph, Eleanor Bimla Schwarz, Daniel Grossman & Diana Greene Foster, *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 ANNALS INTERNAL MED. 238, 238 (2019).

[155] *See* Michelle Oberman, *What Will and Won't Happen When Abortion is Banned*, 9 J.L. & BIOSCIS. 1, 3 (2022).

care.[156] The legal constraints across fourteen states forced people with physical or mental health conditions exacerbated by pregnancy to seek abortions out-of-state.[157] Scrambling for care outside their home state introduced delays that diminished health outcomes.[158] The analysis found that patients had a range of adverse outcomes while navigating abortion logistics across state lines.[159] By mandating travel, the bans disrupt care continuity for those most in need. Related research found that Texas's abortion ban has resulted in higher rates of maternal morbidity.[160] In particular, the study found that delayed abortion care "resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."[161] Collectively, the findings underscore how abortion limitations can endanger patients already facing health vulnerabilities.

In addition, recent polling indicates that 40% of doctors providing obstetric and gynecological care in states where abortion is now banned convey feeling hampered in their ability to handle pregnancy complications and miscarriages after the *Dobbs* decisions.[162] Furthermore, 68% of these clinicians surveyed report that the ruling has degraded their capacity to respond to urgent pregnancy-related medical situations overall.[163] Widespread concerns persist that the prohibitions

[156] Daniel Grossman, Carole Joffe, Shelly Kaller, Katrina Kimport, Elizabeth Kinsey, Klaira Lerma, Natalie Morris & Kari White, *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, ANSIRH: ADVANCING NEW STANDARDS IN REPROD. HEALTH 4 (May 2023), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf [https://perma.cc/TUG3-R2HX].

[157] *Id.* at 12.

[158] *Id.* at 5.

[159] *Id.* at 17.

[160] Anjali Nambiar, Shivani Patel, Patricia Santiago-Munoz, Catherine Y. Spong & David B. Nelson, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 AM. J. OBSTETRICS & GYNECOLOGY 648, 649 (2022).

[161] *Id.*

[162] Brittni Frederiksen, Usha Ranji, Ivette Gomez & Alina Salganicoff, *A National Survey of OBGYNs' Experiences After Dobbs*, KFF (June 21, 2023), https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs [https://perma.cc/YSN4-AW8H].

[163] *Id.*

could increase rates of maternal mortality (64% of physicians polled) and worsen racial and socioeconomic inequities in access to reproductive healthcare (70% of physicians polled).[164] Separate research found that 93% of physicians working in states with abortion bans said either they or their colleagues have been unable to adhere to clinical best practices due to newly implemented legal constraints.[165]

Even in cases that surely fall within states' health exceptions, abortions are often delayed or denied, resulting in dangerous outcomes.[166] For example, one study found that "[p]atients with pregnancy complications or preexisting medical conditions that may be exacerbated by pregnancy are being forced to delay an abortion until their conditions become life-threatening and qualify as medical emergencies, or until fetal cardiac activity is no longer detectable."[167] Furthermore, several states have multiple abortion bans in effect with inconsistent exceptions between them, creating confusion.[168] Pregnant people are unsure if their case legally qualifies for an abortion while providers struggle to determine if requested abortions can lawfully be provided.[169] This legal quagmire, resulting from overlapping bans with conflicting allowances, leaves patients uncertain about the circumstances under which abortion remains permitted.[170]

Pregnant people are also being denied adequate information because of abortion bans. A year after *Dobbs*, the Kaiser Family Foundation found that in states with total abortion bans, 78% of physicians said they do not provide out-of-state referrals for abortion services, while 30% do not inform patients about online resources detailing their abortion options.[171] Even in states with gestational limits on abortion, the

[164] *Id.*

[165] Erika L. Sabbath, Samantha M. McKetchnie, Kavita S. Arora & Mara Buchbinder, *US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans*, 7 JAMA OBSTETRICS & GYNECOLOGY 1, 5 (Jan. 17, 2024).

[166] *See* Whitney Arey, Klaira Lerma, Anitra Beasley, Lorie Harper, Ghazaleh Moayedi & Kari White, *A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8*, 387 NEW ENG. J. MED. 388, 389 (2022).

[167] *Id.*

[168] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

[169] *Id.*

[170] *Id.*

[171] Frederiksen et al., *supra* note 162.

landscape is scarcely better — 44% of physicians still refrain from making referrals, and 10% decline to offer informational support regarding available choices.[172] In another study, researchers impersonating pregnant women found that Oklahoma hospitals struggled to articulate clear emergency abortion protocols, often deferring questions to lawyers instead.[173] Furthermore, polling reveals nearly half of women in states with abortion bans do not know if medication abortion remains legal.[174] This chilling environment delays needed care, encourages physicians to practice overly cautious medicine to avoid legal risks, overrides evidence-based practice, and disrupts essential health services.

Ultimately, abortion restrictions yield widespread suffering. One-third of women may now forgo pregnancy due to worries around emergency abortion care access post-*Dobbs*.[175] Though comprehensive data is lacking, initial research reveals few people are receiving abortions under existing health exceptions in states with bans.[176] As the public health implications of stripping reproductive healthcare become increasingly apparent, the narrowness of purported health exceptions intensifies resulting hardships. The next Part elucidates how these restrictions disproportionately impact people with disabilities, compounding a long history of inadequate reproductive healthcare for this community and reinforcing discriminatory barriers.

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[172] *Id.*

[173] CHRISTIAN DE VOS, MICHELE HEISLER, WILLIAM JAFFE, PAYAL SHAH, TAMYA COX-TOURÉ, PRIYA DESAI, NIMRA J. CHOWDHRY, RISA KAUFMAN & RABIA MUQADDAM, NO ONE COULD SAY: ACCESSING EMERGENCY OBSTETRICS INFORMATION AS A PROSPECTIVE PRENATAL PATIENT IN POST-ROE OKLAHOMA 1 (Claudia Rader ed., 2023).

[174] Shefali Luthra, *Americans Don't Know if Abortion is Legal in Their State, New Poll Shows*, THE 19TH (Feb. 1, 2023, 2:00 AM), https://19thnews.org/2023/02/where-is-abortion-legal-americans-unsure-poll-shows/ [https://perma.cc/4LCH-XYQP] (finding that 47% of women in states with abortion bans did not know whether mifepristone was legal in their state).

[175] Priya Elangovan, *New AIT Polling on Abortion and Voter Enthusiasm*, ALL IN TOGETHER (Sept. 13, 2023), https://aitogether.org/republican-motivation-2024/ [https://perma.cc/JDC6-MHGE].

[176] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

II. ABORTION BANS: JEOPARDIZING THE HEALTH AND WELL-BEING OF DISABLED PEOPLE

Abortion bans with vague and narrow health exceptions disproportionately harm people with disabilities, eroding their reproductive rights, jeopardizing their health and well-being, and undermining the trust essential to patient-physician relationships. Despite protections enshrined in disability rights laws, systemic barriers and widespread ableism within the healthcare system obstruct equitable access to reproductive care for disabled people. Ambiguous exceptions in abortion laws based on subjective and narrow criteria only serve to exacerbate these challenges, leaving people with disabilities uniquely vulnerable.

This Part examines the severe consequences of abortion bans with vague health exceptions for people with disabilities. It explores the existing barriers disabled people face when seeking healthcare, highlights their disproportionately high risks of pregnancy-related complications and maternal mortality, critiques the absence of mental health considerations in most abortion law exceptions, and examines how these vague exceptions erode trust in patient-physician relationships. By exploring these critical issues, this Part demonstrates the urgent need for clear, comprehensive health exceptions in abortion statutes that affirm the reproductive rights of people with disabilities and prioritize their health and autonomy. The current legal framework perpetuates systemic ableism, undermines bodily integrity, and unconscionably jeopardizes the lives of an already marginalized population.

A. Exacerbating Barriers to Equitable Healthcare

People with disabilities face significant barriers when seeking healthcare, including reproductive healthcare services and information, despite legal protections such as Section 504 of the Rehabilitation Act of 1973 ("Section 504"),[177] the Americans with Disabilities Act of 1990 ("ADA"),[178] and the Patient Protection and Affordable Care Act

[177] Rehabilitation Act of 1973, 29 U.S.C. § 794(a).

[178] Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213.

("ACA").[179] The vague health exceptions in abortion laws compound these obstacles, providing additional latitude to deny access to reproductive healthcare. Consequently, these ambiguous exceptions create another roadblock, barring equitable access for a community already marginalized within the healthcare system.

Disabled people encounter systemic hurdles across the entire spectrum of healthcare, ranging from interpersonal communication with providers to navigating inaccessible environments.[180] Attitudinal barriers among healthcare professionals significantly obstruct access, with some providers openly admitting to discharging people with disabilities over accommodations requests.[181] Many physicians remain reluctant to accept disabled people requiring communication aids, extra time, or accessibility needs, often citing financial or logistical reasons.[182] Furthermore, inaccessible medical diagnostic equipment and facilities create additional physical impediments despite the federal disability rights laws' requirements for accessible healthcare facilities and equipment.[183] Inaccessible medical tools, such as scales, exam tables, and imaging machines, restrict treatment options for people with disabilities.[184] Surveys have revealed pervasive accessibility barriers within the healthcare system, with only a small percentage of facilities

[179] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[180] Robyn M. Powell, *Applying the Health Justice Framework to Address Health and Health Care Inequities Experienced by People with Disabilities During and After COVID-19*, 96 WASH. L. REV. 93, 104-07 (2021) (describing the current state of health and healthcare inequities for people with disabilities); *see also Common Barriers to Participation Experienced by People with Disabilities*, CDC, (May 2, 2024) https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html [https://perma.cc/9NG9-B4DM].

[181] Tara Lagu, Carol Haywood, Kimberly Reimold, Christene DeJong, Robin Walker Sterling & Lisa I. Iezzoni, *'I Am Not the Doctor for You': Physicians' Attitudes About Caring for People with Disabilities*, 41 HEALTH AFFS. 1387, 1392-93 (2022).

[182] *Id.*

[183] Elizabeth Pendo, *Reducing Disparities Through Health Care Reform: Disability and Accessible Medical Equipment*, 4 UTAH L. REV. 1057, 1057 (2010).

[184] *Id.* at 1059-64.

providing accessible weight scales and height-adjustable examination tables suitable for people with physical disabilities.[185]

In turn, such barriers contribute to harmful health outcomes for people with disabilities. As a group, they experience far worse treatment compared to their nondisabled peers.[186] Although disabled people access healthcare more frequently than nondisabled people, they report lower overall health levels and higher rates of co-occurring conditions.[187] For example, adults with disabilities are four times more likely to report their health to be fair or poor than adults without disabilities (40.3% versus 9.9%).[188] Studies also show that disabled people are less likely to receive essential preventive care, such as dental check-ups, mammograms, and vaccinations, as compared to nondisabled people.[189] These disparities are particularly acute for disabled people of color and LGBTQ+ people with disabilities as they often face the compounded effects of ableism, racism, homophobia, and transphobia, resulting in even more significant barriers to accessing quality healthcare and poorer health outcomes.[190]

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[185] Nancy R. Mudrick, Mary Lou Breslin, Mengke Liang & Silvia Yee, *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews*, 5 DISABILITY & HEALTH J. 159, 159, 165 (2012) (finding that among over 2,000 primary care offices in California accepting Medicaid patients, less than 4% provided accessible weight scales suitable for wheelchair users and people with physical disabilities, and less than 9% had height-adjustable examination tables).

[186] Gloria L. Krahn, Deborah Klein Walker & Rosaly Correa-De-Araujo, *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH S198, S201 (2015); Richard Besser, *Disability Inclusion: Shedding Light on an Urgent Health Equity Issue*, ROBERT WOOD JOHNSON FOUND.: CULTURE OF HEALTH BLOG (Dec. 2, 2019), https://www.rwjf.org/en/blog/2019/12/disability-inclusion-shedding-light-on-an-urgent-health-equity-issue.html [https://perma.cc/KE9W-2RQ7].

[187] NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 23, 34-35 (2009).

[188] Krahn et al., *supra* note 186, at S198.

[189] Heather F. de Vries McClintock, Frances K. Barg, Sam P. Katz, Margaret G. Stineman, Alice Krueger, Patrice M. Colletti, Tom Boellstorff & Hillary R. Bogner, *Health Care Experiences and Perceptions Among People with and Without Disabilities*, 9 DISABILITY & HEALTH J. 74, 74-75 (2016) (reviewing studies).

[190] *See* Willi Horner-Johnson, *Disability, Intersectionality, and Inequity: Life at the Margins*, *in* PUBLIC HEALTH PERSPS. ON DISABILITIES: SCI., SOC. JUST., ETHICS, AND BEYOND 91, 96-98 (Donald J. Lollar, Willi Horner-Johnson & Katherine Froehlich-Grobe, eds., 2nd ed. 2021); Monika Mitra, Linda Long-Bellil & Robyn Powell, *Persons with Disabilities*

Reproductive health inequities among people with disabilities are especially pervasive and stem from systemic denial of equitable healthcare access. According to the World Health Organization ("WHO") and the World Bank, disabled people experience numerous unmet reproductive health needs, including inadequate access to sexual education, contraception, and reproductive health screenings, as well as substantial gaps in provider competencies related to disability, sexuality, and reproduction.[191] Consequently, disabled people face a 40% higher likelihood of experiencing unintended pregnancies.[192] Despite having comparable rates of sexual activity as nondisabled people, disabled people often encounter barriers when seeking reproductive healthcare.[193] A recent study found that 50% of women with disabilities

and Public Health Ethics, *in* THE OXFORD HANDBOOK OF PUBLIC HEALTH ETHICS 219, 225 (Anna C. Mastroianni, Jeffery P. Kahn & Nancy E. Kass eds., 2019); Lesley A. Tarasoff, *"We Exist": The Health and Well-Being of Sexual Minority Women and Trans People with Disabilities*, *in* ELIMINATING INEQUITIES FOR WOMEN WITH DISABILITIES: AN AGENDA FOR HEALTH AND WELLNESS 179, 187-88 (Shari E. Miles-Cohen & Caroline Signore eds., 2016); MEGAN BUCKLES & MIA IVES-RUBLEE, CTR. FOR AM. PROGRESS. IMPROVING HEALTH OUTCOMES FOR BLACK WOMEN AND GIRLS WITH DISABILITIES 1-2 (2022), https://www.americanprogress.org/article/improving-health-outcomes-for-black-women-and-girls-with-disabilities/; EMILY DIMATTEO, OSUB AHMED, VILISSA THOMPSON & MIA IVES-RUBLEE, CTR. FOR AM. PROGRESS, REPRODUCTIVE JUSTICE FOR DISABLED WOMEN: ENDING SYSTEMIC DISCRIMINATION 2-3 (2022), https://www.americanprogress.org/article/reproductive-justice-for-disabled-women-ending-systemic-discrimination/.

[191] *See* WORLD HEALTH ORG. & THE WORLD BANK, WORLD REPORT ON DISABILITY 60-61, 77-79 (2011), https://apps.who.int/iris/handle/10665/44575 [https://perma.cc/4Q4Q-2T6X].

[192] *See* Willi Horner-Johnson, Mekhala Dissanayake, Justine P. Wu, Aaron B. Caughey & Blair G. Darney, *Pregnancy Intendedness by Maternal Disability Status and Type in the United States*, 52 PERSPS. ON SEXUAL & REPROD. HEALTH 31, 33 (2020) (finding a higher proportion of pregnancies were unintended among disabled women compared to nondisabled women); *see also* Jeanne L. Alhusen, Tina Bloom, Kathryn Laughon, Lillian Behan & Rosemary B. Hughes, *Perceptions of Barriers to Effective Family Planning Services Among Women with Disabilities*, DISABILITY & HEALTH J., July 2021, at 1, 1-2 (reviewing studies showing higher unintended pregnancy rates among women with disabilities compared to women without disabilities).

[193] Nechama W. Greenwood & Joanne Wilkinson, *Sexual and Reproductive Health Care for Women with Intellectual Disabilities: A Primary Care Perspective*, INT'L J. FAM. MED. 1-2 (Dec. 2013); Annie-Laurie McRee, Abigail A. Haydon & Carolyn Tucker Halpern, *Reproductive Health of Young Adults with Physical Disabilities in the U.S.*, 51 PREVENTATIVE MED. 502, 502 (2010).

have experienced logistical barriers to accessing reproductive health care.[194] Inaccessible medical facilities and equipment, such as narrow doorways, inaccessible exam tables, and lack of accessible information and forms, impede their care.[195] These barriers contribute to disabled people receiving subpar healthcare — including fewer critical cancer screenings — resulting in later diagnosis and lower survival rates.[196] Ableist attitudes among some reproductive health providers further obstruct care, with providers often making incorrect assumptions about disabled people's sexual activity and reproductive health needs.[197] Many providers also lack training in addressing disability-specific reproductive and sexual health issues.[198]

These systemic barriers to reproductive healthcare, coupled with ableist attitudes and lack of provider training, create significant obstacles for people with disabilities seeking abortion care. Ambiguous health exceptions allowing subjective denial of services based on narrow criteria exacerbate these challenges by erecting additional roadblocks and compromising autonomy. Financial limitations, Medicaid restrictions, geographical obstacles, and inaccessible facilities further obstruct abortion access for disabled people.[199] For instance, many disabled people rely on Medicaid, yet prohibitions on using federal funds

[194] M. Antonia Biggs, Rosalyn Schroeder, M. Tara Casebolt, Bianca I. Laureano, Lauren J. Ralph, Shelly Kaller, Aliza Adler & Margaret W. Gichane, *Access to Reproductive Health Services Among People with Disabilities*, JAMA NETWORK OPEN. 1-6 (Nov. 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360 [https://perma.cc/APX2-TW9N].

[195] An Nguyen, *Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review*, 38 SEXUALITY & DISABILITY 371, 374, 382-83 (2020); Heather A. Swadley & Maeve Keeley-Mehrad, *"Deeply Rooted": Abortion Federalism, Divided Citizenship, and Disability Reproductive (In)justice*, 45 J. WOMEN, POL. & POL'Y 59, 67-69 (2024).

[196] Swadley & Keeley-Mehrad, *supra* note 195, at 68.

[197] *See* Nguyen, *supra* note 195, at 383; Laura H. Taouk, Michael F. Fialkow & Jay A. Schulkin, *Provision of Reproductive Healthcare to Women with Disabilities: A Survey of Obstetrician–Gynecologists' Training, Practices, and Perceived Barriers*, 2 HEALTH EQUITY 207, 208, 212-13 (2018).

[198] Taouk et al., *supra* note 197, at 208.

[199] Swadley & Keeley-Mehrad, *supra* note 195, at 68.

for abortion significantly increase financial barriers to accessing care.[200] Moreover, the scarcity of accessible facilities creates pronounced hurdles to accessing abortion.[201] This lack of access is especially burdensome in states with abortion restrictions and impacts 52% of all disabled women.[202] Together, existing systemic barriers and vague health exceptions place a disproportionate burden on disabled people, restricting their reproductive rights and ability to make informed decisions about their bodies and futures.

The numerous barriers to reproductive healthcare, coupled with ambiguous health exceptions in abortion laws, have particularly severe consequences for pregnant people with disabilities. They face widespread ableism and obstacles when accessing essential perinatal care.[203] These barriers include a lack of physically accessible facilities and equipment, gaps in provider disability awareness and training, communication challenges, and financial obstacles related to care costs and insurance limitations.[204] As described next, this pervasive failure to meet the needs of pregnant people with disabilities contributes to the considerably higher rates of adverse outcomes they experience spanning prenatal, labor and delivery, and postpartum contexts. The severity of these outcomes demonstrates the ethical necessity of implementing unambiguous health exceptions to affirm the right of disabled people to access care, ultimately preserving their health and well-being.

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[200] *See generally* Robyn M. Powell, *Including Disabled People in the Battle to Protect Abortion Rights: A Call-to-Action*, 70 UCLA L. REV. 831-32 (2023) (explaining how the Hyde Amendment results in many disabled people having access to abortion care because they receive Medicaid).

[201] NAT'L P'SHIP FOR WOMEN & FAMS. & AUTISTIC SELF ADVOC. NETWORK, ACCESS, AUTONOMY, & DIGNITY: ABORTION CARE FOR PEOPLE WITH DISABILITIES 10 (2021), https://nationalpartnership.org/wp-content/uploads/2023/02/repro-disability-abortion.pdf [https://perma.cc/38UK-VEQM] (describing common barriers to abortion care for people with disabilities, including physical inaccessibility).

[202] KATHERINE GALLAGHER ROBBINS, SHAINA GOODMAN & JOSIA KLEIN, NAT'L P'SHIP FOR WOMEN & FAMS., STATE ABORTION BANS HARM MORE THAN 15 MILLION WOMEN OF COLOR 2 (2023), https://nationalpartnership.org/wp-content/uploads/2023/02/state-abortion-bans-harm-woc.pdf [https://perma.cc/3QBJ-PHV8].

[203] Monika Mitra, Linda M. Long-Bellil, Suzanne C. Smeltzer & Lisa I. Iezzoni, *A Perinatal Health Framework for Women with Physical Disabilities*, 8 DISABILITY & HEALTH J. 499, 502-04 (2015).

[204] *Id.*

B. Ignoring the Risks of Pregnancy-Related Complications

Although many disabled people have low-risk pregnancies and can safely give birth, others face substantial health risks that endanger their lives. This Section examines the disproportionately higher maternal mortality and morbidity rates among disabled people as well as the dangers of disabilities being exacerbated during pregnancy. Banning abortion severely violates bodily integrity by coercively imposing pregnancy's physical burdens on a population already navigating healthcare barriers and inaccessible medical systems unequipped to accommodate their needs. The vague, narrow exceptions in abortion bans eliminate this essential healthcare option, forcing the continuation of high-risk pregnancies without informed consent or meaningful choice. Such bans jeopardize disabled people's access to vital care and compel the assumption of potentially life-threatening pregnancy risks, thus contravening their rights.

Specifically, women with disabilities face significantly elevated risks of severe complications and death during pregnancy and childbirth, encountering over eleven times the maternal mortality rate and substantially higher odds of almost all adverse maternal outcomes compared to nondisabled women.[205] These risks span pregnancy, childbirth, and postpartum, including increased likelihood of gestational diabetes, preeclampsia, depression, cesarean delivery, preterm birth, low-birth-weight infants, stillbirth, and miscarriage.[206]

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[205] Jessica L. Gleason, Jagteshwar Grewal, Zhen Chen, Alison N. Cernich & Katherine L. Grantz, *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, JAMA NETWORK OPEN 1, 4-6 (Dec. 2021), https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2787181 [https://perma.cc/JMN8-GYVE].

[206] *See, e.g.*, Ilhom Akobirshoev, Susan L. Parish, Monika Mitra & Eliana Rosenthal, *Birth Outcomes Among US Women with Intellectual and Developmental Disabilities*, 10 DISABILITY & HEALTH J. 406, 409 (2017) [hereinafter Akobirshoev et al., *Birth Outcomes and Developmental Disabilities*] (finding adverse maternal and child health outcomes among women with intellectual and developmental disabilities); Jeanne L. Alhusen, Rosemary B. Hughes, Genevieve Lyons & Kathryn Laughon, *Depressive Symptoms During the Perinatal Period by Disability Status: Findings from the United States Pregnancy Risk Assessment Monitoring System*, 79 J. ADVANCED NURSING 223, 229 (2023) (finding that women with disabilities are over twice as likely to experience depressive symptoms during pregnancy and postpartum than women without disabilities); Hilary K. Brown & Monika Mitra, *Improved Obstetric Care for People with Disabilities: An Urgent Call for*

Women with physical and sensory disabilities experience strikingly high rates of pregnancy-related complications, including urinary tract infections, blood clots, premature ruptured membranes, cesarean delivery, postpartum depression, and post-delivery injury.[207] Similarly, women with intellectual and developmental disabilities face heightened risks, including over double the maternal mortality rate, elevated preterm birth odds, increased underweight infant probability, and higher stillbirth risk (with non-white women experiencing even more

Accessibility and Inclusion, 31 J. WOMEN'S HEALTH 4, 4 (2022) (citing studies showing increased risk of adverse pregnancy outcomes among disabled women); Mekhala V. Dissanayake, Blair G. Darney, Aaron B. Caughey & Willi Horner-Johnson, *Miscarriage Occurrence and Prevention Efforts by Disability Status and Type in the United States*, 29 J. WOMEN'S HEALTH 345, 350 (2020) (finding that women with disabilities had higher odds of having a miscarriage than women without disabilities); Willi Horner-Johnson, Sheetal Kulkarni-Rajasekhara, Blair G. Darney, Mekhala Dissanayake & Aaron B. Caughey, *Live Birth, Miscarriage, and Abortion Among U.S. Women with and without Disabilities*, 10 DISABILITY & HEALTH J. 382, 384 (2017) (finding that women with complex activity limitations had higher odds of miscarriage); Monika Mitra, Michael M. McKee, Ilhom Akobirshoev, Anne Valentine, Grant Ritter, Jianying Zhang, Kimberly McKee & Lisa I. Iezzoni, *Pregnancy, Birth, and Infant Outcomes Among Women Who Are Deaf or Hard of Hearing*, 58 AM. J. PREVENTATIVE MED. 418, 420 (2020) [hereinafter Mitra et al., *Pregnancy, Birth, and Infant Outcomes Among Women Who Are Deaf or Hard of Hearing*] (documenting that Deaf and hard of hearing women had an increased risk of adverse pregnancy complications); Lesley A. Tarasoff, Saranyah Ravindran, Hannan Malik, Dinara Salaeva & Hilary K. Brown, *Maternal Disability and Risk for Pregnancy, Delivery, and Postpartum Complications*, 222 AM. J. OBSTETRICS & GYNECOLOGY 27, 29-33 (2020) (describing studies on perinatal outcomes among women with disabilities).

[207] *See, e.g.*, Deborah A. Crane, David R. Doody, Melissa A. Schiff & Beth A. Mueller, *Pregnancy Outcomes in Women with Spinal Cord Injuries: A Population-Based Study*, 11 J. PHYSICAL MED. & REHAB. 795, 798-801 (2019) (reporting adverse pregnancy outcomes among women with spinal cord injuries); Monika Mitra, Ilhom Akobirshoev, Michael M. McKee & Lisa I. Iezzoni, *Birth Outcomes Among U.S. Women with Hearing Loss*, 51 AM. J. PREVENTATIVE MED. 865, 867-70 (2016) (documenting pregnancy and birth complications among Deaf and hard of hearing women); Mitra et al., *Pregnancy, Birth, and Infant Outcomes Among Women Who Are Deaf or Hard of Hearing*, *supra* note 206, at 420 (finding poor maternal and child outcomes among Deaf and hard of hearing women); Melissa A. Schiff, David R. Doody, Deborah A. Crane & Beth A. Mueller, *Pregnancy Outcomes Among Visually Impaired Women in Washington State, 1987–2014*, 14 DISABILITY & HEALTH J. 452, 454 (2021) (analysis showed higher rates of poor pregnancy outcomes among women who were blind or had low vision).

significant disparities).[208] Women with mental health disabilities, such as bipolar disorder and schizophrenia, also experience increased risks of gestational diabetes, preeclampsia, hypertension, and preterm birth.[209]

Pregnant women with other disabilities, such as epilepsy, diabetes, and chronic conditions, also encounter increased risks of complications like preeclampsia, preterm delivery, ruptured membranes, fetal anomalies, macrosomia, neonatal hypoglycemia, and neonatal

[208] *See, e.g.*, Akobirshoev et al., *Birth Outcomes and Developmental Disabilities*, *supra* note 206, at 408-10 (reporting adverse birth outcomes among newborns of women with intellectual and developmental disabilities); Ilhom Akobirshoev, Monika Mitra, Susan L. Parish, Tiffany A. Moore Simas, Robbie Dembo & Collette N. Ncube, *Racial and Ethnic Disparities in Birth Outcomes and Labour and Delivery-Related Charges Among Women with Intellectual and Developmental Disabilities*, 63 J. INTELL. DISABILITY RSCH. 313, 318-19 (2019) (revealing adverse birth outcomes among women of color with intellectual and developmental disabilities); Monika Mitra, Ilhom Akobirshoev, Anne Valentine, Hilary K. Brown & Tiffany A. Moore Simas, *Severe Maternal Morbidity and Maternal Mortality in Women With Intellectual and Developmental Disabilities*, 61 AM. J. PREVENTATIVE MED. 872, 877 (2021) (showing severe maternal morbidity and maternal mortality among women with intellectual and developmental disabilities); Monika Mitra, Susan L. Parish, Karen M. Clements, Xiaohui Cui & Hafsatou Diop, *Pregnancy Outcomes Among Women with Intellectual and Developmental Disabilities*, 48 AM. J. PREVENTATIVE MED. 300, 306 (2015) (finding that women with intellectual and developmental disabilities experience increased rates of poor pregnancy outcomes); Beth A. Mueller, Deborah Crane, David R. Doody, Sally N. Stuart & Melissa A. Schiff, *Pregnancy Course, Infant Outcomes, Rehospitalization, and Mortality Among Women with Intellectual Disability*, 12 DISABILITY & HEALTH J. 452, 454 (2019) (documenting maternal morbidity among women with intellectual and developmental disabilities); Eric Rubenstein, Deborah B. Ehrenthal, David C. Mallinson, Lauren Bishop, Hsiang-Huo Kuo & Maureen S. Durkin, *Birth Outcomes Affecting Infants of Mothers with Intellectual and Developmental Disabilities*, 35 PAEDIATRIC & PERINATAL EPI. 706, 709 (2021) (finding that women with intellectual and developmental disabilities experience poor birth outcomes).

[209] *See, e.g.*, Malak A. Mohamed, Abdulrahman Elhelbawy, Maria Khalid, Latifa A. AbdAllatif & Hagar E. Lialy, *Effects of Bipolar Disorder on Maternal and Fetal Health During Pregnancy: A Systematic Review*, 23 BMC PREGNANCY CHILDBIRTH 1, 10 (2023) (describing risks of maternal and child health complications among women with mental health disabilities); Thinh N. Nguyen, Deb Faulkner, Jacqueline S. Frayne, Suzanna Allen, Yvonne L. Hauck, Daniel Rock & Jonathan Rampono, *Obstetric and Neonatal Outcomes of Pregnant Women with Severe Mental Illness at a Specialist Antenatal Clinic*, 199 MED. J. AUSTL. S26, S28 (2012) (finding adverse obstetric and neonatal outcomes associated with severe mental illness).

hyperbilirubinemia.[210] Women with multiple chronic conditions have significantly higher rates of preterm birth, cesarean section delivery, and severe maternal morbidity and mortality, facing a 276% greater risk of serious complications or death during childbirth.[211] Furthermore, people with conditions like autoimmune disorders, blood disorders, heart disease, and kidney disease face substantially increased pregnancy risks despite close monitoring, often presenting heightened dangers of major complications or death.[212] Thus, some healthcare providers advise people with these conditions against pregnancy, while some pregnant people opt to terminate pregnancies that could pose significant health risks.[213] Yet, abortion bans with narrow exceptions jeopardize lives by mandating that individuals carry such hazardous pregnancies to term

[210] *See, e.g.*, AM. DIABETES ASS'N, *Management of Diabetes in Pregnancy: Standards of Medical Care in Diabetes — 2018*, 41 DIABETES CARE S137, S137 (2018) (describing increased risks of pregnancy complications among people with diabetes); Lori M. Gawron, Jessica N. Sanders, Katherine Sward, Azadeh E. Poursaid, Rebecca Simmons & David K. Turok, *Multi-Morbidity and Highly Effective Contraception in Reproductive-Age Women in the US Intermountain West: A Retrospective Cohort Study*, 35 J. OF GEN. INTERNAL MED. 637, 637 (2019) (explaining increased risks of pregnancy-related complications experienced by people with chronic health conditions); Sima I. Patel & Page B. Pennell, *Management of Epilepsy During Pregnancy: An Update*, 9 THERAPEUTIC ADVANCES IN NEUROLOGICAL DISORDERS 118, 124 (2016) (exploring issues related to pregnancy among people with epilepsy); Ajleeta Sangtani, Lauren Owens, David T. Broome, Preethi Gogineni, William H. Herman, Lisa H. Harris & Lauren Oshman, *The Impact of New and Renewed Restrictive State Abortion Laws on Pregnancy-Capable People with Diabetes*, 23 CURRENT DIABETES REPS. 175, 176-77 (2023) (discussing how abortion restrictions harm people with diabetes who are at greater risk of pregnancy complications); *Chronic Health Conditions and Pregnancy*, MARCH OF DIMES, https://www.marchofdimes.org/find-support/topics/planning-baby/chronic-health-conditions-and-pregnancy (last visited Feb. 23, 2024) [https://perma.cc/KSS2-8BT5] (reviewing issues impacting pregnant people with chronic health conditions).

[211] Lindsay K. Admon, Tyler N.A. Winkelman, Michele Heisler & Vanessa K. Dalton, *Obstetric Outcomes and Delivery-Related Health Care Utilization and Costs Among Pregnant Women with Multiple Chronic Conditions*, 15 PREVENTING CHRONIC DISEASE 1, 3 (2018), https://www.cdc.gov/pcd/issues/2018/17_0397.htm [https://perma.cc/EH9Y-BYSC].

[212] *See* Lynda A. Tyer-Viola & Ruth Palan Lopez, *Pregnancy with Chronic Illness*, 43 JOGNN 25, 25 (2014); *Pre-Existing Maternal Medical Conditions*, UNIV. OF ROCHESTER MED. CTR., https://www.urmc.rochester.edu/ob-gyn/maternal-fetal-care/maternal-care/maternal-conditions-we-treat.aspx (last visited Aug. 20, 2024) [https://perma.cc/5JPK-DDMW].

[213] Tyer-Viola & Lopez, *supra* note 212, at 25; Allison M. Whelan, *Chronic Conditions and Reproduction in a Post-*Dobbs *World*, 77 OKLA. L. REV. 93, 109 (2024).

without accommodating the substantial health threats to this community.

Beyond maternal mortality and morbidity rates, the physical burdens of pregnancy can directly exacerbate some disabilities and impose significant physiological changes that can severely compromise health for those with chronic conditions.[214] For example, women with relapsing-remitting multiple sclerosis who discontinue treatment with Natalizumab before or during pregnancy have been shown to experience multiple sclerosis relapses during or after pregnancy.[215] Women with existing heart conditions can experience intensified cardiovascular system stress during pregnancy that seriously endangers them by exacerbating their disability.[216] Pregnancy can also suddenly worsen lupus, an autoimmune disorder, and potentially cause life-threatening blood clots.[217] Asymptomatic valvular heart defects may start leaking or improperly closing under the cardiovascular strain.[218] Kidney disorders like Alport syndrome often deteriorate from fluid shifts and volume

[214] *Abortion Can Be Medically Necessary*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS: NEWS RELEASES, ADVOC. AND POL'Y (Sept. 25, 2019), https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary [https://perma.cc/69SG-73CK] ("Pregnancy imposes significant physiological changes on a person's body. These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death.").

[215] Kerstin Hellwig, Marianne Tokic, Sandra Thiel, Nina Esters, Charlotte Spicher, Nina Timmesfeld, Andrea I. Ciplea, Ralf Gold & Annette Langer-Gould, *Multiple Sclerosis Disease Activity and Disability Following Discontinuation of Natalizumab for Pregnancy*, JAMA NETWORK OPEN 1, 1 (Jan. 2022), https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2788309 [https://perma.cc/5N6S-H8DZ].

[216] Mayo Clinic Staff, *Heart Conditions and Pregnancy: Know the Risks*, MAYO CLINIC (Aug. 10, 2023), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20045977 [https://perma.cc/BA3N-2H2C].

[217] J. Cortes-Hernandez, J. Ordi-Ros, F. Paredes, M. Casellas, F. Castillo & M. Vilardell-Tarres, *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 RHEUMATOLOGY 643, 646-47 (2002); Robert Silver, Sabrina Craigo, Flint Porter, Sarah S. Osmundson & Jeffery A. Kuller, Mary E. Norton & Soc'y for Maternal-Fetal Med., *Society for Maternal-Fetal Medicine Consult Series #64: Systemic Lupus Erythematosus in Pregnancy*, 228 AM. J. OBSTETRICS & GYNECOLOGY B41, B41 (2023).

[218] Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 HEART 552, 553, 555 (2007).

spikes.[219] Pregnant people with pulmonary hypertension can experience dangerously increased pressure in the blood vessels of the lungs.[220] Meanwhile, preexisting diabetes often severely decompensates under the metabolic demands of pregnancy, leading to extreme risks like pregnancy-induced blindness.[221]

As experts observe, "[p]regnancy can be disabling for many people, but people with chronic health conditions must consider pregnancy as a potential *further* disabling event."[222] Abortion may be crucial for one's well-being when medications contraindicated during pregnancy become necessary for disabilities.[223] For example, abruptly discontinuing psychiatric medications risks severe withdrawal effects and heightened suicide risk.[224] Similarly, many epilepsy medications heighten fetal abnormality risks, but suddenly stopping them can trigger seizures, endangering the pregnant person and fetus.[225] Thus, some disabled people may opt for abortion due to health-related concerns rather than endure the threats of suspending critical treatment.

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[219] Koji Matsuo, Erika L. Tudor & Ahmet A. Baschat, *Alport Syndrome and Pregnancy*, 109 OBSTETRICS & GYNECOLOGY 531, 531-32 (2007).

[220] David G. Kiely, Robin Condliffe, Vicki J. Wilson, Suarabh V. Gandhi & Charlie A. Elliot, *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 OBSTETRIC MED. 144, 146 (2013).

[221] Am. Coll. of Obstetricians & Gynecologists Comm. on Prac. Bulls. — Obstetrics, *ACOG Practice Bulletin No. 190: Gestational Diabetes Mellitus*, 131 OBSTETRICS & GYNECOLOGY e49, e49 (2018).

[222] Hassan et al., *supra* note 23, at 198 (emphasis in original).

[223] *See An Overlooked Perspective: The Implications of Roe v. Wade Being Overturned for People with Disabilities*, ABLE S.C., https://www.able-sc.org/resource-library/position/an-overlooked-perspective-the-implications-of-roe-v-wade-being-overturned-for-people-with-disabilities/ (last visited Aug. 7, 2024) [https://perma.cc/69SS-RRFR] [hereinafter ABLE S.C.]; *see also* Lori M. Gawron, Jessica N. Sanders, Katherine Sward, Azadeh E. Poursaid, Rebecca Simmons & Davis K. Turok, *Multi-Morbidity and Highly Effective Contraception in Reproductive-Age Women in the US Intermountain West: A Retrospective Cohort Study*, 35 J. GEN. INTERNAL MED. 637, 637 (2019).

[224] ABLE S.C., *supra* note 223.

[225] *See* Mark S. Yerby, *Clinical Care of Pregnant Women with Epilepsy: Neural Tube Defects and Folic Acid Supplementation*, 44 EPILEPSIA 33, 37 (2003); Naymee J. Velez Ruiz, *Pregnancy*, EPILEPSY FOUNDATION (Nov 5, 2023), https://www.epilepsy.com/treatment/medicines/pregnancy; *Epilepsy and Pregnancy: What You Need to Know*, MAYO CLINIC (Aug. 12, 2022), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20048417# [https://perma.cc/8EQZ-EAVP].

Abortion bans are clearly detrimental because they heighten health risks for disabled people. They disregard rights to healthcare access and self-determination over pregnancy, an intensely personal medical situation with severe potential consequences for those with complex conditions. The ambiguous health exceptions utilize hopelessly narrow qualification standards, failing to account for disabilities' wide-ranging nature and complexities. This actively denies disabled people the agency to protect their well-being when seeking necessary care according to their doctors' advice. Moreover, forcing the continuation of precarious pregnancies against medical recommendations shows negligence, making conditions potentially worse or life-threatening. The outcome is a loss of abilities, independence, and longevity instead of affirming access to essential treatment. Ultimately, the current legal framework ignores reproductive autonomy rights and disregards the medical realities disabled people face, unconscionably jeopardizing health in already vulnerable populations. Restricting abortion access places disabled people at unacceptable and avoidable risk — a risk that deeply undermines personal rights and well-being rather than upholding equality.

C. Disregarding Mental Health Disabilities

At least one in five pregnant women experience mental health disabilities during the perinatal period, either exacerbating a pre-existing condition or newly developing one while pregnant or postpartum.[226] Moreover, mental health conditions are a leading cause of pregnancy-related deaths in the United States.[227] This substantial prevalence demonstrates the critical need for abortion policy to account for mental health conditions with appropriately defined exceptions to prevent severe harm.

Despite this evident prevalence, most abortion bans consciously exclude mental health within their exceptions.[228] By intentionally omitting protections for mental health conditions in abortion restrictions, policymakers completely fail to account for pregnancy's

[226] CLARKE ET AL., *supra* note 105, at 44.

[227] *See* Trost et al., *supra* note 106.

[228] *See supra* Part I.D.

substantial psychological impact. Moreover, reluctance to incorporate mental health considerations into abortion exceptions persists. This is evident in the exclusion of mental health proposals from ballot initiatives due to fears of undermining passage, as well as ongoing opposition arguing that such inclusions enable overly broad statutory interpretation.[229] Yet, carrying unwanted or emotionally traumatic pregnancies to term often severely provokes or intensifies mental health symptoms. The deliberate dismissal of psychiatric factors and refusal to include mental health considerations in statutory abortion exceptions demonstrate ignorance of the evidence exemplifying perinatal mood disorders' risks and pregnancy's heightened effect on mental well-being. Ultimately, exclusions force the continuation of mentally dangerous pregnancies, disregarding both the significant number of people affected and the resulting harms that contradict appropriate care standards

Pregnancy and the postpartum period represent times of heightened mental health risk. While many individuals develop or exacerbate anxiety and mood disorders during this time that cause distress without suicidal or psychotic symptoms,[230] others experience severe or even life-threatening conditions marked by active suicidal plans or psychosis.[231] These symptoms may also compel self-harm or the harming of others.[232] Specifically, the perinatal period substantially raises the risks of relapse and symptom exacerbation for those with pre-existing mental health conditions. Exacerbation of such conditions during pregnancy continues even with continued treatment. For example, a study of women with obsessive-compulsive disorder found 33% experienced worsening symptoms during pregnancy.[233] Another study found that

[229] *See* Fernando, *supra* note 118 (discussing unsuccessful efforts to add mental health to exceptions).

[230] Michael W. O'Hara & Katherine L. Wisner, *Perinatal Mental Illness: Definition, Description and Aetiology*, 28 BEST PRAC. & RSCH. CLINICAL OBSTETRICS & GYNECOLOGY 3, 5 (2014); *see* Richard A. Epstein, Katherine M. Moore & William V. Bobo, *Treatment of Bipolar Disorders During Pregnancy: Maternal and Fetal Safety and Challenges*, 7 DRUG, HEALTHCARE & PATIENT SAFETY 7, 7 (2015).

[231] *See* O'Hara & Wisner, *supra* note 230, at 6; Epstein et al., *supra* note 230, at 9.

[232] *See* sources cited *supra* note 231.

[233] Valeria Guglielmi, Nienke C. C. Vulink, Damiaan Denys, Ying Wang, Jack F. Samuels & Gerald Nestadt, *Obsessive-Compulsive Disorder and Female Reproductive Cycle*

among women with depression taking medication, 26% endured recurrent major depressive episodes.[234] And despite mood stabilizers, another study found that 37% of people with bipolar disorder relapsed while pregnant.[235] Moreover, 55% of those with pre-existing bipolar disorder experienced another mood episode during pregnancy, according to another study.[236]

Recurrence during this vulnerable time risks longer-lasting mental health impacts. Relapsing can provoke symptoms like delusions that make regaining stability much more difficult.[237] It also predicts worse postpartum outcomes. Mood episodes among pregnant women with bipolar disorder raise the likelihood of continued or new symptoms after birth tenfold.[238] Therefore, mental health instability during pregnancy and the postpartum period often leads to long-term challenges rather than being a temporary condition that resolves on its own.

The high rates of recurrence and relapse of mental health conditions during pregnancy underscore the serious consequences of omitting mental health exceptions in abortion laws. By eliminating access to necessary abortion care when pregnancy poses significant mental health

Events: Results from the OCD and Reproduction Collaborative Study, 31 DEPRESSION & ANXIETY 979, 979 (2014).

[234] Lee S. Cohen, Lori L. Altshuler, Bernard L. Harlow, Ruta Nonacs, D. Jeffrey Newport, Adele C. Viguera, Rita Suri, Vivien K. Burt, Victoria Hendrick, Alison M. Reminick, Ada Loughead, Allison F. Vitonis & Zachary N. Stowe, *Relapse of Major Depression During Pregnancy in Women Who Maintain or Discontinue Antidepressant Treatment*, 295 JAMA 499, 504 (2006).

[235] *See* Adele C. Viguera, Theodore Whitfield, Ross J. Baldessarini, D. Jeffrey Newport, Zachary Stowe, Alison Reminick, Amanda Zurick & Lee S. Cohen, *Risk of Recurrence in Women with Bipolar Disorder During Pregnancy: Prospective Study of Mood Stabilizer Discontinuation*, 164 AM. J. PSYCHIATRY 1817, 1820 (2007).

[236] Grace A. Masters, Julie Hugunin, Lulu Xu, Christine M. Ulbricht, Tiffany A. Moore Simas, Jean Y. Ko & Nancy Byatt, *Prevalence of Bipolar Disorder in Perinatal Women: A Systematic Review and Meta-Analysis*, 83 J. CLINICAL PSYCHIATRY 1, 6 (2022).

[237] *See* Laura Wakil, Elena Perea, Kenan Penaskovic, Alison Stuebe & Samanta Meltzer-Brody, *Exacerbation of Psychotic Disorder During Pregnancy in the Context of Medication Discontinuation*, 54 PSYCHOSOMATICS 290, 292 (2013).

[238] Cynthia L. Battle, Lauren M. Weinstock & Margaret Howard, *Clinical Correlates of Perinatal Bipolar Disorder in an Interdisciplinary Obstetrical Hospital Setting*, 158 J. AFFECTIVE DISORDERS 97, 97 (2014).

risks, these omissions force the continuation of pregnancies that endanger people's mental well-being, potentially leading to long-term negative outcomes.

Pregnant people with mental health conditions face difficult choices, balancing the risks of fetal exposure to medications with the risks of discontinuing treatment. For example, women with current or past mental health conditions have heightened chances of postpartum hemorrhage.[239] Uses of antidepressants before childbirth raise these odds.[240] However, quitting psychiatric medications during pregnancy also poses significant dangers. For example, one study found nearly 71% of pregnant women with bipolar disorder who discontinued mood-stabilizing treatment experienced a subsequent mood episode during pregnancy, compared to only 37% among those who maintained the mood-stabilizing medication.[241] Stopping benzodiazepines for anxiety may provoke "life-threatening" withdrawal symptoms without gradual tapering over months.[242] In another study, 68% of mothers with depression who stopped antidepressants during pregnancy relapsed.[243] Similarly, a striking 85.5% of people with bipolar disorder who stopped medication experienced a relapse in another study.[244] Women stopping these bipolar disorder medications face a 2.3 times higher recurrence of relapse as compared to those maintaining treatment.[245] Stopping necessary medication during pregnancy can also lead to prolonged periods of depression or mood issues. This cessation of treatment leaves people vulnerable to worsening symptoms, a situation that pregnancy

[239] Alkistis Skalkidou, Inger Sundström, Anna Wikman, Susanne Hesselman, Anna-Karin Wikström & Evangelia Elenis, *SSRI Use During Pregnancy and Risk for Postpartum Haemorrhage: A National Register-Based Cohort Study in Sweden*, 127 BRITISH J. OBSTETRICS & GYNAECOLOGY 1366, 1366 (2020) ("Postpartum haemorrhage prevalence was . . . 7.6% among women with prior or current psychiatric illness . . . .").

[240] *Id.* ("Postpartum hemorrhage prevalence was . . . 9.1% among women treated with SSRI.").

[241] Viguera et al., *supra* note 235, at 1820.

[242] *See* Jonathan Brett & Bridin Murnion, *Management of Benzodiazepine Misuse and Dependence*, 38 AUSTL. PRESCRIBER 152, 154 (2015).

[243] Cohen et al., *supra* note 234, at 504.

[244] Viguera et al., *supra* note 235, at 1820.

[245] *Id.*

itself can further exacerbate.[246] Therefore, pregnant people discontinuing psychiatric drugs confront heightened risks that deeply undermine mental health. By omitting mental health conditions from abortion policy exceptions, the complex risk tradeoffs that pregnant people with these conditions face are unconscionably discounted, eliminating vital access to care necessary when either medication discontinuation or continuation may provoke serious harm.

The deliberate exclusion of mental health considerations from abortion policy exceptions is unconscionable given the clear evidence of pregnancy's psychological toll. Between the high baseline prevalence of mental health conditions, recurrence risks despite treatment, and complex medication trade-offs, legal frameworks currently fail to account for mental health realities. This glaring omission enables the continuation of emotionally and mentally hazardous pregnancies, forcing endangerment and eliminating meaningful choices for affected people. Lives hang in the balance without evidence-based policy aligning with medical realities through appropriately defined mental health exceptions. Such exceptions represent a moral and ethical necessity to preserve access when continuation poses grave psychological harm. The deliberate dismissal of mental health conditions means that vital care is blocked despite overwhelming proof of risks.

D. Undermining the Patient-Physician Relationship

The patient-physician relationship is the bedrock of ethical medical practice, with professional guidelines mandating patient well-being as the primary consideration in all clinical judgments.[247] This relationship,

[246] *See id.* at 1822; Salvatore Gentile, *Lithium in Pregnancy: The Need to Treat, the Duty to Ensure Safety*, 11 EXPERT OPINION ON DRUG SAFETY 1, 1-2 (2012).

[247] AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, CODE OF PROFESSIONAL ETHICS 2 (Dec. 2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf [https://perma.cc/K6QX-WUSB] ("The patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments."); *see* CODE OF MEDICAL ETHICS 1.1.1 (AM. MED. ASS'N. 2017), https://policysearch.ama-assn.org/policyfinder/detail/1.1.1?uri=%2FAMADoc%2FEthics.xml-E-1.1.1.xml [https://perma.cc/HE96-RHZ2] (noting that physicians have an "ethical responsibility to place patients' welfare above the physician's own self-interest

built upon trust, open communication, and shared decision-making is particularly crucial for people with disabilities who have historically faced discrimination and mistreatment in healthcare settings.[248] However, abortion bans with ambiguous health exceptions threaten to erode this essential bond, disproportionately impacting disabled people by introducing confusion and fear into the clinical setting. As physicians navigate vague legal language and make subjective determinations about permissible abortions, they may be deterred from offering comprehensive care. As a result, people with disabilities encounter heightened barriers to accessing necessary reproductive healthcare services.

The history of abuse, exploitation, and mistreatment endured by people with disabilities at the hands of the medical system has left a legacy of distrust and trauma.[249] From forced sterilization to institutionalization, harmful practices have violated the rights and dignity of disabled people.[250] Despite progress in advancing disability rights, ongoing stigma, dismissal of agency, and questioning of capacity within healthcare settings continue to undermine the patient-physician relationship.[251] Providers' biases and misconceptions about the lives and abilities of disabled people, stemming from a lack of education and training in disability-related issues as well as deep-rooted societal

or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare").

[248] *See* NAT'L P'SHIP FOR WOMEN & FAMILIES & AUTISTIC SELF ADVOC. NETWORK, *supra* note 201, at 12-16 (describing a history of mistreatment of disabled people by the healthcare field).

[249] *See A Million Conversations: How We're Bridging the Healthcare 'Trust Gap' with Marginalized Communities*, SANOFI (Jan. 1, 2023), https://www.sanofi.com/en/magazine/social-impact/global-poll [https://perma.cc/QTQ6-N2VC] (discussing the "legacy of distrust in healthcare systems amongst marginalized groups, such as ethnic minorities, LGBTQ+ and people with disabilities"); *see also* Mary Crossley, *Ending-Life Decisions: Some Disability Perspectives*, 33 GA. ST. U. L. REV. 893, 897 (2017) ("Historical examples abound of instances where physicians, public health officials, and government programs have discriminated against, abused, or isolated people with disabilities, often with society's sanction.").

[250] *See* Crossley, *supra* note 249, at 897-900.

[251] *See* Lisa I. Iezzoni, *Stigma and Persons with Disabilities*, *in* STIGMA AND PREJUDICE: TOUCHSTONES IN UNDERSTANDING DIVERSITY IN HEALTHCARE 3, 12-15 (Ranna Parekh & Ed W. Childs eds., 2016).

stigma, erode trust and communication between patients and providers.[252]

Abortion bans with vague and narrow health exceptions have introduced significant confusion regarding permissible abortions. Ambiguous language, such as "medical emergencies" or "substantial and irreversible impairment," leaves healthcare providers uncertain about when they can legally provide abortion care.[253] This lack of clarity erodes trust in the patient-physician relationship as providers struggle to interpret the law and patients face uncertainty about access to necessary care. Moreover, these exceptions often require providers to make subjective determinations about a patient's health status or the imminence of health threats, reinforcing harmful stereotypes and assumptions about the inherent capabilities of disabled people.

The ambiguity surrounding health exceptions creates a chilling effect on healthcare providers who must choose between interpreting the exceptions broadly to accommodate their patients' needs or denying care until conditions deteriorate.[254] Providers face the risk of criminal penalties, loss of licensure, and reputational damage if their judgments are later disputed, thus disproportionately impacting people with disabilities who may require earlier interventions to prevent serious health complications. Furthermore, these vague exceptions place an extraordinary responsibility on healthcare providers to parse complex legal language and align their judgments with patients' worldviews, navigating the tension between ethical obligations to prioritize patient well-being and legal restrictions that limit their ability to provide care.

The erosion of trust in the patient-physician relationship caused by abortion bans with vague health exceptions can deter people with disabilities from seeking essential reproductive healthcare services. When trust is undermined, disabled people may be less likely to disclose sensitive information, ask questions, or follow through with recommended treatments, leading to delayed or foregone care that puts their health and well-being at risk.[255] This erosion of trust and

[252] *See id.*

[253] *See supra* Part I.B.

[254] *See supra* Part I.F.

[255] *See* Leana Wen, *I'm Pregnant. What Would Happen if I Couldn't Afford Health Care?*, NPR (Mar. 11, 2017, 5:00 AM ET), https://www.npr.org/sections/health-shots/2017/03/11/

deterrence from seeking care can lead to worsened health outcomes and heightened risks, such as increased rates of unintended pregnancy, pregnancy complications, and maternal morbidity and mortality.[256]

Abortion bans with vague health exceptions reinforce the discrimination and barriers people with disabilities face in accessing equitable reproductive healthcare. By perpetuating ableist assumptions and undermining trust in the patient-physician relationship, these laws make it even more difficult for disabled people to receive the care they need and deserve, leading to widening health disparities and further marginalization of an already underserved population. The erosion of trust caused by these bans contributes to the perpetuation of profound distrust in the medical establishment among people with disabilities. This distrust is rooted in a long history of abuse, neglect, and discrimination,[257] and is further compounded by ongoing experiences of bias and lack of cultural competency in healthcare settings.[258]

Ultimately, abortion bans with vague health exceptions weaponize the healthcare system against people with disabilities and erode trust, perpetuate discrimination, and undermine access to essential reproductive care. The ambiguity of these exceptions burdens patients and providers, forcing them to navigate a treacherous legal landscape that prioritizes political ideology over patient well-being. The erosion of trust in the patient-physician relationship caused by these bans is a critical issue that demands urgent attention and action because it

519416036/im-pregnant-what-would-happen-if-i-couldnt-afford-health-care ("Women without prenatal care are seven times more likely give birth to premature babies, and five times more likely to have infants who die."); *see also* Willi Horner-Johnson, Frances M. Biel, Aaron B. Caughey & Blair G. Darney, *Differences in Prenatal Care by Presence and Type of Maternal Disability*, 56 AM. J. PREVENTIVE MED. 376, 380-81 (2019) (finding women with disabilities are more likely to delay prenatal care).

[256] *See* Wen, *supra* note 255.

[257] *See, e.g.*, PAUL K. LONGMORE & LAURI UMANSKY, THE NEW DISABILITY HISTORY: AMERICAN PERSPECTIVES 33-57 (2001) (discussing historical abuses in medical institutions); SUSAN M. SCHWEIK, THE UGLY LAWS: DISABILITY IN PUBLIC 63-100 (2009) (detailing discriminatory laws and practices).

[258] *See* NAT'L P'SHIP FOR WOMEN & FAMILIES & AUTISTIC SELF ADVOC. NETWORK, *supra* note 201, at 12 (describing contemporary discrimination within the healthcare system).

undermines the fundamental principles of medical ethics and perpetuates systemic ableism within the healthcare system.[259]

III. THE ABSENCE OF LEGITIMATE GOVERNMENTAL INTEREST IN ABORTION BANS: PERPETUATING DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES

In the aftermath of *Dobbs*, states have enacted a patchwork of laws restricting abortion access, many of which include vague and narrow exceptions to purportedly protect the life or health of the pregnant person. Though proponents argue that these measures advance legitimate government interests, including the prevention of discrimination against people with disabilities, such claims ring hollow. Abortion bans with ill-defined health exceptions disproportionately endanger the lives and well-being of people with disabilities, contradicting the core principles of the disability rights movement. This Part demonstrates that these laws fail to serve any legitimate state interest and instead perpetuate discrimination. It examines how vague health exceptions endanger people with disabilities by obstructing access to necessary reproductive healthcare. This Part then argues that restricting access to abortion contradicts the fundamental disability rights principles of bodily autonomy and self-determination. Finally, it contends that even under the lenient rational basis standard of review, abortion bans with vague health exceptions still fail to advance any legitimate government interest.

A. Endangering Disabled People

Abortion bans with vague health exceptions do not protect people with disabilities — they harm them. Disabled people already face multitudes of barriers to accessing healthcare, and additional confusion over abortion ban health exceptions increases the likelihood of total denial of health-preserving and life-saving reproductive healthcare.[260] Restricting access through ambiguous statutes does not protect

[259] *See generally* TOM L. BEAUCHAMP & JAMES E. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (8th ed. 2019) (describing the four ethical principles that serve as the basis of analysis in the field of bioethics: autonomy, beneficence, justice, and non-maleficence).

[260] *See supra* Part II.A.

disabled people nor advance any legitimate state interest. It only exacerbates discrimination by essentially forcing the continuation of high-risk pregnancies while stripping people with disabilities of bodily autonomy and self-determination.

Research confirms that people with disabilities face substantially greater health risks related to pregnancy and childbirth compared to nondisabled people.[261] This long-documented vulnerability makes robust legal protection for abortion care essential. Ideally, disabled people would retain autonomy over their bodies, entitled to get abortions without having to experience a medical emergency that threatens their health or lives. However, *Dobbs* eliminated that right, forcing reliance on exceptions to restrictive abortion laws instead.

Current restrictions have a chilling effect on evidence-based care, denying procedures until people's health reaches emergency status.[262] Such deterrence further endangers disabled people, forcing futile suffering in conflict with medical ethics.[263] Requiring one to wait until there is a medical emergency further threatens the life of the pregnant person and does not serve a compelling state interest. Protecting a person's right to life requires access to abortion when there is a probability that the continuation of the pregnancy will endanger their life due to the pregnancy itself or due to a medical condition that they currently have or are likely to acquire during the pregnancy.[264]

B. Contradicting Disability Rights Principles

Bodily autonomy and self-determination are hallmarks of the disability rights movement.[265] A fundamental aspect of the disability

[261] *See supra* Part II.B.

[262] *See supra* Part I.C.

[263] *See supra* Part II.C.

[264] *See, e.g.*, Okla. Call for Reprod. Just. v. Drummond, 526 P.3d 1123, 1130 (Okla. 2023) (opining that protecting a person's right to life requires access to abortion when there is a "probability that the continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer from during the pregnancy").

[265] Samuel R. Bagenstos & Margo Schlanger, *Hedonic Damages, Hedonic Adaptation, and Disability*, 60 VAND. L. REV. 745, 795 (2007) ("[P]aternalism has historically been one of the most significant contributors to the disadvantage people with disabilities

rights movement involves challenging paternalism and the belief that people with disabilities should rely on others, such as family members and professionals, to make decisions on their behalf.[266] Disabled people are often denied reproductive decision-making control, and abortion restrictions further impede their ability to exercise their fundamental rights to bodily autonomy and self-determination.[267]

Access to abortion services is a critical means of ensuring disabled people can navigate the severe disadvantages they endure, including inadequate reproductive healthcare, poverty, and violence.[268] These inequities are further compounded for those who live at the intersection of disability and other marginalized identities.[269] Ironically, the Court in *Dobbs* held that states have a legitimate interest in regulating abortion to "prevent[] discrimination" against people with disabilities.[270] However, restricting abortion access directly contradicts bodily autonomy and self-determination. History reveals restrictions on disabled people's choices as deeply patronizing, dehumanizing paternalism that discriminates under the guise of protection.[271] Claiming to advance disability rights or prevent discrimination through vehicles denying reproductive freedom and health access ultimately rings hollow.

experience. Non-disabled parents, teachers, doctors, rehabilitation counselors, employers, and others have arrogated to themselves the prerogative to decide what is best for people with disabilities. In so doing, they have deprived people with disabilities of opportunities to work and participate in the community. They have denied people with disabilities the autonomy that consists in making one's own choices. And they have denied people with disabilities the 'dignity of risk' — 'the opportunity to develop their skills, test them in the world, and succeed or fail according to their talents.'" (footnotes omitted) (quoting Samuel R. Bagenstos, *The Americans with Disabilities Act as Welfare Reform*, 44 WM. & MARY L. REV. 921, 997 (2003))).

[266] *See* JAMES I. CHARLTON, NOTHING ABOUT US WITHOUT US: DISABILITY OPPRESSION AND EMPOWERMENT 3 (1998).

[267] Powell, *Including Disabled People in the Battle to Protect Abortion Rights*, *supra* note 200, at 812-14 (2023).

[268] *Id.* at 794, 814.

[269] *Id.* at 779-80.

[270] Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 301 (2022).

[271] *See* Robyn M. Powell, *Confronting Eugenics Means Finally Confronting its Ableist Roots*, 27 WM. & MARY J. RACE, GENDER, & SOC. JUST. 607, 612-15 (2021).

C. Lacking Rational Basis

In overturning *Roe*, the Court held that abortion access is no longer "a fundamental constitutional right."[272] As a result, state restrictions are now only subject to rational basis review, the most lenient judicial standard favoring government regulation. Under this test, a law "must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests."[273] Because these "legitimate interests include respect for and preservation of prenatal life at all stages of development," laws disproportionately limiting disabled people's access through vague health exceptions fail to meet even this low bar.[274]

First, as established above, restricting abortion access for people with disabilities directly contradicts the core disability rights principles of bodily autonomy and self-determination.[275] It is irrational to claim that laws infringing on these fundamental values somehow prevent discrimination against disabled people. Second, unclear and inconsistent standards in health exceptions actually jeopardize the health and lives of pregnant people with disabilities who face heightened risks from pregnancy and childbirth.[276] Forcing them to forego medically necessary abortions until reaching the precipice of a life-threatening emergency lacks any legitimate rationale. Finally, vague laws chill the provision of essential healthcare by creating uncertainty regarding where the line is drawn between lawful and criminal conduct.[277] This deters physicians from providing abortions even when clearly necessary to preserve health, an utterly unreasonable result.

Thus, so long as ambiguity persists, people with disabilities will remain disproportionately endangered by abortion bans with ill-defined health exceptions. These laws not only contradict core disability rights principles, but they also jeopardize the health and lives of an already vulnerable population. Ultimately, restricting disabled people's access

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[272] *Dobbs*, 597 U.S. at 300.

[273] *Id.* at 301.

[274] *Id.*

[275] *See supra* Part III.B.

[276] *See supra* Part II.B.

[277] *See supra* Part I.F.

to vital reproductive healthcare fails to advance any legitimate government interest and instead perpetuates discrimination. Disability rights demand clear, consistent legal standards that safeguard the bodily autonomy and self-determination of all people, including access to abortion.

IV. CHARTING A COURSE TO REPRODUCTIVE JUSTICE FOR ALL: LEGAL STRATEGIES AND PROPOSED REFORMS

The fight for abortion rights has entered a new and perilous phase. As states rush to enact restrictive abortion laws, the reproductive rights and lives of all people, particularly those with disabilities, are under threat. In this critical moment, disability rights advocates and their allies must employ a multifaceted strategy to protect abortion access and advance reproductive justice for the disability community. This Part explores key avenues for safeguarding abortion rights in a post-*Dobbs* landscape, including leveraging state constitutional provisions, expanding and clarifying health exceptions in abortion laws, protecting providers and patients through statutory presumptions and burden-shifting, and driving incremental change through cross-movement advocacy and coalition-building. Additionally, this Part grapples with the potential pitfalls of overmedicalizing the fight for abortion rights and the urgent need to move beyond a narrow focus on health exceptions toward a more holistic, intersectional vision of reproductive justice that fully includes and empowers people with disabilities. By pursuing these strategies in tandem, centering the voices and experiences of the disability community, and building solidarity across movements, advocates can work to mitigate the devastating impact of abortion bans and lay the groundwork for a future in which reproductive autonomy is a reality for all.

A. Constitutional Avenues and Opportunities

The recent wave of state-level abortion restrictions poses significant threats to reproductive rights, particularly for people with disabilities. As these laws take effect, it is crucial to explore the constitutional avenues and opportunities available to challenge their validity and protect the fundamental rights of people with disabilities. By leveraging

state constitutional provisions — such as the right to life, equal protection, and due process clauses — advocates can build strong legal arguments to safeguard abortion access and ensure that these restrictive measures do not disproportionately harm people with disabilities.

Many state constitutions explicitly guarantee the right to life, liberty, and safety.[278] For instance, the Texas constitution states: "No citizen of this State shall be deprived of life, liberty, property, privileges or immunities, or in any manner disfranchised, except by the due course of the law of the land."[279] Similarly, Oklahoma's constitution affirms: "All persons have the inherent right to life, liberty, the pursuit of happiness, and the enjoyment of the gains of their own industry."[280] Under these provisions, people with disabilities have an established right to protect their lives, including their health and well-being.

Research consistently demonstrates that people with disabilities face substantially more significant health risks related to pregnancy and childbirth compared to non-disabled people.[281] They are more likely to experience complications such as preeclampsia, gestational diabetes, and postpartum hemorrhage, which can lead to severe morbidity and even mortality.[282] Furthermore, pregnancy can exacerbate disabilities, placing the lives of pregnant people with disabilities at risk.[283] Given these heightened risks, abortion access is crucial for people with disabilities to protect their constitutional right to life. When a pregnancy threatens the life or health of a person with a disability, denying them access to abortion services effectively deprives them of their right to life as guaranteed by state constitutions.

State right-to-life provisions must also be interpreted in conjunction with the constitutional guarantee of equal protection under the law. Although abortion bans may not explicitly distinguish between disabled and nondisabled people, they can have a discriminatory effect on people

[278] *See, e.g.*, GA. CONST. art. I, § 1, ¶ I ("No person shall be deprived of life, liberty, or property except by due process of law.").

[279] TEX. CONST. art. I, § 19.

[280] OKLA. CONST. art. II, § 2.

[281] *See supra* Part II.B.

[282] *Id.*

[283] *Id.*

with disabilities by disproportionately impacting those who face life-threatening pregnancies or have limited access to healthcare. While the Supreme Court's decision in *City of Cleburne v. Cleburne Living Center, Inc.*[284] limits federal equal protection claims involving disability discrimination, state constitutions offer an alternative pathway for protecting the rights of people with disabilities in the context of abortion access. Some state courts have applied heightened scrutiny to laws with a discriminatory effect on people with disabilities under their state's equal protection clause.[285] Some state constitutions explicitly prohibit disability-based discrimination, reinforcing the potential for state-level protections.[286] Consequently, state constitutions remain a vital tool for safeguarding the rights of people with disabilities in the face of abortion bans, despite the limitations imposed by federal precedents like *Cleburne*.

Moreover, many of the new abortion bans contain vague health exceptions that fail to provide "sufficient definiteness" such that "ordinary people can understand what conduct is prohibited," as required by due process principles.[287] These statutes also use undefined terms like "serious risk," "substantial and irreversible impairment," and "major bodily functions," making it difficult for physicians to determine what care is allowed, especially in the context of providing care for disabled people.[288] Conflicting provisions and exceptions further

[284] City of Cleburne, Tex. v. Cleburne Living Ctr., 473 U.S. 432, 446 (1985) (holding rational basis is the appropriate level of constitutional scrutiny of state action in cases involving people with intellectual disabilities). The Court has since extended rational basis to all people with disabilities. *See* Bd. of Trs. of the Univ. of Ala. v. Garrett, 531 U.S. 356, 367 (2001) ("States are not required by the Fourteenth Amendment to make special accommodations for the disabled, so long as their actions toward such individuals are rational.").

[285] *See* Michael E. Waterstone, *Disability Constitutional Law*, 63 EMORY L.J. 527, 573-80 (2014).

[286] *See, e.g.*, CONN. CONST. art. 1, § 20 ("No person shall be denied the equal protection of the law nor be subjected to segregation or discrimination in the exercise or enjoyment of his or her civil or political rights because of religion, race, color, ancestry, national origin, sex or *physical or mental disability*." (emphasis added)); FLA. CONST. art. I, § 2 ("No person shall be deprived of any right because of race, religion, national origin, or *physical disability*." (emphasis added)).

[287] Kolender v. Lawson, 461 U.S. 352, 357 (1983).

[288] *See supra* Part I.B.

compound this ambiguity. As a result, these laws may have a chilling effect on constitutionally protected rights and the ability of people with disabilities to receive necessary medical care. Courts should, therefore, strike down these statutes as unconstitutionally vague per the void-for-vagueness doctrine.[289] After all, "a vague law is no law at all."[290]

In conclusion, as states continue to enact restrictive abortion laws, advocates and legal professionals must utilize the full range of constitutional arguments available to protect the rights and lives of people with disabilities. By invoking state constitutional provisions that guarantee the right to life, equal protection, and due process, challengers can demonstrate how these laws disproportionately impact and discriminate against people with disabilities. Successful legal challenges can not only strike down unconstitutional abortion bans but also establish important precedents that recognize the unique risks and challenges faced by people with disabilities in the context of reproductive healthcare. Ultimately, by pursuing these constitutional avenues and opportunities, we can work towards a future where the rights and dignity of all people, including those with disabilities, are respected and protected in the face of ongoing threats to reproductive freedom.

B. Expanding and Clarifying Health Exceptions

To adequately protect the reproductive rights and well-being of people with disabilities, advocacy efforts must also prioritize the expansion and clarification of health exceptions in abortion statutes. Current exceptions often fail to explicitly include disabilities and mental health conditions, leaving many pregnant people without access to necessary care. By working to broaden the scope of these exceptions and ensure they encompass both physical and mental health disabilities, advocates can create a more equitable legal framework that recognizes the diverse needs of the disability community.

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[289] United States v. Lanier, 520 U.S. 259, 266 (1997) (describing the rule of lenity and void-for-vagueness doctrine as "related manifestations of the fair warning requirement" of due process); Bouie v. Columbia, 378 U.S. 347, 350-51 (1964) (outlining the Court's earlier opinions on the void-for-vagueness doctrine).

[290] United States v. Davis, 588 U.S. 445, 447 (2019).

Pregnancy can exacerbate disabilities and, in some cases, even cause life-threatening complications.[291] For example, people with autoimmune disorders or mental health conditions may face severe flare-ups or relapses during pregnancy, jeopardizing their carefully managed treatment plans and overall stability.[292] Furthermore, forcing people with disabilities to continue pregnancies against their will can inflict grave physical and psychological harm, violating the principles of bodily autonomy, self-determination, and freedom from cruel and unusual treatment. The anguish and trauma associated with being denied access to abortion care can have long-lasting effects on an individual's physical and psychological well-being, relationships, and ability to function in daily life.[293]

Explicitly including mental health considerations in abortion exceptions is particularly critical for protecting the rights and well-being of people with disabilities. Mental health conditions such as depression, anxiety disorders, and post-traumatic stress disorder ("PTSD") can be significantly exacerbated by pregnancy and childbirth, leading to severe symptoms and even suicide.[294] Recognizing the profound impact of pregnancy on both physical and mental health aligns with the comprehensive definition of health put forth by the WHO, which emphasizes "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[295] Incorporating this holistic understanding of health into abortion exceptions would ensure that pregnant people with disabilities can access abortion care to maintain their overall well-being and quality of life.

Moreover, the ADA offers a comprehensive framework for understanding the wide range of activities and functions essential to a person's health and well-being. The ADA broadly defines "major life activities" to include, but not be limited to, "caring for oneself,

[291] *See supra* Part II.B.

[292] *Id.*

[293] Christina Caron, *Does Being Denied an Abortion Harm Mental Health?*, N.Y. TIMES, https://www.nytimes.com/2022/05/24/well/mind/abortion-access-mental-health.html (last updated June 22, 2023).

[294] *See supra* Part II.C.

[295] Constitution of the World Health Organization, July 22, 1946, 14 U.N.T.S. 185 (entered into force Apr. 7, 1948).

performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[296] Additionally, major life activities encompass "the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."[297] By integrating this expansive understanding of disability into abortion law exceptions, pregnant people with disabilities would receive more comprehensive protection. This approach recognizes that threats to their mental health, social well-being, and ability to participate in major life activities can be as significant as threats to their physical health.

To effectively advocate for the inclusion of clear and comprehensive disability and mental health provisions in health exceptions, collaboration with disability rights advocates, mental health experts, and people with lived experience is essential. Their insights can help develop language that accurately reflects the diverse range of conditions and needs that may necessitate access to abortion care. Lawmakers must be educated on the profound impact of pregnancy on both physical and mental health disabilities and the importance of protecting the autonomy and well-being of this community.

Expanding and clarifying health exceptions in abortion legislation is a crucial step toward safeguarding the reproductive rights and overall well-being of people with disabilities. By explicitly including disability and mental health considerations, lawmakers can create a more equitable legal framework that recognizes the full spectrum of human health and affirms the dignity and autonomy of the disability community. Advocates must work to ensure that these exceptions are comprehensive, clearly defined, and grounded in the lived experiences of people with disabilities. Through these efforts, we can move closer to a future where pregnant people with disabilities have access to the reproductive healthcare they need to live healthy, self-determined lives.

[296] 42 U.S.C. § 12102(2)(A).

[297] 42 U.S.C. § 12102(2)(B).

C. Mitigating the Chilling Effect on Abortion Providers

Furthermore, to ensure that healthcare providers can confidently provide appropriate and timely care, abortion health exceptions must include robust legal protections for physicians exercising good-faith medical judgment. Some states problematically frame health exceptions as "affirmative defenses" rather than actual exceptions, placing the burden on physicians to prove that performed abortions meet narrow exception criteria.[298] For example, Tennessee's abortion prohibition, enacted after *Dobbs*, initially established an affirmative defense permitting abortions solely to prevent death or major bodily harm if proven that a physician acted in accordance with "reasonable medical judgment."[299] But meeting this defense posed steep burdens by requiring physicians to prove necessity by a preponderance of evidence.[300] This construct deliberately aimed to halt "quasi-elective" abortions.[301] Stories soon emerged of people denied abortion care despite life-threatening pregnancy complications.[302] Despite mounting pressure to amend the strict ban, the state's National Right to Life affiliate held a webinar urging legislators to maintain the rigid

[298] *A Review of Exceptions in State Abortion Bans*, *supra* note 56; Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few are Granted*, N.Y. TIMES (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html.

[299] TENN. CODE ANN. § 39-15-213(c) (2024).

[300] Kavitha Surana, *"We Need to Defend This Law": Inside an Anti-Abortion Meeting with Tennessee's GOP Lawmakers*, PROPUBLICA (Nov. 15, 2022), https://www.propublica.org/article/inside-anti-abortion-meeting-with-tennessee-republican-lawmakers [https://perma.cc/D6WP-EZGP] [hereinafter Surana, *"We Need to Defend This Law": Inside an Anti-Abortion Meeting with Tennessee's GOP Lawmakers*].

[301] Kavitha Surana, *Tennessee Lobbyists Oppose New Lifesaving Exceptions in Abortion Ban*, PROPUBLICA (Feb. 24, 2023), https://www.propublica.org/article/tennessee-lobbyists-oppose-new-life-saving-exceptions-abortion-ban [https://perma.cc/HF9Q-ZMTT] [hereinafter Surana, *Tennessee Lobbyists Oppose New Lifesaving Exceptions in Abortion Bans*]; *see* Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion*, PROPUBLICA (Mar. 14, 2023), https://www.propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy [https://perma.cc/HUL5-SFND] [hereinafter Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion*].

[302] Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion*, *supra* note 301.

approach.[303] Ultimately, their efforts failed.[304] In 2023, Tennessee amended the prohibition to add a standard medical emergency exception and clarified that physicians performing legal abortions would not face criminal charges.[305]

These laws allow states to prosecute doctors for providing lifesaving abortions, forcing physicians to argue at trial that the procedures were essential to safeguard their patients' health.[306] Though the state need only show an abortion was performed, doctors must then prove its medical necessity to avoid conviction, reversing the typical presumption of innocence.[307] Classifying abortion to protect a person's life or health as an "affirmative defense" has a chilling effect that discourages doctors from providing necessary care even when medically appropriate.[308] As physicians risk prosecution unless they can prove in court that the abortion was justified by medical necessity, this imposes unreasonable personal burdens and costs on healthcare professionals who want to prioritize patient wellbeing.

Some states' abortion bans lack explicit health exceptions. Instead, these laws identify narrow situations that may be used as an "affirmative defense" if a doctor is criminally charged for performing an abortion.[309] An "affirmative defense" allows someone accused of a crime to argue in court that their illegal conduct was justified under the circumstances.[310] However, critically, an affirmative defense does not make it legal for

[303] Surana, "*We Need to Defend This Law*": *Inside an Anti-Abortion Meeting with Tennessee's GOP Lawmakers*, *supra* note 300.

[304] *Id.*

[305] TENN. CODE ANN. § 39-15-213 (2024).

[306] *See, e.g.*, Janelle Bludau, *'There's So Much Confusion.' Houston Doctors Join Five Texas Women in Suing The State Over Abortion Law*, KHOU 11 (Mar. 9, 2023), https://www.khou.com/article/news/local/texas/texas-abortion-lawsuit-houston-doctors/285-53b56eda-166f-42db-8899-1a04ad3d39ba [https://perma.cc/CHS3-UUC9] (describing case involving five women and two physicians suing the state of Texas regarding abortion ban and health exceptions).

[307] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

[308] Walker, *supra* note 298.

[309] *A Review of Exceptions in State Abortion Bans*, *supra* note 56 (providing examples for states that lack exceptions but allow affirmative defenses, including Tennessee's six-week ban, Idaho's total ban, Kentucky's fifteen-week ban, but not Kentucky's earlier gestational bans, and all of Missouri's bans).

[310] *A Review of Exceptions in State Abortion Bans*, *supra* note 56.

doctors to perform abortions in the situations outlined.[311] Instead, it means clinicians who provide abortions may still be prosecuted — even if the abortion is performed to save a patient's life — and would bear the full burden of proof to demonstrate they provided care according to the precise conditions serving as permissible affirmative defenses.[312] This inverted presumption of guilt chills the provision of abortion services even when clearly medically necessitated and places undue burdens on pregnant people seeking abortions for health-related reasons, particularly those with disabilities.

To address these concerns and ensure that abortion remains accessible to those who need it, lawmakers should establish a statutory presumption that abortions performed for health-related reasons, including those related to physical or mental disabilities, qualify under health exceptions. This presumption would shift the burden of proof to the state to demonstrate that a provider violated the exception rather than placing the onus on physicians to prove the necessity of the care they provided. By providing physicians with greater legal protection and certainty, this approach enables them to make decisions based on their medical expertise and judgment without fear of unwarranted prosecution. Furthermore, lawmakers should establish clear guidelines for what constitutes sufficient documentation of medical necessity in the context of disability-related health exceptions. These guidelines should be developed in consultation with medical experts, disability rights advocates, mental health experts, and people with lived experience to ensure that they reflect the diverse range of health risks and complications that people with disabilities face during pregnancy. By providing physicians with a roadmap for how to document the medical basis for an abortion, these guidelines can help to ensure that health exceptions are applied consistently and fairly across cases.

Ultimately, the goal of these advocacy efforts should be to create a legal framework that recognizes abortion as essential healthcare, respects the expertise and judgment of healthcare providers, and ensures that all people have access to the reproductive healthcare they need to live healthy, self-determined lives. While statutory

[311] *Id.*

[312] *Id.*

presumptions can play an essential role in achieving these goals, they must be paired with clear, comprehensive, and medically appropriate health exceptions that explicitly include both physical and mental health disabilities to truly protect the rights and well-being of people with disabilities in the post-*Dobbs* era.

D. Incremental Advocacy and Coalition-Building

The fight for abortion rights and bodily autonomy is at a critical juncture, and the disability community is uniquely positioned to lead the way in advancing reproductive justice for all.[313] By centering the experiences and needs of people with disabilities, advocates can catalyze incremental changes that pave the way for broader systemic reforms. The disability community faces disproportionate risks and barriers when it comes to reproductive healthcare, including higher rates of pregnancy complications, maternal morbidity, and mortality.[314] By advocating for policies that address these disparities head-on, such as expanding health exceptions in abortion bans and pushing for clearer, more comprehensive protections, disability rights activists can secure critical gains that benefit not only their community but all people seeking reproductive autonomy.

Incremental progress, such as establishing more inclusive and accessible health exceptions, sets a precedent for further reforms and challenges the notion that abortion bans can be implemented without causing grave harm to marginalized groups. Research shows that most people agree that abortion should remain legal if a pregnancy endangers a person's health or life.[315] As policymakers and the public confront the

[313] Powell, *Including Disabled People in the Battle to Protect Abortion Rights*, *supra* note 200, at 819-20, 822-26 (calling for the inclusion of people with disabilities in the abortion rights movement).

[314] *See supra* Part II.B.

[315] A very small minority of Americans (9%) believe that abortion should be illegal in all circumstances. Shefali Luthra, *Total Abortion Bans are Not at All Popular, Poll Finds*, THE 19TH (Sept. 18, 2023), https://19thnews.org/2023/09/poll-abortion-americans-complex-views/ [https://perma.cc/L3GT-S75G]. The majority believe that abortion should be legal in all cases when: (1) the patient's health is endangered (66%), (2) the patient's life is endangered (74%), (3) the pregnancy is the result of rape or incest (74%), (4) the fetus is not expected to survive (63%), and (5) the fetus is expected to have serious birth defects (56%). *Id.* In contrast, 42% of respondents believe that abortion

real-life consequences of these restrictions on people with disabilities, it becomes increasingly difficult to justify the continued existence of such restrictive abortion laws. Moreover, by grounding advocacy efforts in the lived experiences and expertise of the disability community, advocates can build a more compelling, intersectional narrative highlighting the fundamental importance of bodily autonomy and self-determination for all people.

Alongside legislative advocacy, disability rights and reproductive justice groups should also pursue strategic litigation to challenge the constitutionality of abortion bans and push for broader interpretations of existing health exceptions. This may involve filing lawsuits in state courts that argue that abortion bans violate state constitutional protections or submitting amicus briefs in federal court cases arguing that abortion bans violate the ADA and other federal disability rights laws. When pursuing litigation, advocates should seek to center the stories and experiences of people with disabilities who have been directly impacted by abortion restrictions, recruiting plaintiffs who can speak to how abortion bans have jeopardized their health, exacerbated their disabilities, or forced them to carry pregnancies to term against their will. By putting a human face on the consequences of abortion restrictions, advocates can help to build public understanding and support for their cause.

This incremental approach also provides opportunities for coalition building and intersectional collaboration. Historically, disability rights and reproductive rights groups have not always worked in tandem, and there have been tensions between the two movements surrounding issues such as prenatal testing and disability-selective abortion.[316] However, there is a growing recognition that these movements share

should be legal in all circumstances for people "who do not wish to be pregnant." *Id.*; *see also* Laura Wronski, *PORES/SurveyMonkey Poll: Abortion*, NBC NEWS (Oct. 2022), https://www.surveymonkey.com/curiosity/pores-poll-abortion/ [https://perma.cc/KC4N-TKUK] (finding that 86% of respondents who identified as Republican believe that abortion should be legal if the pregnancy puts the women's health in serious danger, and 59% believe abortion should be legal if the fetus has an anomaly likely to require serious medical care and limit the infant's quality of life).

[316] Sujatha Jesudason & Julia Epstein, *The Paradox of Disability in Abortion Debates: Bringing the Pro-Choice and Disability Rights Communities Together*, 84 CONTRACEPTION 541, 541-42 (2011).

common goals and face common threats.[317] As disability rights advocates work to advance reproductive justice, they can forge alliances with other marginalized communities facing similar barriers and challenges. Importantly, people with disabilities constitute a significant community that favors abortion rights, with a national poll indicating that 53% of people with disabilities believe that abortion should be legal in most circumstances, closely mirroring the 55% of people without disabilities who hold the same view.[318] These partnerships not only amplify the collective power and reach of the movement but also foster a deeper understanding of the interconnected nature of reproductive oppression and the need for solidarity in the face of systemic injustice.[319]

By focusing on the specific needs and experiences of people with disabilities, advocates can develop more targeted, effective strategies for overcoming obstacles to reproductive justice. For example, by collecting and analyzing data on the impact of abortion bans on disabled people, advocates can build a stronger evidence base to support their claims in the courtroom and the court of public opinion. Collaboration with public health experts and healthcare providers will be essential for collecting and analyzing evidence on the prevalence and impact of pregnancy complications among people with disabilities — including rates of maternal morbidity and mortality, exacerbation of disabilities, development of new health conditions, and other adverse outcomes.[320] Armed with this data, advocates can make a compelling case that restrictive abortion laws are not only unconstitutional but also

[317] Char Adams, *Disability Rights Groups Are Fighting for Abortion Access — And Against Ableism*, NBC NEWS (July 21, 2022), https://www.nbcnews.com/news/us-news/disability-rights-groups-are-fighting-abortion-access-ableism-rcna38703 [https://perma.cc/7TW6-8QUY].

[318] Sara Luterman, *Exclusive: How Do People with Disabilities Feel About Abortion? New Poll Sheds Light for The First Time*, THE 19TH (May 10, 2022), https://19thnews.org/2022/05/how-people-with-disabilities-feel-abortion/ [https://perma.cc/Y2ZM-34LH].

[319] Powell, *Including Disabled People in the Battle to Protect Abortion Rights*, *supra* note 200, at 824 (recommending that "movements must work collectively to confront the attack on reproductive freedom, and that deliberately incorporating the needs, experiences, and perspectives of people with disabilities is essential to developing and implementing legal and policy responses.").

[320] Robyn M. Powell, *Reproductive Justice for Disabled People Post-*Dobbs*: A Call-to-Action for Researchers*, 17 DISABILITY & HEALTH J. 101572, 101572 (2024).

dangerous and discriminatory in their impact on disabled people, violating the basic principles of equal protection and human rights.

Ballot initiatives offer another powerful tool for advancing incremental change in states where legislatures are hostile to abortion rights. By working together in cross-movement advocacy to draft policies and campaign for initiatives that establish clear health exceptions and protections for people with disabilities, advocates can bypass legislative barriers and build broad public support for reproductive justice. However, the success of these campaigns is threatened by voter suppression tactics and gerrymandering, which disproportionately impact marginalized communities, including people with disabilities.[321] Strict voter identification laws disproportionately impact people with disabilities, who may face challenges in obtaining the necessary documentation due to accessibility barriers.[322] Inaccessible polling places and a lack of accessible voting machines also create significant obstacles for disabled voters.[323] Similarly, these tactics can hinder disability rights activists' efforts to ensure that the voices and needs of their community are represented in the policymaking process. To counter these challenges, disability rights advocates must collaborate with voting rights groups and other civil rights organizations to combat discriminatory laws and practices, ensuring that the disability community can fully participate in the democratic process and advocate for their reproductive rights.

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[321] David Landau & Rosalind Dixon, Dobbs*, Democracy, and Dysfunction*, 2023 WISC. L. REV. 1569, 1577-78 (2023); Leah Litman, Melissa Murray & Kate Shaw, *The Link Between Voting Rights and the Abortion Ruling*, WASH. POST (June 28, 2022), https://www.washingtonpost.com/outlook/2022/06/28/dobbs-voting-rights-minority-rule/; Alex Tausanovitch & Danielle Root, *How Partisan Gerrymandering Limits Voting Rights*, CTR. FOR AM. PROGRESS (July 8, 2020), https://www.americanprogress.org/article/partisan-gerrymandering-limits-voting-rights/ [https://perma.cc/Q2M3-4XFH].

[322] S.E. Smith, *Voting is Already Hard for People with Disabilities. Voter ID Laws Make it Even Harder.*, VOX (Apr. 1, 2016), https://www.vox.com/2016/4/1/11346714/voter-id-laws-disabilities [https://perma.cc/H7DR-WJXF].

[323] Katherine Gilyard, *'There Is Still Work to be Done': Voters with Disabilities Face Unaddressed Barriers to the Ballot*, THE 19TH (Nov. 9, 2023), https://19thnews.org/2023/11/voters-with-disabilities-unaddressed-barriers-accessibility/ [https://perma.cc/67FP-2QQV].

Thus, by centering the fight for abortion rights on the experiences of people with disabilities, advocates can create a more inclusive, intersectional, and effective movement for reproductive justice. Each victory achieved, each barrier overcome, and each alliance forged brings us one step closer to a world where every person, regardless of their identity or circumstances, has the freedom and autonomy to make decisions about their bodies and futures. As disability rights activists lead the way in this fight, they not only advance the cause of their community but also light the path toward a more just and equitable society for all. Through their efforts and commitment to intersectional advocacy, the disability community is poised to play a pivotal role in the struggle for reproductive justice, driving incremental change that will ultimately transform the lives of countless people and communities for generations to come.

E. Reconsidering the Medicalization of Abortion

Finally, as we navigate the complex landscape of abortion rights post-*Dobbs*, it is crucial to consider the potential pitfalls of overmedicalizing this struggle, especially for people with disabilities.[324] While advocating for robust health exceptions is a necessary short-term strategy, we must also recognize the ways in which a primarily medicalized framing can perpetuate ableism and undermine the broader goals of reproductive justice. The disability rights movement has long challenged the medicalization of disability, which reduces the complex lived experiences of disabled people to narrow diagnoses and frames disability as an individual "problem" to be fixed through medical intervention.[325] This medical model fails to recognize the societal barriers and discrimination that are truly disabling.[326] Applying a

[324] Professor Ruth Colker offers a robust analysis of these issues in a newly published article. *See* Ruth Colker, *Overmedicalization?*, 46 HARV. J.L. & GENDER 205, 256-62 (2023).

[325] Bradley A. Areheart, *When Disability Isn't "Just Right": The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma*, 83 IND. L.J. 181, 186-87 (2008); Jamelia N. Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401, 1406 (2021).

[326] Rabia Belt & Doron Dorfman, *Disability, Law, and the Humanities: The Rise of Disability Legal Studies*, *in* THE OXFORD HANDBOOK OF LAW AND HUMANITIES 145, 147 (Simon Stern, Maksymilian Del Mar, & Bernadette Meyler eds., 2020); *see* Rabia Belt &

similarly medicalized lens to abortion rights raises concerns, as it can center the judgment of doctors over the autonomy of pregnant people and create a hierarchy of "deserving" versus "undeserving" abortions based on medical necessity.[327]

The Court's decision in *Roe*, while groundbreaking in its recognition of the right to abortion, relied heavily on a medicalized framing that centered the judgment of doctors over the autonomy of pregnant people.[328] The trimester framework established in *Roe* was based on medical understandings of fetal viability and maternal health risks rather than on a fundamental commitment to reproductive freedom as a matter of personal liberty and bodily integrity.[329] This medicalized approach to abortion rights can be problematic for people with disabilities as it may perpetuate stigmatizing assumptions about their pregnancies and reproductive choices.

For people with disabilities, the impact of this medicalized framing can be particularly harmful. It can perpetuate stigmatizing assumptions that disabled people's pregnancies are inherently "high-risk" or that their abortion decisions are only valid if based on medical grounds related to their disabilities.[330] This fails to capture the full range of factors that shape disabled people's reproductive choices, including

Doron Dorfman, Response, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176, 186-87 (2020).

[327] *See* Claire Pierson & Fiona Bloomer, *Macro- and Micro-Political Vernaculizations of Rights: Human Rights and Abortion Discourses in Northern Ireland*, 19 HEALTH & HUM. RTS. J. 173, 181 (2017).

[328] *See* Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199 (1992) ("The idea of the woman in control of her destiny and her place in society was less prominent in the Roe decision . . .").

[329] Colker, *supra* note 324, at 256-57.

[330] *See* Anita Silvers, Leslie Francis & Brittany Badesch, *Reproductive Rights and Access to Reproductive Services for Women with Disabilities*, 18 AMA J. ETHICS 430, 432 (2016) (noting that healthcare providers often have misguided or overblown concerns about the risks of pregnancy for women with disabilities, frequently labeling their pregnancies as "high-risk" and ordering unnecessary tests or specialist referrals even when the woman's disability does not affect her reproductive health); Dympna Walsh-Gallagher, Marlene Sinclair & Roy Mc Conkey, *The Ambiguity of Disabled Women's Experiences of Pregnancy, Childbirth and Motherhood: A Phenomenological Understanding*, 28 MIDWIFERY 156, 158, 160, 161 (2012) (finding that women with disabilities are frequently categorized as "high risk" regardless of the presence or absence of additional risk factors).

societal barriers, lack of support services, discrimination by the family policing system, and more.[331] That is, a purely medicalized approach may exclude or stigmatize disabled people who seek abortions for non-medical reasons, creating a dichotomy of "good" abortions (those obtained for medical reasons or due to rape or incest) versus "bad" abortions (those obtained for other reasons like financial hardship or life circumstances).[332] Such a framing reinforces the notion that disabled people's pregnancies are inherently problematic and that their abortion decisions are only acceptable if based on medical grounds related to their disabilities.

While the concerns surrounding overmedicalization are undoubtedly valid, it is important to acknowledge the urgent short-term need for clear, expansive health exceptions to protect the lives and well-being of people with disabilities facing pregnancy complications in the current legal landscape. Advocating for laws that allow abortion when necessary to prevent serious risks to health or to prevent the exacerbation of disabilities can provide much-needed clarity and protection. However, these efforts must be situated within a larger, ongoing fight for reproductive justice that challenges ableist assumptions and structural barriers. Relying too heavily on a medicalized framework risks reinforcing the notion that only "medically necessary" abortions are valid instead of affirming the fundamental right of all people to make autonomous decisions about their bodies and lives.[333]

Thus, the goal should be to move beyond a medicalized framework and towards a vision of reproductive justice that fully includes and empowers people with disabilities. This means recognizing that disabled people's reproductive autonomy is shaped by a wide range of social, economic, and political factors — not just medical necessity. It means centering the voices and experiences of disabled people in the

[331] *See* Robyn M. Powell, *Disability Reproductive Justice*, 170 U. PA. L. REV. 1851, 1860-81; (2022); Robyn M. Powell, *Forced to Bear, Denied to Rear: The Cruelty of* Dobbs *for Disabled People*, 112 GEO. L.J. (forthcoming 2024) (manuscript at 14-29) (on file with author).

[332] Alison Norris, Danielle Bessett, Julia R. Steinberg, Megan L. Kavanaugh, Silvia De Zordo & Davida Becker, *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN'S HEALTH ISSUES S49, S50 (2011).

[333] Colker, *supra* note **Error! Bookmark not defined.**, at 263.

movement and challenging the stigma and discrimination that still surrounds disability and sexuality. A reproductive justice approach demands not only the right to abortion but also the right to have children and to parent with dignity and support.[334] It challenges the ableist assumptions and structural barriers that limit disabled people's reproductive freedoms and fights for a society in which all people can thrive and make meaningful choices about their bodies and lives.

Building this inclusive vision of reproductive justice will require collaboration and solidarity between the disability rights and reproductive justice movements. It will mean amplifying the voices of disabled activists and recognizing the diversity of the disability community and the many factors that shape individual reproductive experiences. Some people with disabilities may need access to abortion to protect their health and well-being, while others may need support and accommodation to parent successfully. Some may choose not to have children at all. All of these choices are valid and deserving of respect and support. It will also require a commitment to dismantling ableist assumptions and fighting for a society in which all people, regardless of disability status, have the resources, support, and freedom to make meaningful choices about their bodies and lives.

In the short term, advocating for robust health exceptions is a crucial safeguard for disabled people navigating a post-*Dobbs* landscape. But this must be part of a larger, ongoing struggle for true reproductive justice — one that recognizes the interconnectedness of bodily autonomy and disability rights. By grounding our efforts in the lived experiences of people with disabilities, challenging medicalization and ableism, and building cross-movement solidarity, we can work towards a future where reproductive freedom is a reality for all. This means not only fighting for the right to receive an abortion but also advocating for policies and practices that support disabled people's right to parent and build families on their own terms. It means challenging the ableist

334 Dorothy Roberts, *Reproductive Justice, Not Just Rights*, DISSENT (2015), https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights [https://perma.cc/U2E6-CDGG]; *see also* Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 343 (2013) (explaining that "reproductive justice is equally about the right to not have children, the right to have children, the right to parent with dignity, and the means to achieve these rights").

assumptions that devalue the lives of people with disabilities and limit their reproductive options. By centering disability rights within the reproductive justice movement, we can build a more inclusive, equitable, and just society for all.[335]

CONCLUSION

The fight for abortion rights and bodily autonomy stands at a critical juncture, and the disability community finds itself on the frontlines of this battle. As states rush to enact increasingly restrictive abortion laws in the wake of *Dobbs*, people with disabilities face disproportionate harms and barriers to accessing essential reproductive healthcare. Vague and narrow health exceptions, the omission of mental health considerations, and the pervasive stigma surrounding disability and sexuality all contribute to a post-*Dobbs* landscape that undermines the fundamental rights and dignity of the disability community. These laws fail to advance any legitimate government interest and instead perpetuate discrimination, endanger lives, and contradict core disability rights principles of autonomy and self-determination.

To protect the rights and well-being of people with disabilities, advocates must pursue a multifaceted strategy that includes constitutional litigation, statutory reform, and cross-movement coalition-building. By leveraging state constitutional provisions, expanding and clarifying health exceptions, and challenging the medicalization of abortion rights, we can work to mitigate the harms of these restrictive laws and lay the groundwork for a more inclusive, equitable, and just approach to reproductive justice. Central to this effort must be the voices and experiences of people with disabilities themselves, who have long been at the forefront of the fight for bodily autonomy and self-determination. As we navigate the complex landscape of abortion rights post-*Dobbs*, it is essential that we center the disability community and recognize the intersectionality of this struggle. Only by working together — across movements and identities

[335] Powell, *Including Disabled People in the Battle to Protect Abortion Rights*, *supra* note 200, at 822-26 (discussing the importance of centering disabled people in the fight for abortion rights).

— can we hope to achieve a future in which reproductive freedom is a reality for all.