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Galina Varchena

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IF ROE FALLS: WHOLE WOMAN'S HEALTH ACT AS A
NECESSARY STOP-GAP ON THE WAY TO FULL
PROTECTION OF BODILY AUTONOMY IN VIRGINIA

*Galina Varchena**

*Galina Varchena is the Policy and Communications Director for NARAL Pro-Choice Virginia, an organization that has been both instrumental in lobbying for the Whole Woman's Health Act and a policy leader in Virginia for abortion rights.

ABSTRACT

In 2016, the Supreme Court clarified the scenarios in which an “undue burden” is imposed on a pregnant person seeking an abortion in Whole Woman’s Health v. Hellerstedt. As a result, the constitutionality of many of Virginia’s abortion regulations seems in doubt. These unconstitutional regulations include the TRAP regulation that limits the type of facilities that can provide abortions, and statutes relating to informed consent and mandatory waiting periods. Thus, the outlook following the Court’s ruling in Whole Woman’s Health looked, if not bright, then at least hopeful for reproductive rights. That changed, though, with the Court’s 2018 ruling in National Institute of Family & Life Advocates v. Becerra and the retirement of Justice Anthony Kennedy. Both the Court’s seeming reversal of some of the progress made in Whole Woman’s Health in Becerra and Justice Kennedy’s retirement have darkened the outlook for reproductive rights going forward. Therefore, it is now necessary more than ever for Virginia to pass the Whole Woman’s Health Act to protect Virginians access to affordable and safe abortion services. The Whole Woman’s Health Act, that has been twice proposed and twice dismissed with little debate, would strike the statutes that Whole Woman’s Health suggested were unconstitutional from the Virginia Code. Thus, ensuring safe and equal access to abortion services for all those who are need of these critical health care services.

INTRODUCTION

In May 2018, the Special Session of the General Assembly was just coming to an end, and the goal for this paper was to make a strong argument that the General Assembly should pass the Whole Woman’s Health Act in Virginia because the 2016 Supreme Court decision, *Whole Woman’s Health v. Hellerstedt*, made many of Virginia’s abortion restrictions plainly unconstitutional.¹ The future looked, if not bright, then at least hopeful for reproductive rights.²

¹ See *Whole Women’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

² See Laura Vozzella & Gregory S. Schneider, *Virginia General Assembly Approves Medicaid Expansion to 400,000 Low-Income Residents*, WASH. POST (May 30, 2018), https://www.washingtonpost.com/local/virginia-politics/virginia-senate-approves-medicaid-expansion-to-400000-low-income-residents/2018/05/30/5df5e304-640d-11e8-a768-ed043e33f1dc_story.html?utm_term=.69aaf08351d5.

Then came *National Institute of Family & Life Advocates v. Becerra* (*NIFLA v. Becerra*) and the retirement of Justice Anthony Kennedy.³ *NIFLA v. Becerra*, in dicta, reaffirmed the Supreme Court's approval for persuasion-based regulations of abortion upheld in *Planned Parenthood v. Casey*,⁴ this time on First Amendment grounds, with little room for a balancing test or a fact-based inquiry.⁵ Additionally, Justice Kennedy's retirement and the nomination of Judge Brett Kavanaugh to the Supreme Court put the decision in *Whole Woman's Health*, if not the entirety of *Roe v. Wade*,⁶ in jeopardy.⁷ Meanwhile, in Virginia, the Board of Health moved to re-open the question of the Targeted Regulation of Abortion Providers (TRAP) regulations by directing the Commissioner of Health to restart the review process and issue a new Notice of Intended Regulatory Action (NOIRA).⁸ Additionally, several independent abortion providers filed a comprehensive federal lawsuit in the United States District Court for the Eastern District of Virginia challenging the very same statutes and regulations that the *Whole Women's Health Act* proposed to strip out of Virginia's civil and criminal code.⁹

In an ideal world, the constitutionality of a given statute would not depend on the current composition of the Supreme Court.¹⁰ This has never re-

³ Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018); see Michael D. Shear, *Supreme Court Justice Anthony Kennedy Will Retire*, N.Y. TIMES (June 27, 2018), <https://www.nytimes.com/2018/06/27/us/politics/anthony-kennedy-retire-supreme-court.html>.

⁴ *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

⁵ See *Becerra*, 138 S. Ct. at 2371–72 (“[T]his Court has not recognized ‘professional speech’ as a separate category of speech,” so “[s]peech is not unprotected merely because it is uttered by ‘professionals.’”).

⁶ *Roe v. Wade*, 410 U.S. 113 (1973).

⁷ David S. Cohen, *Scenario 3: The Right's Incremental Push to Make Abortion Illegal, With Kavanaugh's Help*, REWIRE NEWS (July 23, 2018), <https://rewire.news/article/2018/07/23/right-push-abortion-illegal-kavanaugh/>; Dawn Laguens, *Kavanaugh Will Not Uphold Roe*, THE HILL (July 10, 2018), <http://thehill.com/opinion/healthcare/396309-kavanaugh-will-not-uphold-roe>; see also Carol Joffe, *With the Appointment of Brett Kavanaugh, Roe v. Wade is Likely Dead*, WASH. POST (July 10, 2018), https://www.washingtonpost.com/news/made-by-history/wp/2018/07/10/with-the-appointment-of-brett-kavanaugh-roe-v-wade-is-likely-dead/?utm_term=.9db7426566ad (explaining that “[m]uch of the debate over the nomination of Brett Kavanaugh to succeed Anthony M. Kennedy on the Supreme Court will center on the fate of *Roe v. Wade* and the future of abortion rights in America.”).

⁸ Meeting Minutes, Va. State Bd. of Health (June 7, 2018), <http://www.vdh.virginia.gov/content/uploads/sites/4/2018/06/Minutes-June-2018-draft.pdf>.

⁹ See Complaint at 1, *Falls Church Med. Ctr. v. Oliver*, No. 3:18-cv-428 (E.D. Va. 2018) [hereinafter *Falls Church Complaint*]; see also Am. Civil Liberties Union of Va., *Virginia Health Care Providers File New LawsUIT Challenging Longstanding Abortion Restrictions*, ACLU VIRGINIA (June 22, 2018), <https://acluva.org/en/press-releases/virginia-health-care-providers-file-new-lawsuit-challenging-longstanding-abortion>.

¹⁰ This seems an impossibly idealistic standard, even looking at the different interpretations of the constitutionality of abortion regulations adopted by Justice Breyer and Justice Kennedy in *Whole Woman's Health* and *Stenberg v. Carhart*, and *Casey* respectively. For example, “[i]n *Gonzales v. Carhart*, Justice Kennedy emphasized a wide range of permissible state interests implicated by abortion,” putting preference on deference to state interests, “[w]here [the State] has a rational basis to act, and it does not im-

ally been true, as the ideology of the Court has swung back and forth throughout the decades.¹¹ But never before has the decision about the nomination of an associate justice to the Supreme Court been so blatantly based on a single litmus test as to make it improbable that the confirmation of Judge Kavanaugh will have no impact on the future of *Roe*.¹² After all, President Trump promised his constituents that he would appoint pro-life judges to the Supreme Court to overturn *Roe*.¹³

Even if *Roe* is not overturned outright and the shell of the right to abortion remains intact, it is highly likely that the constitutional right to a safe and legal abortion will continue to erode and the gains made in *Whole Woman's Health* will be swiftly reversed as new abortion cases reach the Supreme Court.¹⁴ The fundamental promise of *Roe*, that the pre-viability right to an abortion would be protected as a fundamental right wherein any government interference with the right would be required to satisfy a "strict

pose an undue burden, the State may use its regulatory power" to impose regulations "in furtherance of its legitimate interests." Laura Wolk & O. Carter Snead, *Irreconcilable Differences? Whole Woman's Health, Gonzales, and Justice Kennedy's Vision of American Abortion Jurisprudence*, 41 HARV. J.L. & PUB. POL'Y 719, 719 (2018) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007)). While in *Whole Woman's Health*, Justice Breyer wrote that "*Casey* requires courts to 'consider the burdens a law imposes on abortion access together with the benefits those laws confer' on pregnant women." *Id.* at 719–20 (quoting *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016)). This decision harkens back to "the approach he took in authoring *Stenberg v. Carhart*, another of the Supreme Court's seminal abortion decisions." *Id.* at 720 (citing *Stenberg v. Carhart*, 530 U.S. 914 (2000)). The complaint of judicial inconsistency goes both ways, with pro- and anti-abortion advocates noting the fluctuations in the application of the standards of review. See Kevin C. Walsh, *Symposium: The Constitutional Law of Abortion after Whole Woman's Health – What Comes Next?*, SCOTUS BLOG (June 28, 2016), <http://www.scotusblog.com/2016/06/symposium-the-constitutional-law-of-abortion-after-whole-womans-health-what-comes-next/>.

¹¹ See Alvin Chang, *The Volatility of the Supreme Court, Explained in a Cartoon*, VOX (July 2, 2018), <https://www.vox.com/2018/7/2/17518822/supreme-court-kennedy-median-justice-volatile-cartoon>.

¹² See, e.g., Linda Greenhouse, *A Kavanaugh Signal on Abortion?*, N.Y. TIMES (July 18, 2018), <https://www.nytimes.com/2018/07/18/opinion/abortion-kavanaugh-trump-supreme-court.html>; Aaron Blake, *Trump Makes Clear Roe v. Wade is on the Chopping Block*, WASH. POST (July 1, 2018), https://www.washingtonpost.com/news/the-fix/wp/2018/07/02/trump-makes-clear-roe-v-wade-is-on-the-chopping-block/?utm_term=.d781aac837bb; Barbara Sprunt, *Trump Downplays Roe v. Wade Litmus Test as He Considers a Supreme Court Nominee*, NAT'L PUB. RADIO (July 1, 2018), <https://www.npr.org/2018/07/01/625100343/trump-downplays-roe-v-wade-litmus-test-as-he-considers-a-supreme-court-nominee>.

¹³ See Dan Mangan, *Trump: I'll Appoint Supreme Court Justices to Overturn Roe v. Wade Abortion Case*, CNBC (Oct. 19, 2016), <https://www.cnbc.com/2016/10/19/trump-ill-appoint-supreme-court-justices-to-overturn-roe-v-wade-abortion-case.html>.

¹⁴ Even if *Roe* is overturned, abortion would not become illegal overnight and the determination of legality of abortion would return to the states. Dan Horn, *Ending Roe v. Wade Wouldn't End Abortion in America. This is What Happens Next.*, THE CINCINNATI ENQUIRER (July 9, 2018), <https://www.cincinnati.com/story/news/politics/2018/07/09/roe-v-wade-what-happens-if-supreme-court-scotus-overturns-abortion-precedent/759500002/>; Scott Lemieux, *Commentary: How SCOTUS Can Stop Abortions Without Overruling Roe*, REUTERS (July 10, 2018), <https://www.reuters.com/article/us-lemieux-scotus-commentary/commentary-how-scotus-can-stop-abortions-without-overruling-roe-idUSKBN1K025M> (explaining that "Chief Justice John Roberts' court is unlikely to overturn the *Roe v. Wade* ruling before the 2020 elections.").

scrutiny” test, has been watered down significantly, perhaps most notably by Justice Kennedy in the *Planned Parenthood v. Casey* compromise.¹⁵ The promise of *Roe* has never really been fulfilled for a large number of women due to income and geographic constraints and constant attacks at both the federal and state levels. In many cases, the promise of *Roe* has been illusory rather than real.¹⁶ *Roe* was a “promise of greater reproductive freedom and an end to the fear and secrecy that had plagued many people’s experiences of ending pregnancies,” and a statement that a person’s interests in their own bodily autonomy superseded those of the state, at least pre-viability.¹⁷

However, much like the provider-plaintiffs in the *Falls Church Medical Center v. Oliver*¹⁸ (*Falls Church v. Oliver*) lawsuit against the Commonwealth of Virginia, I am unwilling to concede the fundamental point that many of the statutes and regulations constraining abortion providers currently in place in Virginia are consistent with the United States Constitution.¹⁹ Until *Whole Woman’s Health* is actually overturned it remains good law, thus the General Assembly should act accordingly.

Abortion restrictions within the Virginia Code, even those previously upheld under *Casey*, are unlikely to withstand the undue burden test outlined in *Whole Woman’s Health*.²⁰ The principle of *stare decisis* dictates that the Supreme Court, regardless of its constituent justices, should continue to uphold *Whole Woman’s Health* and protect the right to a safe and legal abortion in the United States.²¹ While it is uncertain whether the Court

¹⁵ See *Roe v. Wade*, 410 U.S. 113, 163 (1973); Barry P. McDonald, *A Hellerstedt Tale: There and Back Again?*, 85 U. CIN. L. REV. 979, 988–89 (2018).

¹⁶ See Emily R. Champlin, Comment, *The Myth of the “Welfare Queen”: Reproductive Oppression in the Welfare System*, GOLDEN GATE U. SCH. OF L. POVERTY L. CONF. 1, 8–12 (2016), <https://digitalcommons.law.ggu.edu/povlaw/6/>.

¹⁷ FARAH DIAZ-TELLO, MELISSA MIKESSELL & JILL E. ADAMS, SIA LEGAL TEAM, *ROE’S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL 1* (2018); see *Roe v. Wade*, 410 U.S. 113, 163–64 (1973).

¹⁸ *Falls Church Med. Ctr. v. Oliver*, No. 3:18-cv-00428 (E.D. Va. filed June 20, 2018).

¹⁹ See Laura Vozzella, *Abortion Rights Groups Sue Virginia Over Restrictions They Call Medically Unnecessary*, WASH. POST (June 20, 2018), https://www.washingtonpost.com/local/virginia-politics/abortion-rights-groups-sue-virginia-over-restrictions-they-call-medically-unnecessary/2018/06/20/c2dd48d8-7499-11e8-b4b7-308400242c2e_story.html?utm_term=.2cd259f75fea (noting that restrictions “that do not advance health and safety constitute ‘undue burden’”).

²⁰ See Mark R. Herring, Va. Attorney Gen., *Statement of Attorney General Mark R. Herring On Supreme Court Ruling in Whole Woman’s Health v. Hellerstedt*, OFF. ATTORNEY GEN. (June 27, 2016), <https://www.oag.state.va.us/media-center/news-releases/772-june-27-2016-on-supreme-court-ruling-in-whole-woman-s-health-v-hellerstedt>.

²¹ *Stare Decisis*, BLACK’S LAW DICTIONARY (5th pocket ed. 2016) (defined as “The doctrine of precedent, under which a court must follow earlier judicial decisions when the same points arise again in litigation.”); Dawn Johnsen, *Entry 14: The Only Good Ruling Would Strike Down Texas’ Terrible Laws*, SLATE (June 26, 2016), http://www.slate.com/articles/news_and_politics/the_breakfast_table/features/2016/supreme_court_brea

will in fact do so, Virginia should follow the example of states like California,²² Montana,²³ and others, and seek to protect the residents of the Commonwealth from unnecessary encroachments on women's access to necessary reproductive healthcare.

While amending the current TRAP regulations through the proposed NOIRA process can provide some relief, it would not be enough to undo all of the unconstitutional and medically unnecessary constraints on abortion.²⁴ And, because of the peculiarities of Virginia's constitutional amendment process, achieving protection for abortion access through that avenue is a long, multi-year prospect.²⁵ Passing the Whole Woman's Health Act (the Act) would undo most of the worst abortion-related laws and regulations in Virginia with one stroke, ensuring that Virginia's laws are both constitutionally sound and consistent with good public health policy.²⁶ The Act would bring abortion in line with other medical procedures, such as colonoscopies, root-canals, and miscarriages.²⁷ The question that *Whole Woman's Health* seems to implicitly posit is this – if treating abortion differently (which never means less stringently) than other healthcare procedures will

kfast_table_for_june_2016/precedent_requires_the_supreme_court_to_save_abortion.html (implying that political party appointment may play a role in whether justices fairly apply precedential tests to future cases).

²² The California Constitution's enumerated right to privacy has been cited by state courts in striking down restrictions. CAL. CONST. art. I, § 1; *see, e.g.*, *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 831 (Cal. 1997) (striking down the parental consent law); *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 798–99 (Cal. 1981) (striking down state funding restrictions for abortion); *see also*, *Reproductive Privacy Act*, CAL. HEALTH & SAFETY CODE §§ 123460–123468 (2018) (codifying *Roe*).

²³ The Montana Constitution's enumerated rights to privacy and individual dignity have been cited by state courts in overturning abortion restrictions. MONT. CONST. art. II, §§ 4, 10; *see, e.g.*, *Planned Parenthood v. State*, No. BDV 95-722, 1999 Mont. Dist. LEXIS 1117, at *22 (1st Jud. Dist. Ct. Mont. Mar. 12, 1999) (granting permanent injunction against the 24-hour waiting period and state mandated informed consent requirements, and finding informed consent requirements unconstitutionally vague under state law); *Wicklund v. State*, No. ADV 97-671, 1999 Mont. Dist. LEXIS 1116, at *23 (1st Jud. Dist. Ct. Mont. Feb. 11, 1999) (overturning a parental notice or judicial waiver requirement before a minor can obtain an abortion); *Jeannette R. v. Ellery*, No. BDV-94-811, 1995 Mont. Dist. LEXIS 795, at *24 (1st Jud. Dist. Ct. Mont. May 22, 1995) (finding a regulation limiting state medical assistance for abortion in cases of life endangerment, rape and incest unconstitutional under the state constitution. However, these protections do not extend in Montana to post-viability abortions.).

²⁴ *See Regulatory Process in Virginia*, VA. REG. REGS., <http://register.dls.virginia.gov/process.shtml> (last visited Sept. 2, 2018) (requiring specific identification of the regulation to which an amendments or repeal is proposed).

²⁵ *See* VA. CONST. art. XII, § 1 (An amendment must first be passed by the majority of the General Assembly and then again, by a subsequent session following a general election of the House of Delegates before being placed on a special ballot, to become a part of the Constitution only after being approved by the majority of Virginians voting on the amendment).

²⁶ *See* H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018), (establishing a fundamental right to abortion prior to viability, and limiting enforceability on “any statute that places a burden on a pregnant person's access to abortion without conferring any legitimate health benefit”).

²⁷ *See generally id.* (limiting restrictions placed on abortions to only those “medically necessary”).

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always add additional burdens, then what is the benefit that justifies imposing this additional burden?

Part I of this paper will explain what the Whole Woman's Health Act is and what it would do, if enacted into law. Then, Part II will cover the historical and legal context of the current statutory and regulatory scheme of abortion restrictions in Virginia. This section grapples with the two main arguments that proponents of the many statutes and regulations both in Virginia and elsewhere make: (1) that the state has an inherent interest in the life of the fetus that it has a constitutional right to protect and (2) that the state has an inherent interest in the "health and wellbeing of the mother" which makes these regulations absolutely necessary.²⁸ The former is a question purely of law while the latter is a question of fact.²⁹ This paper argues that the laws the Whole Woman's Health Act would overturn are not grounded in health and safety, as claimed, or even if they originally were, they no longer serve this purpose. Therefore, treating abortion as different for purely ideological reasons goes against the spirit of *Whole Woman's Health* and is not good policy. Next, Part III of this paper will address *Whole Woman's Health* and the Whole Woman's Health Act in the context of *Casey* and *NIFLA v. Becerra* and conclude that it is consistent with both constitutional law and good public policy to enact the Whole Woman's Health Act and reverse the tide of harmful abortion regulations in Virginia. Finally, this paper will end by reiterating the significant need for the Whole Women's Health Act in Virginia.

I. THE WHOLE WOMAN'S HEALTH ACT: WHAT IT IS AND WHAT IT DOES

After *Whole Women's Health* was decided in 2016, abortion advocates were emboldened to tackle abortion restrictions across the states with bold and proactive measures.³⁰ One lane of attack was, of course, the courts.³¹

²⁸ See Steven R. Morrison, *Personhood Amendments after Whole Woman's Health v. Hellerstedt*, 67 CASE W. RES. 447, 450 (2016); Mary Ziegler, *Where the Pro-Life Movement Goes Next*, N.Y. TIMES (July 2, 2016), <https://www.nytimes.com/2016/07/03/opinion/sunday/where-the-pro-life-movement-goes-next.html>.

²⁹ The Court in *Roe* agreed that governments have an "important and legitimate interest in protecting the potentiality of human life." *Roe v. Wade*, 410 U.S. 113, 162 (1973). At the same time, that Court concluded "the unborn have never been recognized in the law as persons in the whole sense." *Id.* However, the growing personhood movement seeks to go beyond expressing an interest in potential life by declaring fetuses legal persons, endowed with the same rights and constitutional protections as people. This is not a question that can be easily resolved with facts, scientific or otherwise, as it is subject to many highly variable and deeply held beliefs, but personhood activists continue to push legislation that would make fetuses legal persons. See Maya Manian, *Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L.J. 75 (2013).

³⁰ CTR. FOR REPROD. RIGHTS, STATE OF THE STATES 2017: A PROACTIVE PUSH IN THE WAKE OF WHOLE WOMAN'S HEALTH 5 (2018).

Across the country, abortion advocates filed lawsuits challenging both new and old abortion restrictions.³² In 2017, anti-abortion state legislators continued to introduce bills restricting abortions, however, more than 400 pro-abortion legislators made their own inroads in many states, including Illinois, Delaware, Oregon, and New York.³³

Virginia's pro-choice democratic lawmakers also introduced their own proactive bills, including the Whole Woman's Health Act. This bill was introduced by Delegate Jennifer Boysko (D-Fairfax) and aimed to undo many of the worst restrictions on abortion in Virginia.³⁴ In 2017, the Act did not even get a hearing.³⁵ The Chair of the House Courts of Justice Committee, Delegate David B. Albo (R-Fairfax), sent a letter to the sponsors of "controversial" bills that read, in part, "As you know, the Committee historically kills bills associated with liberal politics, and the Governor vetoes bills associated with conservative politics, if we spend the effort in hearing these bills, then we would have much less time to review the bills that actually have a chance to become law."³⁶ In 2018, the bill was re-introduced both in the House of Delegates by Delegate Boysko as H.B.1231 and in the State Senate by Senator Jennifer McClellan (D-Richmond) as S.B.910.³⁷ This time it received a hearing in both chambers, though it did not make it out of committee.³⁸

³¹ See, e.g., Complaint, *Whole Woman's Health All. v. Hill*, No. 1:18-cv-1904 (S.D. Ind. 2018); Ted Booker, *Whole Woman's Health Alliance Files Lawsuit over Indiana's Abortion Restrictions*, IND. ECON. DIG. (June 22, 2018), <https://indianaeconomicdigest.com/main.asp?SectionID=31&SubSectionID=91&ArticleID=92543>.

³² CTR. FOR REPROD. RIGHTS, *supra* note 30, at 33. Many of these challenges are still under appeal and on their way to the Supreme Court. Even in Texas, abortion advocates filed another suit challenging a broader spectrum of regulations than *Whole Woman's Health*. Ashley Lopez, *Abortion Providers File Sweeping Lawsuit Against 'Burdensome' Restrictions in Texas*, KUT 90.5 (June 14, 2018), <http://www.kut.org/post/abortion-providers-file-sweeping-lawsuit-against-burdensome-restrictions-texas>. These have not always been successful, with the Eighth Circuit upholding an admitting privileges requirement similar to the one struck down in Texas. CTR. FOR REPROD. RIGHTS, *supra* note 30, at 36. The United States Supreme Court denied the petition in that case on May 29, 2018. Thus, *Planned Parenthood of Ark. & E. Okla. v. Jegley* remains precedent for that circuit. *Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953 (8th Cir. 2017).

³³ CTR. FOR REPROD. RIGHTS, *supra* note 30, at 8, 16–17, 19, 21. For another example of the growing trend towards pro-abortion legislation, see *NC Bill Would Expand Access to Abortion and Protect Reproductive Freedom*, AM. CIV. LIBERTIES UNION (Apr. 4, 2017), <https://www.aclu.org/news/nc-bill-would-expand-access-abortion-and-protect-reproductive-freedom>.

³⁴ H.B. 2186, 2017 Gen. Assemb., Reg. Sess. (Va. 2017).

³⁵ Gregory S. Schneider, *Existential Debate of Lawmaking: If It's Doomed Anyway, Why Take It Up?*, WASH. POST (Feb. 2, 2017), https://www.washingtonpost.com/local/virginia-politics/existential-debate-of-lawmaking-if-its-doomed-anyway-why-take-it-up/2017/02/02/ae9ba600-e979-11e6-bf6f-301b6b443624_story.html?noredirect=on&utm_term=.5c5fa8d7b5e1.

³⁶ *Id.* (Delegate Boysko, the sponsor of the bill held a press conference protesting the move).

³⁷ H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018); S.B. 910, 2018 Gen. Assemb., Reg. Sess. (Va. 2018).

³⁸ *Whole Women's Health Act: Hearing on S.B. 910 Before the S. Comm. on Education and Health*,

The Whole Woman's Health Act would enshrine in the Virginia Code a pregnant person's "fundamental right to obtain an abortion" and would ensure that no statute or regulation would be construed to prohibit abortion before viability or when "necessary to protect the life or health of the pregnant person."³⁹ The Act would also preserve the *Whole Woman's Health* holding that any statute that places a burden on a pregnant person's access to abortion without conferring any legitimate health benefit is unenforceable.⁴⁰ Additionally, it would expand the category of those who can perform a first trimester abortion to include physician's assistants, midwives licensed by the Board of Medicine acting and within the scope of practice, and other advanced practice clinicians (APCs) subject to licensing requirements by the Board of Medicine and the Board of Nursing and acting within their scope of practice.⁴¹ The Act would also broaden the category of those who can perform second trimester abortions to include clinicians acting under supervision of a physician and eliminate the requirement that second trimester abortions be performed in a licensed hospital.⁴² Furthermore, the Act would eliminate the TRAP statute, classifying facilities that perform five or more first trimester abortions as a hospital, and the ultrasound and written consent requirements.⁴³ Lastly, the Act would eliminate the criminalization of abortion and would allow the sale of insurance policies that provide coverage for abortions through the exchanges established in the Commonwealth pursuant to the federal Patient Protection and Affordable Care Act.⁴⁴

2018 Gen. Assemb., Reg. Sess. (Va. 2018) (the bill was passed by indefinitely on an 8-7 vote); *Whole Woman's Health Act: Hearing on H.B. 1231 Before the H. Comm. for Courts of Justice*, 2018 Gen. Assemb., Reg. Sess. (Va. 2018) (the bill was left in Court of Justice committee on February 15, 2018).

³⁹ H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018).

⁴⁰ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016); H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018).

⁴¹ H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.). While the Whole Woman's Health Act would decriminalize abortion in one sense, it would not make forced abortions suddenly legal. Attempting to or actually causing a miscarriage with the intent to end a pregnancy via a non-medical procedure (e.g., striking a pregnant person with an object, poisoning, etc.) would still be covered by the feticide statute, and an unlicensed healthcare provider who violates a section of the Whole Woman's Health Act while performing an abortion would be practicing medicine, nursing, or midwifery without a license which is punishable as a Class 1 Misdemeanor. VA. CODE § 18.2-32.2 (2018); VA. CODE § 54.1-111 (2018). If someone is convicted of this offense three times, the charge is upgraded to a Class 6 Felony. VA. CODE § 54.1-111 (2018). Furthermore, any licensed healthcare provider who violated any provision of this article would be subject to discipline or loss of licensure and/or medical malpractice lawsuits in the same manner as any other violation of a health regulation. *See, e.g.*, H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018). Taking abortion out of the criminal code will simply cease treating it differently from any other medical procedure. *Id.*

II. IT IS NOT ABOUT HEALTH – A HISTORY IN THREE ACTS

Attacks on abortion did not stop after *Roe*. In the beginning, little effort was made to hide behind the veneer of women's health and well-being.⁴⁵ When United States House of Representative member Henry Hyde (R-Illinois) introduced the Hyde Amendment in 1976 to stop government health coverage of abortion care, he explained that "[he] would certainly like to prevent, if [he] could legally, anybody from having an abortion: a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the [Medicaid] bill."⁴⁶ In its current form, the Hyde Amendment prevents not just enrollees of Medicaid, but also enrollees in the Children's Health Insurance Program, the Medicare program, and others, from receiving abortion care funded by the government unless the life of the pregnant person is threatened or the pregnancy is a result of rape or incest.⁴⁷ The Supreme Court upheld the validity of the Hyde Amendment in 1980, justifying its decision by reasoning that the problem of access was caused by the women's poverty, not government action, and while government could not place an "undue burden" on a woman's right to pursue an abortion, it was not required to "guarantee" the right to an abortion.⁴⁸

The anti-abortion movement lauded this decision and clung onto this line of reasoning well into the late 1980s and early 1990s. They believe that since "a human being is formed at conception of equal moral value to born persons; there is (virtually) no justification for ending that life; hence abortion is murder."⁴⁹ Anti-abortion advocates and legislators were thus willing to push for legislation purely and openly designed to reduce the number of abortions, without supplying superfluous justifications or feigning concern for the pregnant person.⁵⁰

⁴⁵ See Mary Ziegler, *The Jurisprudence of Uncertainty: Knowledge, Science, and Abortion*, 2018 WIS. L. REV. 317, 320, 343–45 (2018) (describing the anti-abortion movement which, while funded in the 1960's by the Catholic Church among other ideologically religious backers, "made deliberately secular arguments, spotlighting what pro-lifers described as the right to life of the unborn child.").

⁴⁶ Champlin, *supra* note 16, at 8–12.

⁴⁷ ALYSSA LLAMAS ET AL., PUBLIC HEALTH IMPACTS OF STATE-LEVEL ABORTION RESTRICTIONS 3 (2016).

⁴⁸ *Harris v. McRae*, 448 U.S. 297, 322 (1980) (citing *McGowan v. Maryland*, 366 U. S. 420, 425 (1961)) ("The guarantee of equal protection under the Fifth Amendment is not a source of substantive rights or liberties, but rather a right to be free from invidious discrimination in statutory classifications and other governmental activity. It is well settled that where a statutory classification does not itself impinge on a right or liberty protected by the Constitution, the validity of classification must be sustained unless "the classification rests on grounds wholly irrelevant to the achievement of [any legitimate governmental] objective."); Champlin, *supra* note 16, at 9–10.

⁴⁹ Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1014 (2007).

⁵⁰ See *id.*

In the late 1990s, the focus began to shift. The same people who had been content ignoring the point of view of the woman involved in the equation suddenly found the other interests discussed in *Roe* compelling, perhaps because they faced growing support for women's rights and abortion rights.⁵¹ To rebrand the movement as women-centered, and not fetus-centered as it previously had been, David Reardon, one of the movement's "thought leaders," urged anti-abortion advocates to "always – ALWAYS – place our arguments for the unborn in the middle of a pro-woman sandwich. Our compassion for the woman must be voiced both first and last in all our arguments, and in a manner which shows that our concern for women is a primary and integral part of our opposition to abortion."⁵² A stark distillation of a pro-women argument divorced from the fetus-centric consideration has been summarized thus: "insofar as motherhood is a constitutive end of women's well-being, abortion harms women; thus, abortion is wrong and should be prohibited, restricted, or avoided when possible regardless of the moral status of the fetus."⁵³

It is from these at least partly disingenuous beginnings that one can trace the changes in the policy track taken by anti-abortion advocates and legislatures through the early to mid-2000s and 2010s, as TRAP laws sprung up like weeds from state house to state house under the banner of protecting women's health.⁵⁴ President George W. Bush's "partial birth abortion ban," was affirmed by the Supreme Court in 2007 and justified by Justice Kennedy under the guise of protecting women from "regret" and emotional distress since they would "struggle with grief more anguished and sorrow more profound" upon learning details of the procedure, leaning on a perceived medical uncertainty to rationalize the decision to not interfere with the legislature on this question.⁵⁵ The Court used women's health to justify

⁵¹ David S. Cohen, *Will Rejecting Woman-Protective Justifications for Antiabortion Laws Increase Harassment and Violence?*, 94 *CONTRACEPTION* 441, 441–42 (2016); Lydia Saad, *Public Opinion About Abortion - an In-depth Review*, GALLUP (Jan. 22, 2002), <https://news.gallup.com/poll/9904/public-opinion-about-abortion-indepth-review.aspx> ("In the initial years after the *Roe v. Wade* decision, the number of Americans holding the extreme positions was roughly the same, at the 20% level. In the 1980s, attitudes gradually shifted toward the pro-choice position, so that by 1990, the liberal extreme outnumbered the conservative extreme by a more than two-to-one margin. This trend peaked in June 1992, with 34% saying abortion should be legal in all cases and only 13% saying it should be completely banned.").

⁵² David C. Reardon, *MAKING ABORTION RARE: A HEALING STRATEGY FOR A DIVIDED NATION* 26 (1996).

⁵³ Itzel Mayans & Moisés Vaca, *The Paternalistic Argument Against Abortion*, 33 *HYPATIA* 22 (2018).

⁵⁴ See, e.g., Elizabeth Nash et al., *Laws Affecting Reproductive Health and Rights: State Trends at Mid-year* GUTTMACHER INST. (July 21, 2016), <https://www.guttmacher.org/article/2016/07/laws-affecting-reproductive-health-and-rights-state-trends-midyear-2016>; see also *id.* (showing the philosophical background of state trends concerning abortions).

⁵⁵ *Gonzales v. Carhart*, 550 U.S. 124, 159–60 (2007); ALEX DIBRANCO, *WHOLE WOMAN'S HEALTH'S UNEXPECTED WIN FOR SCIENCE* 18 (2016).

its decision despite the American Congress of Obstetricians and Gynecologists' (ACOG) argument that there was a medical consensus at the time that intact dilation and extraction (D&E) procedures were "safest and offer[ed] significant benefits for women suffering from certain conditions that ma[de] the potential complications of non-intact D&E especially dangerous."⁵⁶ The Court did not even give serious consideration to the question of the lack of exemptions to the prohibition and weighed the paternalistic opinion of the legislature above medical evidence and expertise.⁵⁷

A. Act I – Vestiges of the Pre-Roe Era

In Virginia, as elsewhere, many of the laws challenged by the provider-driven *Falls Church v. Oliver* lawsuit and targeted by the Whole Woman's Health Act were put in place with the specific aim of reducing access to abortion.⁵⁸ Abortion was illegal in Virginia prior to *Roe*.⁵⁹ After 1973, the legislature, instead of legalizing all abortion except in some particular circumstances, legalized only certain exceptions to the criminal statute without getting rid of the statute all together.⁶⁰ This means that in Virginia, if someone is not performing an abortion as prescribed by the law, they are committing a felony offense.⁶¹

If the Whole Woman's Health Act were to be enacted in Virginia, two statutes that currently restrict a woman's access to a safe and legal abortion would be overturned. Those statutes, the "Physicians-Only Law" and the hospital requirement for all post-first trimester abortions ("Hospital Re-

⁵⁶ DIBRANCO, *supra* note 55, at 18 (citing Press Release, American Congress of Obstetricians and Gynecologists, ACOG Statement on the US Supreme Court Decision Upholding the Partial-Birth Abortion Ban Act of 2003 (Apr. 18, 2007) (on file with author)).

⁵⁷ See Chelsea M. Donaldson, Note, *Constitutional Law/Reproductive Justice – Breaking The TRAP: How Whole Woman's Health Protects Abortion Access, and the Substantive Due Process Clauses Rebuke of Anti-Abortion Regulations*, 40 W. NEW ENG. L. REV. 257, 285 (2018).

⁵⁸ Falls Church Complaint, *supra* note 9, at 40.

⁵⁹ VA. CODE § 18.2-71 (2018), *invalidated by* *Roe v. Wade*, 410 U.S. 113 (1973).

⁶⁰ Falls Church Complaint, *supra* note 9, at 19. This Complaint was filed as I was writing this Article, and I found the nomenclature and classification used therein useful and borrowed it for this Article. Most of it is common parlance in the reproductive rights and advocacy field in Virginia, but I should give credit to the drafters of the Complaint for so succinctly framing the problems of the various portions of Virginia's abortion statutory and regulatory scheme.

⁶¹ Criminalization of abortion is another issue entirely, and one worthy of its own detailed review. It should be noted here that prosecutors in Virginia have found creative ways to prosecute women for pregnancy outcomes. For example, consider the case of Michelle Frances Roberts in Chesterfield who currently on trial for an alleged self-induced abortion even though the statute presupposes the culprit inducing an abortion "of another", and the case of Katherine Dellis who was prosecuted, convicted, and later pardoned of a felony concealment of a dead body following a miscarriage. *E.g.* VA. CODE § 18.2-71 (2018); Justin Jouvenal, *Virginia Governor Pardons Woman Convicted of Disposing of Stillborn Fetus*, WASH. POST (June 1, 2018); Mark Bowes, *Judge Clears Way for Prosecution of Chesterfield Woman Charged with Self-Aborting Late-Term Fetus*, RICH. TIMES-DISPATCH (Oct. 27, 2017).

quirement”), were both enacted in 1975.⁶² A lot has changed since 1975 in the field of abortion medicine, making both statutes obsolete.⁶³ The current code criminalizes all abortions in Virginia except those performed by a licensed physician, with violations punishable as a Class 4 Felony with a sentence of up to ten years and exorbitant civil fines.⁶⁴ To escape a criminal penalty, second-trimester abortions must be performed in a licensed hospital, which Virginia’s Department of Health has interpreted to mean facilities operating in compliance with the “Outpatient Surgical Hospital” regulations, including physical facility, personnel, and procedure requirements too onerous for many independent abortion providers to satisfy.⁶⁵

In an interesting twist, the Attorney General for the Commonwealth of Virginia filed a Motion to Dismiss the *Falls Church v. Oliver* Complaint, arguing that the current law does not, in fact, prevent facilities, such as those of the plaintiffs, from performing second-trimester abortions, since they are classified as hospitals under the TRAP statute.⁶⁶ This is a novel interpretation of the statute, one that has not been adopted by either Virginia’s Department of Health or the abortion facilities themselves.⁶⁷ No court has ruled on this interpretation yet and it is unclear whether a court would agree with the Attorney General’s argument given the legislative and regulatory history of the TRAP statute and associated regulations.⁶⁸ If it is a fair inter-

⁶² VA. CODE §§ 18.2-72–18.2-73 (2018); *see also* Falls Church Complaint, *supra* note 9, at 36.

⁶³ *See* Falls Church Complaint, *supra* note 9, at 20, 31–32; Amanda Chatel, *What Getting an Abortion was Like in the ‘60s, ‘70s, and ‘80’s Compared to Now*, BUSTLE (Jan. 22, 2018), <https://www.bustle.com/p/what-getting-abortion-was-like-in-the-60s-70s-80s-compared-to-now-7977732>.

⁶⁴ *See* VA. CODE § 18.2-72 (2018); VA. CODE § 32.1-27(C) (2018); Falls Church Complaint, *supra* note 9, at 36.

⁶⁵ VA. CODE ANN. § 18.2-73 (2018); 12 VA. ADMIN. CODE §§ 5-410-10, 5-410-1150, 5-410-1380 (2018); *see* Falls Church Complaint, *supra* note 9, at 27–28 (noting the “thicket of extensive administrative and bureaucratic requirements” for outpatient surgical hospitals).

⁶⁶ Motion to Dismiss Plaintiff’s Complaint at 6–7, Falls Church Med. Ctr. v. Oliver, No. 3:18-cv-428 (E.D. Va. 2018) (“Plaintiffs here have suffered no injury in fact because they are not subject to criminal prosecution under Section 18.2-73. Section 18.2-73 requires second-trimester abortions to be ‘performed in a hospital licensed by the State Department of Health.’ Plaintiffs argue that their facilities are not ‘hospitals’ under Section 18.2-73, but that argument misreads Virginia law...each plaintiff satisfies exactly the definition of ‘hospital’ under Section 32.1-123 ... each plaintiff is a ‘hospital’ for purposes of Section 18.2-73...As a result, plaintiffs are not subject to criminal liability under Section 18.2-73.”); Laura Vozzella, *Virginia Attorney General Files Motion to Dismiss Lawsuit Challenging State Abortion Restrictions*, WASH. POST (July 15, 2018), https://www.washingtonpost.com/local/virginia-politics/ag-herring-files-motion-to-dismiss-lawsuit-challenging-virginia-abortion-restrictions/2018/07/14/4ebfd6ac-86da-11e8-9e80-403a221946a7_story.html?utm_term=.62fcf874ec58.

⁶⁷ Virginia Coalition to Protect Women’s Health, Comment Letter on Amendments for Regulations for Licensure of Abortion Facilities (Feb. 11, 2015), <https://townhall.virginia.gov/L/viewcomments.cfm?commentid=39140> (pointing out that this requirement is not medically necessary).

⁶⁸ *See generally* Falls Church Complaint, *supra* note 9, at 17, 20; Victoria Cobb, *What’s Mark Herring Doing*, THE FAMILY FOUND. (July 16, 2018), <http://www.familyfoundation.org/blog/whats-mark-herring-doing> (Commenting that abortion opponents are similarly flummoxed by the Attorney General’s

pretation, the legislature could use the Whole Woman's Health Act to offer clarity in this regard.

As currently practiced and interpreted by Virginia's administration and abortion providers, both of the aforementioned 1975 statutes are out of touch with current medical science; viewed through the lens of *Whole Woman's Health's* balancing test, both statutes create burdens without conferring medical benefits on patients, placing their constitutionality in question.⁶⁹ Limiting the kind of clinicians who can perform abortions in Virginia artificially limits the supply of abortion providers. Virginia's regulatory scheme mimics the Virginia Code, preventing APCs, like licensed nurse practitioners, certified nurse-midwives, and physician assistants from providing abortion care.⁷⁰ At the same time, APCs perform other, more dangerous procedures in medical offices all across the Commonwealth every day with no interference.⁷¹ Virginia's Code even allows certified nurse midwives to assist patients with labor and delivery during home-births despite the fact that giving birth is more likely to lead to death or complications than a first trimester surgical abortion.⁷² Moreover, other states allow APCs to provide abortion care.⁷³

This restriction is especially peculiar when one considers the case of medication abortions. Medication abortion is a method of ending an early pregnancy with oral medications. It is extremely safe and associated with

argument, noting that this interpretation "wasn't the General Assembly's intent at all, as evidenced by the past six years of implementation.").

⁶⁹ Falls Church Complaint, *supra* note 9, at 25–28; see R. Alta Charo, *Whole Women's Victory—Or Not?*, 375 NEW ENG. J. MED. 809, 810 (2016) ("The Whole Women's Health decision also made more explicit that whether a law constitutes an 'undue burden' on abortion rights requires looking at whether its purported benefits are reasonable in light of the limitations it imposes.").

⁷⁰ Falls Church Complaint, *supra* note 9, at 36–37; see generally Carole Joffe & Susan Yanow, *Advanced Practice Clinicians as Abortion Providers: Current Developments in the United States*, 12 REPROD. HEALTH MATTERS 198, 199 (2004) (Defining advanced clinical practice more expansively as a "nurse practitioners, certified nurse-midwives and physician assistants, who fill distinct professional roles in US health care...Nurse practitioners may specialize in any one of a number of fields, including women's health. Certified nurse-midwives provide a full range of ob/gyn care. Physician assistants are not nurses, but health professionals with advanced medical training. Like nurse practitioners, physician assistants may specialize in a range of fields, including women's health or obstetrics and gynecology...").

⁷¹ Falls Church Complaint, *supra* note 9, at 37.

⁷² See VA. CODE § 54.1-2957.03(B) (2018); Kaiya A. Lyons, *Proscribing Prescriptions: A Legal Analysis of State Off-Label Restrictions on Medication Abortion*, SUA SPONTE (Nov. 21, 2016), <http://editions.lib.umn.edu/suasponse/2016/11/21/proscribing-prescriptions-a-legal-analysis-of-state-off-label-restrictions-on-medication-abortion/> ("In fact, contrary to state laws that suggest abortions are high-risk procedures, at least one study demonstrates that early surgical abortions are safer than giving birth.").

⁷³ See Falls Church Complaint, *supra* note 9, at 36; see also *An Overview of Abortion Laws*, GUTTMACHER INST. (Sept. 1, 2018), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> ("42 states require an abortion to be performed by a licensed physician.").

few complications because it requires no anesthesia.⁷⁴ Medication abortion involves no surgery or procedure, it is simply the taking of pills.⁷⁵ Complications after medication abortions occur only after the patient has left the clinic and are extremely rare.⁷⁶ Importantly, the rates of adverse events following a medication abortion are far lower than those associated with pregnancy and childbirth.⁷⁷ One would hardly think that a licensed physician's attention is required while taking a pill with such a significant safety record.

However, across the country, these kinds of restrictions are hardly uncommon. Thirty-four states have similar physician-only laws on the books, even for medication-only abortions, and nineteen states prohibit telemedicine of medication abortion, thus requiring that clinicians prescribing the medicine be physically present in the room when the patient takes the medication.⁷⁸ A veritable plethora of medical research, however, demonstrates that medication abortion can be safely and effectively administered through telemedicine by APCs and does not have to be performed by a licensed physician to be safe and effective.⁷⁹ Reducing access by artificially lowering the supply of clinicians available to administer medication abortions places an undue burden on patients who want an early and safe termination of their pregnancy. Medication abortion allows for abortion very early in the pregnancy, something that is both safer than later term abortions and preferred by many American women.⁸⁰

Paradoxically, should a woman suffer a miscarriage or should she have retained tissue in her uterus after an abortion, trained APCs in Virginia are able to "safely provide misoprostol and/or mifepristone to facilitate the

⁷⁴ See *Medical Abortion*, MAYO CLINIC (July 7, 2018), <https://www.mayoclinic.org/tests-procedures/medical-abortion/about/pac-20394687>.

⁷⁵ *Id.*

⁷⁶ Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 OBSTETRICS & GYNECOLOGY 166, 169 (2013) (finding that clinically significant adverse outcomes were rare in abortions administered by Planned Parenthood affiliates); see also *Medical Abortion*, *supra* note 74 (listing the common complications that are associated with medical abortions); Nadine Shehab et al., *Emergency Department Visits for Antibiotic-Associated Adverse Events*, 47 CLINICAL INFECTIOUS DISEASES 735, 738 (2008) (showing the rates of emergency department visits for common antibiotics); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 178 (2015) (showing the rates of complications for medical abortions).

⁷⁷ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 215 (2012), https://journals.lww.com/greenjournal/Fulltext/2012/02000/The_Comparative_Safety_of_Legal_Induced_Abortion.3.aspx.

⁷⁸ LLAMAS ET AL., *supra* note 47, at 12.

⁷⁹ *Id.*

⁸⁰ Linda J. Beckman, *Abortion in the United States: The Continuing Controversy*, 27 FEMINISM & PSYCHOL. 101, 107 (2016).

evacuation of the uterus.”⁸¹ These are the same drugs that must be administered by a physician in the course of the abortion, but they do not require the same kind of oversight or scrutiny when administered for related medical conditions, despite there being no difference in the associated risk to the patient.⁸²

The case for a physician-only law for surgical abortions is no sounder. The *Falls Church v. Oliver* Complaint states in part, “[t]here is no statistically significant benefit, as measured by complication rates, failure rates, or any other outcome, when aspiration abortions⁸³ are performed by physicians as compared to APCs.”⁸⁴ And with respect to first trimester surgical abortions, studies do bear this out.⁸⁵ With a growing shortage of licensed physicians who specialize in patient-oriented care, including primary healthcare, there is a growing movement to broaden the scope of practice for APC’s across all fields to keep up with demand for medical services.⁸⁶ Treating abortion differently than any other similarly situated medical procedures, and thus limiting the number of medical professionals able to assist with abortion care, does nothing to advance patient safety and only restricts access to safe abortions.

The other 1975 vestige, the Hospital Requirement, did once have some basis in medical reality. At the time, the primary method of second trimester abortion was induction.⁸⁷ A patient’s labor was induced by a physi-

⁸¹ Falls Church Complaint, *supra* note 9, at 37; see also *Abortion with Pills vs. Miscarriage: Demystifying the Experience*, NAT’L WOMEN’S HEALTH NETWORK, <http://www.nwhn.org/abortion-pills-vs-miscarriage-demystifying-experience/> (last visited Aug. 25, 2018).

⁸² See Falls Church Complaint, *supra* note 9, at 37.

⁸³ Suction abortion (also called vacuum aspiration) is the most common type of in-clinic abortion. It uses gentle suction to empty a woman’s uterus. *In-Clinic Abortion*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures> (last visited Sept. 25, 2018).

⁸⁴ See Falls Church Complaint, *supra* note 9, at 38.

⁸⁵ Tracy Weitz et al., *Advancing Scope of Practice for Advanced Practice Clinicians: More Than a Matter of Access*, ASS’N REPROD. HEALTH PROFS. (Aug. 2009), <http://arhp.org/publications-and-resources/contraception-journal/august-2009>; see NAT’L COUNCIL OF STATE BDS. OF NURSING, *CHANGES IN HEALTHCARE PROFESSIONS’ SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS 3* (2009); Mary Ann Freedman et al., *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, AM J. PUB. HEALTH 550, 552 (1986); Marlene B. Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services*, AM J. PUB. HEALTH 1352, 1352–53 (2004); Diana Taylor et al., *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion From Advanced Practice Clinician Scope of Practice*, J. MIDWIFERY & WOMEN’S HEALTH 4, 4–5 (2010); IK Warriner et al., *Rates of Complication in First-Trimester Manual Vacuum Aspiration Abortion Done by Doctors and Mid-Level Providers in South Africa and Vietnam: A Randomized Controlled Equivalence Trial*, LANCET 1965, 1965, 1969 (2006).

⁸⁶ John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners - Risks and Rewards*, NEW ENG. J. MED. (2013), <https://www.nejm.org/doi/pdf/10.1056/NEJMhpr1301084> (discussing the necessary expansion of scope-of-practice laws to meet the need for more primary care providers).

⁸⁷ Falls Church Complaint, *supra* note 9, at 20.

cian by means of an injection of medication directly into the patient's amniotic fluid. Such an injection resulted in the patient undergoing the full labor process as if they were giving birth, a painful, potentially dangerous and traumatic procedure requiring close monitoring and potential medical intervention and lasting long enough to sometimes require an overnight stay at a hospital.⁸⁸ Often, the patient's retained placenta had to be surgically removed, leading to other potential complications.⁸⁹ At the time, therefore, both the American Public Health Association (APHA) and ACOG issued opinions stating that second trimester abortions should take place in a hospital due to the associated risks and the need for monitoring and care throughout.⁹⁰

Today, induction abortions are very uncommon in the United States, both because of the risks and the associated cost.⁹¹ Aspiration abortion and D&E abortions have superseded induction as the methods of choice because they are safer and cheaper.⁹² Both are office-based, out-patient procedures that do not require hospital facilities.⁹³ While medicine has moved on, the law has not. The Hospital Requirement, as it has been interpreted, has led to Virginia having only two facilities capable of providing abortions after thirteen weeks.⁹⁴ Both are surgical centers and are required to have "sterile operating rooms of at least 150 square feet or more, depending on sedation level provided; patient corridors at least five or six feet wide, depending on location; and similarly specific requirements regarding HVAC systems, fin-

⁸⁸ See Marc Bygdeman & Kristina Gemzell-Danielsson, *An Historical Overview of Second Trimester Abortion Methods*, 16 REPROD. HEALTH MATTERS 196,196–98 (2008).

⁸⁹ See *id.*

⁹⁰ Falls Church Complaint, *supra* note 9, at 20.

⁹¹ See Chatel, *supra* note 63; Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 AM. J. PUB. HEALTH 623, 626–28 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661467/>.

⁹² See Jones & Weitz, *supra* 91, at 626–27. The divisions between first and second trimester are somewhat artificial, as "[a]bortion care is best understood as a continuum of techniques—from induction to dilation and evacuation and from intact to removal in multiple pieces—rather than as comprising distinct categories," making the arbitrary distinctions between late first term and early second term abortions specious, forcing pregnant people to get procedures at much higher costs when the actual procedures themselves, nor the risks associated, would perceptibly differ, based solely on an arbitrary number of weeks. *Id.* at 623.

⁹³ See Jones & Weitz, *supra* note 91, at 627 (2009) (stating that "Numerous more-minor surgical procedures may be performed in physicians' offices and outpatient clinical settings..."); see also NAT'L ABORTION FED'N, 2017 CLINICAL POLICY GUIDELINES FOR ABORTION CARE 32 (2017) (stating that "Abortion by dilation and evacuation (D&E) after 14 weeks from LMP is a safe outpatient procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.").

⁹⁴ Vozzella, *supra* note 19. And the costs are hefty, with the procedure costing \$1,700 at the Richmond clinic, not including transportation, overnight stays before the procedure for the twenty-four hour wait-period if necessary, missed work, child care, and other costs. See *Fees*, MED. CTR. FOR WOMEN, <http://richmondmedctrforwomen.com/fees/> (last visited Sept. 2, 2018).

ishes for ceilings, walls, and floors, and recovery room dimensions and layout.”⁹⁵ This is in addition to the rigorous and expensive Certificate of Public Need process that surgical centers have to go through before they can receive a license in the first place.⁹⁶

As they apply to the Hospital Requirement, both ACOG and APHA have changed their recommendations, acknowledging the change in medical practice.⁹⁷ Other states without such requirements have not seen a deterioration in care. In fact, research shows that abortions provided in surgical centers do not lead to a statistically significant decrease in complications or adverse results than those performed in out-patient doctors’ offices.⁹⁸ In addition to the lack of medical evidence supporting the law, the statute includes no exception for cases where a pregnant person’s life or health is in danger and they need an emergency abortion in their second trimester.⁹⁹ Even though there are many more first trimester abortions than second, second trimester abortions are sometimes necessary.¹⁰⁰ The lack of adequate access to affordable second trimester abortions has a greater impact on low income people and people of color as well as those seeking an abortion for a wanted pregnancy after discovering a medical reason to have one – punishing those least likely to be able to absorb the added financial burden.¹⁰¹ Studies have shown that “black women, those with lower educational levels, those relying on financial assistance for the procedure, and those who recognized the pregnancy later than seven weeks” after their last menstrual period “were more likely to have received abortions at or after 13 weeks.”¹⁰²

⁹⁵ Falls Church Complaint, *supra* note 9, at 32.

⁹⁶ 12 VA. ADMIN. CODE § 5-220-20 (2018); *see also* VA. CODE § 32.1-102.3 (2018) (discussing the criteria for determining the need sufficient for the obtainment of a Certificate of Public Need).

⁹⁷ *See* Falls Church Complaint, *supra* note 9, at 37; *see also* NAT’L ABORTION FED’N, *supra* note 93, at 32 (stating that “Abortion by dilation and evacuation (D&E) after 14 weeks from LMP is a safe outpatient procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals,” based on numerous studies and professional guidelines, including the 2013 ACOG Abortion Practice Bulletin for Second Trimester Abortions from 2013).

⁹⁸ Advancing New Standards in Reprod. Health, *Safety of Abortion in Ambulatory Surgical Centers vs. Office-Based Settings*, UCSF MED. CTR. (June 2018), https://www.ansrh.org/sites/default/files/publications/files/safety_of_abortion_in_asc_fact_sheet.pdf [hereinafter ANSRH].

⁹⁹ H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018); Falls Church Complaint, *supra* note 9, at 35.

¹⁰⁰ Jones & Weitz, *supra* note 91, at 623–24.

¹⁰¹ *See id.* at 624 (“Several studies indicate that the factors causing women to delay abortions until the second trimester include cost and access barriers, late detection of pregnancy, and difficulty whether to continue the pregnancy. In part because of their increased vulnerability to these barriers, low-income women and women of color are more likely than are other women to have second-trimester abortions.”); *see also* Margie Del Castillo, *Virginia Latina Advocacy TRAP Comment*, VA. REG. TOWN HALL (July 31, 2014), <https://townhall.virginia.gov/L/viewcomments.cfm?commentid=35924> (stating that Virginia’s regulations on women’s health centers create additional barriers to quality healthcare for Latinas which further delay and increase the cost of abortion care for low-income Latinas).

¹⁰² LLAMAS ET AL., *supra* note 47, at 7.

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Abortion regulations do not do their harm in isolation. Increasing the time, distance and cost necessary to receive an abortion can push the wanted abortion further and further out of reach for the already marginalized.

B. Act II – Two Trip Mandatory Delay Law

In the early 2000s, Virginia passed its own informed consent law, requiring that patients seeking an abortion give “informed consent” before receiving an abortion.¹⁰³ They must also be offered materials drafted by the state that contain inaccurate and biased information about the abortion procedure and fetal development, which they can accept or refuse.¹⁰⁴ Should the patient accept the materials, they must receive them in person at least twenty-four hours before the procedure, or if the patient chooses to get them by mail, the materials must be sent to them at least seventy-two hours before the procedure.¹⁰⁵

In 2012, Virginia passed an additional law that required the patient to undergo a transabdominal ultrasound and then wait twenty-four hours before being able to actually undergo an abortion procedure.¹⁰⁶ The statute states that the ultrasound is done for the purpose of determining the gestational age of the fetus.¹⁰⁷ The addition of the mandatory ultrasound turned Virginia into a Two Trip Mandatory Delay State.¹⁰⁸

In addition to performing the ultrasound, however, “[i]f gestational age cannot be determined by a transabdominal ultrasound, then the patient undergoing the abortion shall be verbally offered other ultrasound imaging to determine gestational age, which she may refuse.”¹⁰⁹ Medically speaking, before a certain point in the pregnancy, an ultrasound is not the best method of determining gestational age and, in fact, is not part of standard medical practice.¹¹⁰ However, this procedure is not required if the woman seeking

¹⁰³ VA. CODE § 18.2-76(A) (2018); *see also* VA. CODE § 18.2-76(D) (2018) (defining “informed consent”).

¹⁰⁴ *See* VA. CODE § 18.2-76(D)(5) (2018); *see also* VA. CODE § 18.2-76(F) (2018) (describing the contents of the printed materials); NAT'L ABORTION FED'N, 2003 STATE LEGISLATIVE REPORT 3 (2004) (stating that Virginia passed bills in 2003 adding requirements to biased counseling statutes already enacted).

¹⁰⁵ VA. CODE § 18.2-76(D)(5) (2018).

¹⁰⁶ *Id.* § 18.2-76(B).

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*; Falls Church Complaint, *supra* note 9, at 23.

¹⁰⁹ VA. CODE § 18.2-76(B) (2018).

¹¹⁰ *See* NAT'L ABORTION FED'N, 2018 CLINICAL POLICY GUIDELINES FOR ABORTION CARE 14-15 (2018) (“The use of ultrasound is not a requirement for the provision of first trimester abortion care. Proper use of ultrasound may inform clinical decision-making in abortion care...According to the American Institute of Ultrasound in Medicine (AIUM), in collaboration with the American College of Obstetrics and Gynecology and the American College of Radiology, a ‘limited ultrasound examination’ is per-

an abortion is a “victim of rape or incest” and “if the incident was reported to law-enforcement authorities.”¹¹¹ In addition to performing the ultrasound, the provider must offer the patient the opportunity to “view the ultrasound image, receive a printed copy of the ultrasound image and hear the fetal heart tones” and “shall obtain from the woman written certification that this opportunity was offered and whether or not it was accepted.”¹¹² Finally, the law provides that a woman living more than 100 miles away from an abortion provider can obtain the ultrasound two hours before the procedure.¹¹³

The history of the informed consent requirement is rooted in the anti-choice movement. Part of the informed consent law is based on the original model statute from Ohio, which was championed by pro-life advocates like Jane Hubbard, the President of Akron Right to Life. She insists that it “ensure[s] that a woman who decides to abort her child will have... scientifically and medically accurate information[.]”¹¹⁴ Though not as prescriptive or as extreme as the Akron version, which was struck down by the Supreme Court in 1983,¹¹⁵ the Virginia requirement remains problematic and ultimately is based in the same anti-choice origins.

The very fact that the ultrasound requirement is not linked to medical necessity, which is inconsistent with medical practice, and sets the waiting period cut off arbitrarily at 100 miles is evidence that the requirement bears little relation to patient health and safety.¹¹⁶ While there is some slim evidence that “the process of having the ultrasound image described and displayed may be the tipping point that leads a woman who was in the process of making her decision about whether to have an abortion decide to continue her pregnancy,” this is not necessarily a desirable outcome, as research shows that women who do not receive wanted abortions face many negative consequences.¹¹⁷

Like most of the other restrictions on abortion care, the ultrasound requirement creates a substantial obstacle for those already facing significant barriers to healthcare access. The additional costs of a second visit, which

formed when a specific question requires investigation.”).

¹¹¹ VA. CODE § 18.2-76(B) (2018).

¹¹² *Id.* § 18.2-76(C).

¹¹³ *Id.* § 18.2-76(B).

¹¹⁴ Ziegler, *supra* note 45, at 336.

¹¹⁵ *See City of Akron v. Akron Ctr. for Reprod. Rights*, 462 U.S. 416, 420–26 (1983).

¹¹⁶ In fact, having these requirements can lead to patients not receiving the best abortion services for them, especially when combined with the plethora of other laws and regulations already impeding access. *See COMM. ON REPROD. HEALTH SERVS., NAT’L ACAD. OF SCI., ENG’G & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 77* (2018).

¹¹⁷ LLAMAS ET AL., *supra* note 47, at 11 (quoting UHMA D. UPADHYAY ET AL., EVALUATING THE IMPACT OF A MANDATORY PRE-ABORTION ULTRASOUND VIEWING LAW: A MIXED METHODS STUDY 20 (2017)).

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are not covered by health insurance or government-provided health insurance plans (due to that pesky Hyde amendment), increases the burden for those traveling less than 100 miles to a clinic.¹¹⁸ For hourly employees, part-time workers, and low-wage workers an extra day off work can make the difference between making rent or not, and in some instances even keeping a job or not. Childcare costs, transportation costs, and potential costs for overnight lodging if a patient is able to get back-to-back appointments add up quickly. These costs fall particularly heavily on people of color, those living in rural areas, the low-income, the undocumented, and the otherwise marginalized.¹¹⁹

Even worse, while abortion is very safe, risks increase with gestation.¹²⁰ Because of limits on third-trimester abortions, patients can lose their ability to obtain a legal abortion if they do not make it to a provider in time.¹²¹ Twenty-four hours can stretch into days or weeks when one considers the fact that clinics do not have abortion providers on staff every day of the week, patients' work and child-care needs can make planning two back-to-back appointments difficult, and patients seeking an abortion just before a gestational limit can be priced out of an abortion or prohibited from obtaining a legal abortion due to the delay.¹²² Research shows that women in states with waiting periods are more likely than those in states without to have at least two weeks pass between the initial call to schedule an abortion and the abortion itself.¹²³

There is also research demonstrating that women who receive provider counseling, mandated by state law and drafted by the state, find it less "beneficial" than patients who receive counseling not prescribed by the

¹¹⁸ Falls Church Complaint, *supra* note 9, at 52.

¹¹⁹ *Id.*

¹²⁰ LLAMAS ET AL., *supra* note 47, at 10; Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 *OBSTETRICS & GYNECOLOGY* 258, 262 (2015) (describing statistical results which show that abortion-related mortality rates increase with gestational age).

¹²¹ See RACHEL K. JONES & JENNA JERMAN, *TIME TO APPOINTMENT AND DELAYS IN ACCESSING CARE AMONG U.S. ABORTION PATIENTS* 3 (2016) (explaining that timeliness is key to obtaining a legal abortion because of time requirements for first-trimester abortions and decreased availability of second-trimester abortions).

¹²² See LLAMAS ET AL., *supra* note 47, at 23 (explaining that the twenty-four hour waiting period can turn in to two weeks due to reasons such as limited appointment availability, conflicting work schedules, finding transportation, and coordinating child care); see also JONES & JERMAN, *supra* note 122, at 13 (explaining that due to the higher expense and lower availability of second trimester abortions delays can make abortion inaccessible); Kari White et al., *Experiences Accessing Abortion Care in Alabama among Women Traveling for Services*, 26 *WOMEN'S HEALTH ISSUES* 298, 302 (2016) (explaining the difficulties in arranging multiple appointments).

¹²³ LLAMAS ET AL., *supra* note 47, at 23; see JONES & JERMAN, *supra* note 122, at 11 (explaining that due to the higher expense and lower availability of second trimester abortions delays can make abortion inaccessible).

state.¹²⁴ Clinicians who perform abortions are already bound, like other medical professionals, by training and licensing requirements and codes of ethics to provide “adequate and appropriate information about procedures and receive patients’ consent before performing them.”¹²⁵ Forcing these medical professionals to go against their training and engage in what can be termed, in essence, “ideological speech” forces them to “commit an untenable ethical and professional wrong: deceiving their patients and withholding...clinical data.”¹²⁶

While there have been several attempts to push for revisions to the materials, those provided today are still problematic. For example, in describing complications for vacuum aspiration, the documents currently provided state that “[a]ll complications may require Emergency Room treatment or surgery.” This is misleading because few complications actually require a visit to the emergency room, and if treatment is promptly started, full recovery is generally expected.¹²⁷ Furthermore, in describing the developmental stages of a human embryo-fetus, the materials repeatedly call the pregnant woman “mother,” a loaded term given the context.¹²⁸ Overall, the current materials overstate the risks of abortion, including the psychological consequences, understate the risks of childbirth, and use emotionally loaded language that lacks objectivity.¹²⁹ A panel of experts in human anatomy working on the Informed Consent Project at Rutgers University reviewed the fetal development portion of Virginia’s ‘informed consent’ documents and found 22.29% of the statements to be inaccurate out of the total 157, with thirty-five medically inaccurate statements and 41% of statements about the first trimester inaccurate.¹³⁰

The combination of geography, economics, and the lack of insurance coverage with the already steep costs of the abortion procedures and associated costs of days off, child-care, travel, and ultrasounds ensure that the informed consent and ultrasound provisions are not mere inconveniences.

¹²⁴ LLAMAS ET AL., *supra* note 47, at 10; see Heather Gould et al., *Predictors of Abortion Counseling Receipt and Helpfulness in the United States*, 23 WOMEN’S HEALTH ISSUES e249, e253 (2013).

¹²⁵ LLAMA ET AL., *supra* note 47, at 10.

¹²⁶ *Id.* at 11 (quoting Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, HASTINGS CTR. REP. 21, 21 (2009)).

¹²⁷ Compare VA. DEP’T OF HEALTH, ABORTION: MAKING AN INFORMED DECISION 5 (2018), <http://www.vdh.virginia.gov/content/uploads/sites/38/2016/11/InformedDecision.pdf>, with COMM. ON REPROD. HEALTH SERVS., *supra* note 116, at 57–58.

¹²⁸ VA. DEP’T OF HEALTH, FETAL DEVELOPMENT: UNDERSTANDING THE STAGES (2018), <http://www.vdh.virginia.gov/pregnancy/abortion-making-an-informed-decision/>.

¹²⁹ See generally *id.*; VA. DEP’T OF HEALTH, *supra* note 128.

¹³⁰ *How Does Your State Compare? – Virginia*, INFORMED CONSENT PROJECT, <http://informedconsentproject.com/states/virginia/> (last visited Sept. 1, 2018); see also VA. DEP’T OF HEALTH, *supra* note 129 (providing the materials evaluated by Informed Consent Project).

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Justice Stephen Breyer, in urging the Court to look at undue burden empirically, forced the Court to consider these nuances and think about the actual experiences people have accessing abortion care.¹³¹ The Whole Woman's Health Act would eliminate these needless impediments without sacrificing quality of care. Abortion patients should not be treated differently than other kinds of patients. There is no medically justifiable basis for it. Abortion patients want what all patients want: competent, compassionate care, an honest and respectful relationship with a provider they can trust, and the ability to make the right choice for them in consultation with their provider without jumping through superficial hoops.

C. Act III – The TRAP (Targeted Regulation of Abortion Providers)

Virginia's anti-choice state legislators took their biggest swing at abortion providers during the 2011 General Assembly session with the passage of the "Licensing Statute."¹³² Enacted as Virginia Code Section 32.1-127(B)(1), the statute requires providers that perform five or more abortions per month to be subject to stringent licensing requirements and be regulated as "hospitals."¹³³

As a result of the enactment of the Licensing Statute, the Virginia Department of Health's moved to "convene a medical committee to provide input on the regulatory drafting process."¹³⁴ As explained in the *Falls Church v. Oliver* Complaint, the committee was comprised of relevant experts, such as OB/GYN department chairs from major hospitals in Virginia, and it recommended that "onerous, unnecessary physical plant requirements contained in the regulations not apply to existing clinics, given that they were already providing high quality, safe care."¹³⁵ The Board of Health initially adopted regulations exempting existing clinics, but "in June 2011, Attorney General Ken Cuccinelli – against medical opinion and expertise –

¹³¹ See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2318 (2016).

¹³² See *Falls Church Complaint*, *supra* note 9, at 15. The TRAP was introduced as an amendment to an unrelated bill, SB 924. See Katharine Greenier & Rebecca Glenberg, *Virginia's Targeted Regulations of Abortion Providers: The Attempt to Regulate Abortion out of Existence*, 71 WASH. & LEE L. REV. 1233, 1239 (2014).

¹³³ VA. CODE § 32.1-127(B)(1) (2018). This TRAP law was a surprise amendment to a bill requiring the Board of Health to promulgate regulations defining the minimum standards for hospitals in Virginia, an amendment that saw no public debate and was rammed through the Senate on a 20-20 vote broken by, then, Lieutenant Governor Bill Bolling and signed into law by Governor Bob McDonnell. See Robin Marty, *McDonnell Signs TRAP Bill, Unnecessarily Restricting Women's Access to Reproductive Health Centers*, REWIRE NEWS (Jan. 1, 2013) <https://rewire.news/article/2013/01/01/virginia-governor-signs-trap-bill-to-add-unnecessary-regulations-to-states-reprodu/>.

¹³⁴ *Falls Church Complaint*, *supra* note 9, at 22.

¹³⁵ *Id.*

refused to certify the regulations with exemptions.”¹³⁶ After significant pressure from the Attorney General’s office, including an ominous and threatening letter directed to the members of the Board, the Board of Health promulgated regulations without a waiver in September 2012 on a re-vote.¹³⁷ The regulations became effective in 2013.¹³⁸ As a result of the highly contentious and politicized process, Karen Remley, then Commissioner of Health, resigned from her position.¹³⁹ She wrote to her colleagues explaining that her decision to resign was based upon the fact that “how specific sections of the Virginia Code pertaining to the development and enforcement of these regulations have been and continue to be interpreted has created an environment in which my ability to fulfill my duties is compromised and in good faith I can no longer serve in my role.”¹⁴⁰

As abortion providers began shutting their doors, a new administration took office in January 2014.¹⁴¹ Governor Terry McAuliffe ordered the Board of Health to take another look at the 2013 Licensing Regulations and solicit public comment.¹⁴² Again, the Board of Health heard from experts, providers, and the public. The healthcare community came out in force to make the argument that the regulations in place were completely inappropriate for facilities performing only first trimester abortions.¹⁴³ In the meantime, while the contentious regulatory battle was brewing, the Supreme Court decided *Whole Woman’s Health*.¹⁴⁴

In order to comply with the decision, the Board of Health stripped requirements from the regulations that mandated the “facilities comply with certain provisions of the Guidelines for Designs and Construction of Hospitals and Outpatient Facilities issued by the Facilities Guide Institute.”¹⁴⁵

¹³⁶ *Id.*

¹³⁷ See Jill Abbey et al., Comment Letter on Regulations for Licensure of Abortion Facilities (Jul. 30, 2014), <https://townhall.virginia.gov/L/viewcomments.cfm?commentid=34586>.

¹³⁸ See generally 12 VA. ADMIN. CODE § 5-412 (establishing regulations for licensure of abortion facilities).

¹³⁹ Va. Health Chief Resigns Over New Abortion Clinic Rules, USA TODAY (Oct. 18, 2012), <https://www.usatoday.com/story/news/ondeadline/2012/10/18/virginia-health-commissioner-resigns/1642197/>.

¹⁴⁰ *Id.*

¹⁴¹ See Trip Gabriel, *Terry McAuliffe, Democrat, Is Elected Governor of Virginia in Tight Race*, N.Y. TIMES (Nov. 5, 2013), <https://www.nytimes.com/2013/11/06/us/politics/mcauliffe-is-elected-governor-in-virginia.html>.

¹⁴² See Va. Dep’t of Health, Notice of Intended Regulatory Action Agency Background Document: Regulations for Licensure of Abortion Facilities, VA. REG. TOWN HALL (Nov. 3, 2014), https://townhall.virginia.gov/L/GetFile.cfm?File=58/4295/7120/AgencyStatement_VDH_7120_v1.pdf.

¹⁴³ See Jim Nolan, *Va. Board of Health to Revisit Abortion Clinic Rules*, RICH. TIMES-DISPATCH (Dec. 4, 2014), https://www.richmond.com/r-news/virginia/government-politics/va-board-of-health-to-revisit-abortion-clinic-rules/article_cfd85899-6cfd-55f2-8fc9-67a7bc33ed5b.html.

¹⁴⁴ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016).

¹⁴⁵ Falls Church Complaint, *supra* note 9, at 26–27. “As a result of that June 2016 decision, additional

While these changes were certainly a positive step in the right direction, they did not cure all of the flaws in the regulations. These flaws that remained stemmed from the medically unnecessary and unduly burdensome requirement that the Board regulate facilities that perform five or more abortions as a type of hospital.¹⁴⁶ Governor McAuliffe signed these new regulations, which became effective in May 2017.¹⁴⁷

This history is instructive in demonstrating that even at the inception of the most recent batch of laws and regulations, opinions of medical experts were ignored, as laws and regulations were passed for the express purpose of limiting abortion. After all, Attorney General Cuccinelli openly admitted in an interview that his ultimate goal at the time was to “make abortion disappear in America.”¹⁴⁸

The Virginia TRAP statute and subsequent regulations were not substitutes for regulations already on abortion providers. These were in addition to the already-existing robust regulatory schemes that ensure that any office-based outpatient medical care is safe and effective.¹⁴⁹ In Virginia, the Department of Health Professions' (VDHP) authority, separate from that of the Virginia Department of Health, extends to the regulation of healthcare providers licensed by the boards within VDHP, including the Boards of Medicine, Nursing, and Pharmacy.¹⁵⁰ This Department has its own inspection, investigative, and enforcement authority and can refer violators to the

amendments to the regulations were deemed necessary by the Department based on advice from the Office of the Attorney General. The following additional amendments have been proposed: Onsite Inspections—striking certain requirements; Patient's Rights—Striking specific reference to Joint Commission Standards; Infection Control—Striking specific reference to CDC Guidelines; Maintenance—Striking certain requirements already addressed by existing legal requirements; Firefighting Equipment and Systems—Striking requirements already addressed by existing legal requirements; Design and Construction—Amended to specify that all construction of new buildings and additions, or major renovations to existing buildings for occupancy as an abortion facility shall conform to state and local codes and ordinances. At a special meeting of the Board of Health on October 24th, 2016, several additional amendments to the proposed language were submitted as motions by individual Board members and approved by the Board.” Va. Dep't of Health, *Regulations for Licensure of Abortion Facilities*, VA. REG. TOWN HALL (2017), <https://townhall.virginia.gov/L/ViewAction.cfm?actionid=4295>. It should be noted that this did not come without a controversy. There is an ongoing lawsuit in the Henrico County General District Court, filed by plaintiffs funded by the Family Foundation challenging this mid-process amendment to the regulations. Sean Gorman, *Henrico Judge's Ruling Allows Case Over State Abortion Regulations to Proceed*, RICH. TIMES-DISPATCH (Aug. 23, 2017), https://www.richmond.com/news/local/henrico/henrico-judge-s-ruling-allows-case-over-state-abortion-regulations/article_b216ab8e-8708-54f9-a519-13726a2c5e9e.html.

¹⁴⁶ See 12 VA. ADMIN. CODE § 5-412-100 (2018); see also *id.* § 5-412-10 (defining “abortion facility”).

¹⁴⁷ *Key Dates of Terry McAuliffe's Tenure as Governor of Virginia*, Rich. Times-Dispatch (Jan. 11, 2018), https://www.richmond.com/news/virginia/government-politics/general-assembly/key-dates-of-terry-mcauliffe-s-tenure-as-governor-of/article_b7f6f891-39e2-5563-8e73-257ad897cea2.html.

¹⁴⁸ Falls Church Complaint, *supra* note 9, at 12 (citing Interview by Peter Shinn with Ken Cuccinelli, Va. Att'y Gen. (May 9, 2012)).

¹⁴⁹ See *id.* at 26–27.

¹⁵⁰ *Id.* at 28.

Office of the Attorney General for criminal prosecution when necessary and impose monetary penalties.¹⁵¹ Virginia's Board of Medicine also has enforcement and licensing authority over physicians and clinicians in the Commonwealth.¹⁵² The regulations promulgated by the Board of Medicine further outline standards of practice, covering a plethora of issues ranging from informed consent to discharge policies to administration of anesthesia in office-based settings.¹⁵³ The new licensure requirements under the TRAP statute apply in addition to all the already-existing regulations, arbitrarily adding a medically unnecessary layer of regulation and paperwork.¹⁵⁴ Still, these requirements only apply to facilities performing five or more abortions per month and do not regulate offices where other, riskier procedures take place.¹⁵⁵

Abortions are incredibly safe, but the TRAP regulations contain detailed requirements for clinical protocols, including equipment and supplies, medications, and anesthesia, even more detailed than some of those for required for inpatient hospitals.¹⁵⁶ Studies confirm that abortion safety does not vary based on the type of facility where the abortion is performed, whether an office setting or a full ambulatory surgical center.¹⁵⁷ Thus, the TRAP statute and subsequent regulations at their very core are “not based on scientific evidence and don't protect patient safety.”¹⁵⁸

The worst of the TRAP building requirements were removed from Virginia's regulations in 2016.¹⁵⁹ However, what remain are extensive administrative requirements, inappropriate for small medical offices with limited staff and few resources.¹⁶⁰ These include bloated formalities like a “quality improvement committee” responsible for oversight and supervision of the required “ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided.”¹⁶¹ In addition to the administrative burdens, the licensing requirements involve routine, warrantless, unannounced, and invasive inspections.¹⁶²

¹⁵¹ See VA. CODE §§ 54.1-2505(8)–(10), 54.1-2505(15), 54.1-2505(21) (2018).

¹⁵² See *id.* § 54.1-2915(A).

¹⁵³ 18 VA. ADMIN. CODE §§ 340, 350, 380 (2018).

¹⁵⁴ See *id.* § 85-20 et seq. (2018).

¹⁵⁵ See Falls Church Complaint, *supra* note 9, at 29.

¹⁵⁶ See generally 12 VA. ADMIN. CODE § 5-412 (explaining the significant TRAP requirements for abortion facilities).

¹⁵⁷ ANSRH, *supra* note 98.

¹⁵⁸ *Id.*

¹⁵⁹ See Falls Church Complaint, *supra* note 9, at 24–25.

¹⁶⁰ *Id.* at 28.

¹⁶¹ 12 VA. ADMIN. CODE § 5-412-210 (2018).

¹⁶² Falls Church Complaint, *supra* note 9, at 30.

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There have been no detailed studies of the effect of Virginia's TRAP statute on patient outcomes or experiences, but research from other states throughout the country indicates that TRAP laws can have a deleterious effect on patient outcomes by increasing wait-times and costs and reducing overall access.¹⁶³ Since the TRAP regulations were enacted, abortion clinics have had to devote an increasing amount of time and staff resources to complying with the regulations, time and resources that would otherwise be devoted to patient care.¹⁶⁴

The impact of the TRAP regulations is born out in the fact that in 2008, 85% of Virginia counties had no abortion provider and 54% of women in Virginia lived in those counties. By 2014, after the TRAP regulations were enacted, these numbers had gone up to 92% and 78% respectively, effectively denying Virginian women the right to accessible and affordable abortion services.¹⁶⁵

III. UNDUE BURDEN TEST POST-*WHOLE WOMAN'S HEALTH*

Roe was a flawed decision, one that was subsequently weakened further by the Supreme Court in *Planned Parenthood v. Casey*, *Gonzales v. Carhart*,¹⁶⁶ and others.¹⁶⁷ In case after case, the Court seemed to put a premium on a state's explicit objectives when passing regulations and took little stock of actual circumstances many pregnant people face when they attempt to access their fundamental right.¹⁶⁸ *Whole Woman's Health* appeared to be a watershed moment that could change the tide and open the doors to challenge the hundreds of abortion restrictions passed throughout the country over the last few years.¹⁶⁹

¹⁶³ Nichole Austin & Sam Harper, *Assessing the Impact of TRAP Laws on Abortion and Women's Health in the USA: A Systematic Review*, 44 *BMJ SEXUAL & REPROD. HEALTH* 128, 130, 132 (2018).

¹⁶⁴ *E.g.*, Falls Church Complaint, *supra* note 9, at 40.

¹⁶⁵ *State Facts About Abortion*, GUTTMACHER INST. (2011), <https://web.archive.org/web/20120920001329/http://www.guttmacher.org/pubs/sfaa/virginia.html>; *State Facts About Abortion*, GUTTMACHER INST. (2018), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-virginia>.

¹⁶⁶ *Gonzales v. Carhart*, 550 U.S. 124, 163–64 (2007).

¹⁶⁷ See Emily Crockett, *How the Supreme Court Weakened Roe v. Wade and Set the Stage for A New Abortion Case*, VOX (Mar. 1, 2016), https://www.vox.com/2016/1/22/10815708/roe-v-wade-supreme-court-weakened-abortion_ (stating that *Roe v. Wade* was subsequently weakened by *Ayotte v. Planned Parenthood* and *Gonzales v. Carhart*).

¹⁶⁸ *E.g.*, *Gonzales*, 550 U.S. at 163–64 (stating that in cases of medical uncertainty, states have “wide discretion” to pass legislation).

¹⁶⁹ See Ted Booker, *Whole Women's Health Alliance Files Lawsuit Challenging Indiana Abortion Restrictions*, SOUTH BEND TRIB. (June 22, 2018), https://www.southbendtribune.com/news/local/whole-woman-s-health-alliance-files-lawsuit-challenging-indiana-abortion/article_12e6063c-c547-5516-9fe1-b12f82a5fcf1.html (stating that Whole Women's Health Alliance was able to challenge abortion restrictions in other states following *Whole Women's Health v. Hellerstedt*).

Perhaps the most important take-away from *Whole Woman's Health*, aside from the re-affirmation that abortion is a constitutionally protected right, was the majority's deference to empiricism.¹⁷⁰ The Court did not just accept Texas' stated health and safety reasons for the restrictions, but instead assessed the underlying basis for the professed health benefits and the actual effects on access.¹⁷¹ The Court rejected the notion that courts are not "competent" to review the benefits and burdens abortion restrictions impose when the restriction "purportedly was enacted to promote an interest in potential life."¹⁷² Instead, the Court reaffirmed that "[t]he statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court's case law," and that *Gonzales* really meant that "court[s] retain [] an independent constitutional duty to review factual findings where constitutional rights are at stake."¹⁷³

When substantial burdens are imposed on pregnant people accessing their constitutionally guaranteed rights with no compelling evidence of benefits, as was the case in Texas, the law must be struck down as unconstitutional.¹⁷⁴ In Virginia, the overall legal scheme that would be struck down by the Whole Woman's Health Act is exactly of this ilk. There are no real health benefits to any portion of the TRAP statute and regulations, the abortion criminalization statutes, or the informed consent statutes. Despite the regulatory changes made in 2016, the current regulations remain an impediment to the opening of new facilities and create undue burdens for patients as they try to access abortion care.

IV. THE POST-WHOLE WOMAN'S HEALTH WORLD - SO WHAT ABOUT CASEY?

Whole Woman's Health did not overturn the confusing and problematic history of Supreme Court decisions on abortion by presenting a new test.¹⁷⁵ *Casey* and *Gonzales* were not reversed by this decision, and the damage to abortion access already done was not completely undone with one stroke. The Court did flesh out the undue burden balancing tests, placing it on more

¹⁷⁰ See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310–11 (2016).

¹⁷¹ See *id.* at 2310–13.

¹⁷² Leah M. Litman, *Unduly Burdening Women's Health: How Lower Courts are Undermining Whole Woman's Health v. Hellerstedt*, 116 MICH. L. REV. 50, 57 (2017) (citing *Whole Woman's Health*, 136 S. Ct. at 2309).

¹⁷³ *Id.* at 55–57 (citing *Whole Woman's Health*, 136 S. Ct. at 2309–10).

¹⁷⁴ See *Whole Woman's Health*, 136 S. Ct. at 2318.

¹⁷⁵ See *id.* at 2309–10 (using the undue burden standard to find a Texas law's admitting-privileges and surgical-center requirements for its abortion clinics unconstitutional).

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solid ground and thereby giving some room to re-examine statutes previously deemed constitutional.¹⁷⁶

Given the retirement of Justice Kennedy and the fact that the Trump administration will, in all likelihood, be able to appoint a justice to the Supreme Court, the future of *Whole Woman's Health* is uncertain.¹⁷⁷ However, even if the decision is untouched, there remain questions about its effects on statutes that are not directly analogous to those found unconstitutional in Texas. It is unclear how *Whole Women's Health* would impact the 24-hour waiting period, mandatory ultrasound, non-structural TRAP regulations, criminalization of abortion, and the other laws and regulations the Whole Woman's Health Act would strike from the Virginia Code.¹⁷⁸

While *Casey* has not been overturned, and in fact has been reaffirmed in dicta by the majority in *NIFLA v. Becerra* on First Amendment grounds, the fact-based inquiry the Supreme Court requires in *Whole Woman's Health* should extend to the regulations and laws previously upheld by the Court.¹⁷⁹ The regulations ought not be judged as constitutional or not based solely on their content, but rather, they should be judged on their impact – a fact-specific inquiry to be undertaken in each individual case.

After *Roe*, *Casey* was the next watershed decision in abortion politics. In it, the Supreme Court abandoned strict scrutiny as the standard of review on abortion rights and instead adopted the undue burden standard.¹⁸⁰ While the undue burden standard is simple to state, a state's regulation of abortion is constitutional so long as it does not pose an "undue burden" on the pregnant person seeking an abortion, it has remained difficult to apply.¹⁸¹ The undue burden test is a unique standard of review applicable only to abortion.¹⁸² By adopting it, the Court rejected *Roe*'s support of a woman's interest in her own body and the devaluation of states' interest that occurred in *Roe*.¹⁸³ Therefore, "the undue burden standard provided 'the appropriate means of reconciling the State's interest with the woman's constitutionally protected

¹⁷⁶ See *id.* at 2310–16.

¹⁷⁷ See Robert Barnes, *Justice Kennedy, the Pivotal Swing Vote on the Supreme Court, Announces His Retirement*, WASH. POST (June 27, 2018), https://www.washingtonpost.com/politics/courts_law/justice-kennedy-the-pivotal-swing-vote-on-the-supreme-court-announces-retirement/2018/06/27/a40a8c64-5932-11e7-a204-ad706461fa4f_story.html?utm_term=.485d9efeda6d.

¹⁷⁸ See H.B. 1231, 2018 Gen. Assemb., Reg. Sess. (Va. 2018). See generally *Whole Woman's Health*, 136 S. Ct. 2292 (holding that the Texas law regulating access to abortion violated the constitution).

¹⁷⁹ See Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2372 (2018); *Whole Woman's Health*, 136 S. Ct. at 2310–15.

¹⁸⁰ *Planned Parenthood v. Casey*, 505 U.S. 833, 874, 877 (1992).

¹⁸¹ See Donaldson, *supra* note 57, at 280, 282.

¹⁸² See *id.* at 280.

¹⁸³ See *Casey*, 505 U.S. at 869, 873.

liberty.”¹⁸⁴ The deference shown by the Court to the legislature in *Casey* emboldened anti-abortion advocates and other states’ legislatures and opened the doors for numerous restrictions across the country, leading to the closure of hundreds of clinics.¹⁸⁵

Using *Casey*’s undue burden tests as the cornerstone of subsequent decisions, the Court upheld the “partial birth abortion” ban in *Gonzales*.¹⁸⁶ In its decision, the Court relinquished its duty as fact-finder and bowed with significant deference to Congressional findings, including Congress’ reliance on pseudoscience.¹⁸⁷ The Court reached its conclusions despite evidence from medical professionals concerning the efficacy and safety of the procedure and the need for a health and safety exceptions to the ban.¹⁸⁸ As a result, while some states like California made abortion easier and more accessible, in other parts of the country abortion deserts formed, with clinic numbers cratering and access becoming all but impossible for many.¹⁸⁹

Then came *Whole Woman’s Health v. Hellerstedt*. While it did not overturn *Casey* or *Gonzales* directly, it did open a door to challenge analogous statutes and regulations in the future.¹⁹⁰ Post-*Whole Woman’s Health*, multiple lawsuits have been filed across the country challenging existing abortion restrictions, including the *Falls Church v. Oliver* litigation.¹⁹¹ Each challenge is rooted in a fact-specific inquiry, leaning heavily on the position that fact-based evidence, not ideology, should rule the day when it comes to determining what is and is not an undue burden.¹⁹² The plaintiffs in these cases argue that courts should take into account the full impact of abortion restrictions imposed on pregnant people, and not just those explicitly acknowledged by the legislatures.¹⁹³

¹⁸⁴ Wolk & Snead, *supra* note 10, at 724 (citing *Casey*, 505 U.S. at 876).

¹⁸⁵ *See id.* at 722–24 (2018) (citing *Casey*, 505 U.S. 833).

¹⁸⁶ *See Gonzales*, 550 U.S. at 132–33 (2007).

¹⁸⁷ Caroline Reilly, More than a Minor Burden: A Post-Whole Women’s Health Analysis of Parental Involvement Laws 35 (May 10, 2017) (unpublished student paper), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2960375.

¹⁸⁸ Donaldson, *supra* note 57, at 285 (citing *Gonzales*, 550 U.S. at 147).

¹⁸⁹ Lisa M. Kelly, *Abortion Travel and the Limits of Choice*, 12 FLA. INT’L U.L. REV. 27, 39–40 (2016).

¹⁹⁰ *See Ziegler, supra* note 45, at 352 (explaining how the Supreme Court’s decision in *Whole Woman’s Health v. Hellerstedt* could be reconciled with the Court’s decision in *Gonzales v. Carhart*).

¹⁹¹ *See, e.g., Falls Church Med. Ctr. v. Oliver*, No. 3:18-cv-428 (E.D. Va. filed June 20, 2018).

¹⁹² *See Donaldson, supra* note 57, at 285–86 (discussing *Gonzales*, 550 U.S. 124 (Ginsburg, J., dissenting) (regarding the legitimacy of factual findings based on evidence of pseudoscience)).

¹⁹³ *See, e.g. Complaint* at 1, 14, *Whole Woman’s Health All. v. Hill*, No. 1:18-cv-1904 (S.D. Ind. 2018) (challenging the extensive burdens of Indiana’s TRAP statutes; the restrictions on the use of Mifepristone; the mandatory disclosure and waiting period laws; the parental involvement laws; and the criminalization of abortion).

Whole Woman's Health rested on medical evidence, or rather the lack of medical evidence, to support the stated interest in imposing a burden to protect health.¹⁹⁴ Justice Breyer, writing for the majority, stated that the courts, in reviewing regulations under the undue burden standard had an obligation to examine “the existence or nonexistence of medical benefits” and to look at the actual effects of regulatory changes on the experience of pregnant people.¹⁹⁵ However, in *NIFLA v. Becerra* the Court, in the course of ruling California's attempts to impose regulations on crisis pregnancy center communications with their patients unconstitutional, reaffirmed the *Casey* ruling concerning informed consent requirements on free speech grounds.¹⁹⁶ In the Court's opinion, Justice Clarence Thomas characterized Pennsylvania's informed consent statute as simply “a law requiring physicians to obtain informed consent before they could perform an abortion.”¹⁹⁷ The Court further stated that *Casey* rejected the free-speech challenge because the informed consent requirement “for constitutional purposes, [was] no different from a requirement that a doctor give certain specific information about any medical procedure.”¹⁹⁸ The Whole Woman's Health Act would remove similar informed consent statutes from Virginia law, and the *Falls Church v. Oliver* lawsuit challenges the validity of such statutes based on the undue burden standard found in *Whole Woman's Health*, not on free speech grounds.¹⁹⁹ While in the abstract requiring medical professionals to obtain informed consent would not be viewed as an unconstitutional infringement on a medical professional's free speech, if anything can be carried away from *Whole Woman's Health*, it is that the actual requirements and their effects have to be viewed empirically, and not in the abstract, when determining whether they impose an undue burden on access to abortion.²⁰⁰

CONCLUSION

The history of abortion laws and regulations in Virginia is rooted in anti-abortion animus, rather than genuine concern for the health and safety of the patients. Arising from these beginnings, it is no surprise that many of Virginia's abortion statutes and associated regulations remain on the books

¹⁹⁴ See Donaldson, *supra* note 57, at 288.

¹⁹⁵ See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016); Donaldson, *supra* note 57, at 290.

¹⁹⁶ See *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2373 (2018).

¹⁹⁷ *Id.* at 2373 (citing *Planned Parenthood v. Casey*, 505 U.S. 833, 884 (1992)).

¹⁹⁸ *Id.*

¹⁹⁹ See *Falls Church Complaint*, *supra* note 9, at 55.

²⁰⁰ *Whole Woman's Health*, 136 S. Ct. at 2309–10; see Cathren Cohen, *Beyond Rational Belief: Evaluating Health-Justified Abortion Restrictions after Whole Woman's Health*, 42 N.Y.U. REV. L. & SOC. CHANGE 173, 190–91 (2018).

and create unnecessary burdens for pregnant Virginians seeking abortion access. The Whole Woman's Health Act, a comprehensive bill that would excise the most pernicious of the baseless abortion statutes from the Virginia Code, has failed to make it through the General Assembly for two years in a row, with only limited consideration. Adopting the Whole Woman's Health Act would reflect the underlying principle in the *Whole Woman's Health v. Hellerstedt* decision and the clarified 'undue burden' standard, removing medically unnecessary impediments to abortion access. While the recent developments regarding the composition of the Supreme Court and more recent Supreme Court decisions may make it seem less urgent, the need for this law remains critical.