STUDENT WORKS

HINDERING WEBCAM OUTREACH ON THE WOMEN'S HEALTHCARE FRONTIER: WHY ABORTION-SPECIFIC RESTRICTIONS ON TELEMEDICINE ARE UNCONSTITUTIONAL

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I. INTRODUCTION

> *Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter.*[1]

Access to safe, legal healthcare is something that no person should be without. This is especially true when it comes to women's healthcare,[2] and abortion is no exception. As evidenced

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1. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 850 (1992).

2. Recognizing the importance of accessible women's healthcare and family-planning services, the Obama administration recently approved a final rule issued by the United States Department of Health and Human Services (HHS) that will require almost all health insurance plans to provide coverage for contraceptive services without charging a co-pay or deductible. U.S. Dep't of Health & Human Servs., *News Release: A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius*, http://www.hhs.gov/news/press/2012pres/01/20120120a.html (Jan. 20, 2012).

by the state of abortion in the United States pre-*Roe* and in countries that have yet to legalize it, having access to legal abortion can drastically improve women's health.[3] Regardless of whether it is legal, women will obtain abortions.[4] The only difference is in the procedure's safety.[5] Where legal abortion is not available or is inaccessible, women will often undergo unsafe and unhealthy abortion procedures, feeling as if they have no other option.[6] Notably, safe abortion services can be made unattainable by illegalizing the procedure or by simply making such procedures inaccessible for women.[7] The latter is the threat presented by abortion-specific restrictions on telemedicine.

As described in detail below, telemedicine abortions merely involve implementing existing telecommunications technology (essentially, webcams) in the abortion context.[8] Physicians at Planned Parenthood of the Heartland began using this technology to remotely prescribe mifepristone to rural patients.[9] Although telemedicine has received wide acclaim in other medical practice areas, it has not been similarly embraced in the abortion context.[10] A number of states have enacted laws that effectively or expressly make telemedicine abortions illegal.[11]

The Author proposes that abortion-specific restrictions on telemedicine are unconstitutional under the Fourteenth Amendment. These laws have the purpose or effect of placing a substantial obstacle on a rural, lower-income woman's ability to consider

3. *See* Cynthia Dailard & Alan Guttmacher Inst., *Abortion in Context: United States and Worldwide*, 1999 Issues in Br. 4 (available at http://www.guttmacher.org/pubs/ib_0599.pdf).

4. *See infra* n. 56 and accompanying text (explaining the lack of a correlation between the legality of abortion and the number of abortions that are obtained).

5. *See infra* n. 59 and accompanying text (describing how the legality of abortion directly impacts the safety of the abortion procedure).

6. *See infra* n. 60 and accompanying text (noting that outlawing abortion has a negative effect on public health because doing so merely changes the circumstances under which abortions are obtained).

7. *See infra* n. 61 and accompanying text (providing that abortion can be made inaccessible either expressly or effectively).

8. *See infra* n. 144 and accompanying text (portraying the use of telecommunications technology for the provision of remote medication-abortion services).

9. *See infra* n. 137 and accompanying text (explaining that Planned Parenthood of the Heartland began offering telemedicine abortion services in July of 2008).

10. *See infra* n. 135 (describing the variety of practice areas in which telemedicine has been successfully implemented).

11. *See infra* pt. VI(B) (enumerating the states that have proposed or enacted preemptive legislation placing restrictions on telemedicine abortion).

abortion a realistic option and therefore fail the undue burden test. Because these laws affect specifically rural, lower-income women[12] and operate as a substantial obstacle in a significant number of cases, they cannot pass constitutional muster.

Part II of this Article briefly lays out the federal judicial framework that has given way to the present-day abortion right. Part III addresses the disparity among states with respect to access to abortion services. Part IV introduces mifepristone, the medical abortion pill, and describes its history of use and its safety record. Part V describes the history and present-day use of telemedicine technology and then describes its transition to the abortion context as a way of remotely prescribing and dispensing mifepristone to rural women seeking an early abortion. Part VI delves into the governmental response that telemedicine abortion has received on both the state and federal level. Part VII analyzes abortion-specific restrictions on telemedicine under the undue burden test. Finally, Part VIII suggests that abortion-specific restrictions on telemedicine are not reasonably related to a legitimate state interest. Even if a court could find that legislation of this sort is reasonably related to a legitimate state interest, the legislation still could not withstand constitutional review under the undue burden test.

II. A CONSTITUTIONAL, BUT NOT ABSOLUTE, RIGHT TO CHOOSE ABORTION

Prior to 1973, abortion's legality in the United States varied by state and year.[13] With the United States Supreme Court's monumental decision in *Roe v. Wade*,[14] however, came the nationwide decriminalization of abortion.[15] The Court held that a woman has a right to decide in consultation with her physician

12. *See infra* n. 63 and accompanying text (explaining that rural, lower-income women are far more likely to lack access to an early abortion option).

13. *See* Nat'l Abortion Fed'n, *About Abortion*, *History of Abortion*, "Abortion Was Legal," http://www.prochoice.org/about_abortion/history_abortion.html (accessed Jan. 29, 2013) (explaining that abortion had been a legal phenomenon in the United States since the time of colonization, but that states began to pass laws outlawing abortion during the 1800s). Starting in 1967, states began to liberalize or repeal their existing criminal abortion laws, with one-third of them having done so by the Supreme Court's decision in *Roe v. Wade*. *Id.* at "Liberalization of Abortion Laws."

14. 410 U.S. 113 (1973).

15. *Id.* at 166.

whether to carry her pregnancy to term.[16] The Court found this to be a personal right that is encompassed by the fundamental right to privacy that is "implicit in the concept of ordered liberty"[17] and thereby constitutionally protected under the Due Process Clause of the Fourteenth Amendment.[18]

Although a woman has a constitutionally protected right to abortion, this right is subject to limitations.[19] The *Roe* Court recognized that state interests in health, the practice of medicine, and prenatal life increase with the pregnancy's duration, and that a point comes in the pregnancy where those interests are sufficient to allow a state to restrict, and eventually proscribe, abortion.[20]

Almost twenty years later, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[21] the Court analyzed the constitutional validity of Pennsylvania's recently amended abortion law, which placed several new restrictions on women seeking an abortion.[22] Declining the respondents' invitation to overrule *Roe*, the Court instead affirmed *Roe*'s three-part holding that: (1) a woman has a constitutional right "to choose to have an abortion before viability and to obtain it without undue interference from the [s]tate"; (2) the state may restrict abortions after the pregnancy reaches the point of fetal viability, so long as it provides an exception for pregnancies that endanger the life or health of the mother; and (3) the state has legitimate interests from the pregnancy's outset in maternal health and in the developing fetus that may ultimately become a child.[23]

16. *Id.* at 164.

17. *Id.* at 152–153 (quoting *Palko v. Conn.*, 302 U.S. 319, 325 (1937)) (internal quotations marks omitted).

18. *Id.* at 164.

19. *Id.* at 154–155.

20. *Id.* at 155. The *Roe* Court employed a trimester framework for measuring state interests against the woman's constitutional right. *Id.* at 164–165. Specifically, it held that: (1) during the first trimester, the state cannot interfere with a woman's decision to seek an abortion; (2) during the second trimester, the state may regulate abortion procedures consistent with its interest in maternal health; and (3) after the point of viability, the state may assert its interest in potential life and regulate or proscribe abortion, so long as it provides an exception for abortions necessary to preserve the mother's life or health. *Id.*

21. 505 U.S. 833.

22. *Id.* at 844.

23. *Id.* at 846.

Instead of employing a strict scrutiny analysis to determine the constitutional validity of the Pennsylvania law, the Court imposed a new standard for analyzing pre-viability abortion restrictions: the undue burden test.[24] A pre-viability abortion restriction will be found to constitute an undue burden—and will thus be void as unconstitutional—when it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[25] Pursuant to this plain language, the Court considered both the underlying purpose of the law and the actual effect it has on women.[26] While the Court did not provide a bright-line rule for determining whether something constitutes a "substantial obstacle," it did provide a framework for lower courts to employ when conducting case-by-case analyses of pre-viability abortion restrictions.[27] The Court's analysis of Pennsylvania's spousal notification law demonstrated that the first step is to identify "the group [of people] for whom the law is a restriction."[28] This requires a *specific* definition of the people impacted by the law.[29] The Court made this clear when it refuted respondents' argument that the spousal notification law could not be facially invalid because only about one percent of women seeking an abortion were affected by it.[30] The Court clarified that it is with that one percent of affected women that the constitutional inquiry must begin.[31] The constitutional question then becomes whether, in a significant number of these cases, the regulation is outcome-determinative as to whether the affected women will seek an abortion.[32] If this question is answered affirmatively, then the regulation operates as a "substantial obstacle" and is thus unconstitutional under the undue burden test.[33]

24. *Id.* at 876.
25. *Id.* at 877.
26. *Id.*
27. *Id.* at 877–878.
28. *Id.* at 894.
29. *See id.* at 894–895 (clarifying that the group targeted by Pennsylvania's spousal notification law was not "women who wish to obtain abortions," as asserted by the respondents, but was instead a much narrower group, namely "married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement").
30. *Id.* at 894.
31. *Id.*
32. *Id.* at 895.
33. *Id.*

Fifteen years later in *Gonzales v. Carhart*,[34] the Supreme Court reaffirmed *Casey*'s holding[35] and applied the undue burden test in a facial challenge to the federal Partial-Birth Abortion Ban Act of 2003.[36] In what has largely been perceived as a controversial decision,[37] a divided Court upheld the Act as constitutional despite the fact that the Act did not contain a health exception.[38] The majority's holding shocked the four dissenting Justices because it ignored over thirty years of precedent and upheld an abortion restriction lacking a health exception for the first time since the Court legalized abortion in *Roe*.[39] The majority justified this deviation from precedent by citing the existence of medical uncertainty as to whether the banned procedure would ever be necessary to preserve the mother's health.[40] Specifically, the majority highlighted the inconsistencies between the medical opinions presented in Congress' findings (that the procedure would never be necessary) and those asserted by the expert witnesses who testified before the three preceding trial courts (that in some cases the banned procedure would be safer than the remaining alternatives).[41]

The dissent took marked exception to the majority's reasons for holding that the Act did not require a health exception.[42] In particular, the dissent found the majority's deference to Congress' findings "alarming" due to the disparity between the quantity of

34. 550 U.S. 124 (2007).

35. *Id.* at 146. Specifically, the Court stressed that the balance struck in *Casey* between the state's interests and the woman's right to choose to have an abortion "was central to its holding." *Id.* Prior to viability, a state may not deprive a woman of the right to choose to terminate her pregnancy or impose an undue burden upon that right. *Id.* (citing *Casey*, 505 U.S. at 878–879). Because the state has an interest in the fetus' potential life from the outset of the pregnancy, regulations that merely provide a mechanism for expressing that interest are permissible, so long as they are not a substantial obstacle to the woman's right to choose. *Id.* (citing *Casey*, 505 U.S. at 877).

36. *Id.*

37. *See e.g.* Susan Frelich Appleton, *Reproduction and Regret*, 23 Yale J.L. & Feminism 255, 261–262 (2011) (explaining the "torrent of disapproval" following the Court's reasoning in *Gonzales* that some women who obtained an abortion inevitably come to regret their decision); B. Jessie Hill, *A Radically Immodest Judicial Modesty: The End of Facial Challenges to Abortion Regulations and the Future of the Health Exception in the Roberts Era*, 59 Case W. L. Rev. 997, 999 (2009) (describing the Court's decision in *Gonzales* as "highly unsettling with respect to prior precedent").

38. *Gonzales*, 550 U.S. at 168.

39. *Id.* at 170–171 (Ginsburg, Stevens, Souter & Breyer, JJ., dissenting).

40. *Id.* at 165–166 (majority).

41. *Id.*

42. *Id.* at 170–171 (Ginsburg, Stevens, Souter & Breyer, JJ., dissenting).

evidence and its manner of collection by the trial courts and by Congress.[43] After affording substantial deference to Congress in reviewing the accuracy of its findings, the preceding district courts, affirmed by their respective circuit courts, found that the findings were unreasonable under any level of deference.[44] The majority did not provide an explanation for ignoring the consensus in the lower courts.[45] The dissent further pointed out that even if Congress' findings were given the presumption of accuracy, that would not negate the fact that "significant medical authority support[s] the proposition that in some circumstances, [the banned procedure] would be the safest procedure."[46] Such a finding would have led the Court, prior to this case, to conclude that a ban on that procedure was unconstitutional absent a health exception.[47]

III. ABORTION ACCESS DISPARITY IN THE UNITED STATES

Although women in the United States have a constitutionally protected right to seek a pre-viability abortion without undue governmental interference, effectuating that right presents another obstacle. For many women in the United States, the closest abortion provider may be hundreds of miles away.[48] A 2008 study by the Guttmacher Institute found that eighty-seven percent of United States counties do not have an abortion provider.[49]

43. *Id.* at 170, 177–180.

44. *Planned Parenthood Fed'n v. Ashcroft*, 320 F. Supp. 2d 957 (N.D. Cal. 2004), *aff'd*, 435 F.3d 1163 (9th Cir. 2006); *Carhart v. Ashcroft*, 331 F. Supp. 2d 805 (D. Neb. 2004), *aff'd*, 413 F.3d 791 (8th Cir. 2005); *Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp. 2d 436 (S.D.N.Y. 2004), *aff'd*, 437 F.3d 278 (2d Cir. 2006).

45. *Gonzales*, 550 U.S. at 179 (Ginsburg, Stevens, Souter & Breyer, JJ., dissenting).

46. *Id.* at 180 (quoting *Stenberg v. Carhart*, 530 U.S. 914, 932 (2000)) (internal quotation marks omitted).

47. *See id.* at 173–174 (citing *Stenberg*, 530 U.S. at 937–938) (explaining that the Court in *Stenberg*, in holding unconstitutional a state ban on the same abortion procedure that was banned by the Act, acknowledged that medical uncertainty persisted as to the relative safety of the banned procedure, but held that a health exception is required when substantial medical authority shows that banning the procedure could be dangerous for women's health).

48. Nat'l Abortion Fed'n, *Factsheet: Abortion after Twelve Weeks* (revised 2003) (available at http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/abortion_after_12_weeks.pdf).

49. Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States*, 43 Persps. on Sexual & Reprod. Health 41, 46 (2011).

Further, thirty-five percent of the reproductive-aged women (women aged fifteen to forty-four) in the United States live in those counties that do not have an abortion provider.[50] Not surprisingly, women in rural areas of the country face the most difficulty in accessing abortion services.[51] An overwhelming ninety-seven percent of nonmetropolitan counties do not have a provider of abortion services within their borders.[52] Ninety-two percent of nonmetropolitan women of reproductive age reside in those counties.[53]

Access to safe abortion procedures is a matter of paramount importance for women in the United States, but it is also a matter that legislators all too often overlook. One merely needs to tune in to any major news station to hear about a proposal that would impede access to or illegalize abortion.[54] The motivation behind policymaking of this sort is generally a desire to reduce the rate of abortions.[55] As evidenced by abortion incidence in developing countries and in the United States pre-*Roe*, however, the correlation between the legality of the procedure and the number of abortions obtained is weak at best.[56] Instead, the leading factor affecting abortion rate is the incidence of unintended pregnancies.[57] For many women, the decision to terminate a pregnancy is one born of desperation, a feeling that is prevalent regardless of the current state of the law with respect to abortion.[58]

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50. *Id.* at 41.

51. Kathleen Reeves, RH Reality Check, *A Pioneering Effort to Increase Rural Women's Access to Safe Abortion in Iowa*, http://www.rhrealitycheck.org/blog/2010/08/20/ppiowas-pioneering-efforts-ensure-rural-access (Aug. 23, 2010, 7:00 a.m. ET).

52. Jones & Kooistra, *supra* n. 49, at 46.

53. *Id.*

54. *E.g.* Jason Linkins, *Anti-Abortion Georgia Lawmaker Proposes Law That Would Criminalize Miscarriages*, Huffington Post, http://www.huffingtonpost.com/2011/02/23/antiabortion-georgia-lawm_n_827340.html (Feb. 23, 2011, 5:22 p.m. ET); *The Diane Rehm Show*, Radio Broad., "Consequences of Granting Legalized Status to a Fertilized Human Egg" (Nat'l Pub. Radio Oct. 31, 2011) (transcript available at http://thedianerehmshow.org/shows/2011-10-31/consequences-granting-legal-status-fertilized-human-egg/transcript).

55. Dailard & Alan Guttmacher Inst., *supra* n. 3, at 1.

56. *Id.*

57. *Id.*; Guttmacher Inst., *Facts on Induced Abortion in the United States* 1 (Aug. 2011) (available at http://www.guttmacher.org/pubs/fb_induced_abortion.pdf). Forty-nine percent of pregnancies in the United States are unintended, and roughly four out of ten unintended pregnancies are terminated. *Id.*; Andrzej Kulczycki, *Abortion and Postabortion Care*, *Maternal and Child Health: Global Challenges, Programs, and Policies* 191, 195 (John Ehiri ed., Springer 2009).

58. *See* Susan Dudley & Nat'l Abortion Fed'n, *About Abortion*, *Abortion Facts*, *Economics of Abortion*, "Before and After *Roe v. Wade*," http://www.prochoice.org/about

While abortion's legal status has only a marginal effect on abortion rate, it has a profound effect on procedural safety.[59] When a legal abortion is unattainable, many women will go to great, and often dangerous, lengths to terminate their pregnancies.[60] It is important to note that legal abortion can be made unattainable either *expressly* (prohibited by law) or *effectively* (inability to access abortion services).[61] Women in the United States face the latter problem, particularly those living below the poverty level[62] and those living in rural areas of the country.[63]

The safety of abortion procedures is something that can largely be controlled, especially in a highly developed country such as the United States.[64] While abortion-restricting legislation is often advanced pursuant to a stated concern for the safety of women undergoing abortion procedures, this concern is unfortu-

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_abortion/facts/economics.html (updated 2003) (explaining that when abortion was illegal in the United States prior to the Supreme Court's decision in *Roe*, desperate women would go to extensive lengths to obtain illegal abortions); Lynne V. & Feminist Women's Health Ctr., *What 1,000 Abortions Have Taught Me*, http://www.fwhc.org/abortion/1000ab.htm (1993) (explaining that women consider several factors when deciding whether to obtain an abortion and stating that women who choose abortion often do so after finding that it is the "lesser of two evils").

59. Susan A. Cohen, *Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide*, 12 Guttmacher Policy Rev. 2, 2 (Nov. 4, 2009). It is important to note that legal access to abortion does not by itself guarantee a safe procedure; other factors play a part. For example, the quality of available post-abortion care, particularly in developing countries, has a tremendous impact on the overall safety of abortion procedures. David A. Grimes et al., *Unsafe Abortion: The Preventable Pandemic*, 368 Lancet 1908, 1916 (2006).

60. *See* Kulczycki, *supra* n. 57, at 192 (explaining that outlawing abortion merely impairs the circumstances under which abortions are obtained, thus resulting in an adverse effect on public health).

61. *Id.* at 193 (concluding that legal abortion does not include a guarantee that safe abortion services are readily available, as evidenced by the situation in India where abortion is legal but services are insufficient, leading to many unsafe clandestine procedures and resulting in India having the highest incidence of abortion-related deaths).

62. Comm. on Health Care for Underserved Women, *Abortion Access and Training* 2 (ACOG Comm. Op. Series No. 424, 2009) (available at http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co424.ashx?dmc=1&ts=20120101T1544559956); Cara V. James et al., *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* 96 (Henry J. Kaiser Family Found. 2009) (available at http://www.kff.org/minorityhealth/upload/7886.pdf).

63. Beth Jordan & Wayne C. Shields, *Happy Anniversary Mifepristone: A Decade of Promise and Challenges*, 82 Contraception 219, 219 (2010).

64. *See* Dailard & Alan Guttmacher Inst., *supra* n. 55, at 4 (explaining that the legal status of abortion in a country, the availability of qualified medical professionals, and the extent to which women are aware of legal abortion all have an impact on the safety of abortion procedures).

nately misplaced. Legal abortion[65] in developed nations "has emerged as one of the safest procedures in contemporary medical practice."[66]

A strong consensus exists among women's healthcare practitioners that for a woman seeking to obtain an abortion, earlier is better.[67] The health risks associated with obtaining an abortion increase greatly with the length of a woman's pregnancy.[68] Upon consulting with her physician, a woman is apprised of these risks before undergoing any procedure.[69] This becomes an issue when, as is all too often the case, a woman's inability to access abortion services causes her to obtain an abortion later in her pregnancy than she would have if an abortion provider had been readily accessible to her.[70] This Article is particularly concerned with those women who are delayed in, or effectively prohibited from, seeking an abortion due to restrictive state abortion laws.

As discussed in detail below, the medical community has made great strides in improving the accessibility of early abortion services, particularly with the development of early medication abortion and, more recently, with the use of telemedicine technology to provide medication-abortion services.[71] But these medical developments have not been without legislative opposition.[72] State restrictions that impede access to abortion care come in a variety of forms, including: mandatory waiting periods and coun-

65. A "legal abortion" is one that is "performed by a licensed physician, or an appropriately licensed advanced practice clinician acting under the supervision of a licensed physician." Ctrs. for Disease Control & Prevention, *Surveillance Summaries: Abortion Surveillance—United States, 2007*, 60 Morbidity & Mortality Wkly. Rpt. 2 (Feb. 25, 2011).

66. Grimes et al., *supra* n. 59, at 1908.

67. FamilyDoctor.org, *Drug Information*, *Procedures & Devices*, *Ending a Pregnancy*, "Are Abortions Safe?" http://familydoctor.org/familydoctor/en/drugs-procedures-devices/procedures-devices/ending-a-pregnancy.html (updated Sept. 2010).

68. Guttmacher Inst., *supra* n. 57, at 2. An abortion performed at or before eight weeks of pregnancy has an associated risk of death of one in one million. *Id.* If the abortion is performed after twenty-one weeks of pregnancy, however, the risk of death increases to one in eleven thousand. *Id.*

69. Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 Geo. Wash. L. Rev. 1599, 1603 (2008).

70. Kulczycki, *supra* n. 57, at 192.

71. NARAL Pro-Choice Am. Found., *Mifepristone: The Impact of Abortion Politics on Women's Health and Scientific Research* 2 (Jan. 1, 2012) (available at http://www.naral.org/media/fact-sheets/abortion-ru486-politics.pdf).

72. *See id.* at 3 (noting the opposition to mifepristone even though it has been approved by the FDA and has been widely accepted).

seling requirements,[73] laws imposing additional duties or restrictions on abortion providers that are not imposed on other healthcare providers (also known as "TRAP" laws),[74] and funding restrictions prohibiting the use of insurance or Medicaid funds to pay for abortion services.[75] As discussed in detail below, this Article focuses on the recent occurrence of restrictions that, in so many words, ban telemedicine abortions—those involving a physician consulting with a patient via webcam before remotely dispensing the medication-abortion drugs at the patient's location. These laws generally require that the acting physician be in the same room as the woman obtaining an abortion, effectively making the provision of medication abortion via telemedicine illegal.[76]

IV. MIFEPRISTONE: THE MEDICATION-ABORTION METHOD

Mifepristone,[77] distributed under the brand name Mifeprex, is a method of medication abortion that is available to women seeking to terminate an early pregnancy.[78] Mifepristone provides an FDA-approved pharmaceutical alternative to the surgical aspiration abortion procedure.[79] Mifepristone is an option available to

73. Guttmacher Inst., *State Policies in Brief: Counseling and Waiting Periods for Abortion* 1 (Sept. 1, 2012) (available at http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf).

74. Ctr. for Reprod. Rights, *Targeted Regulation of Abortion Providers (TRAP)*, http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap (Mar. 5, 2009).

75. NARAL Pro-Choice Am. Found., *Discriminatory Restrictions on Abortion Funding Threaten Women's Health* 3 (Jan. 1, 2012) (available at http://www.naral.org/media/fact-sheets/abortion-funding-restrictions.pdf).

76. *See* Guttmacher Inst., *State Policies in Brief: Medication Abortion* 2 (Sept. 1, 2012) (available at http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf) (providing that six states currently have laws—one of which is enjoined by court order from enforcing its telemedicine abortion restrictions—that require a physician performing a medication abortion to be in the same room as the patient).

77. Mifepristone is widely referred to as the "abortion pill" or "RU-486." Reprod. Health Techs. Project, *Abortion*, *Mifepristone*, http://www.rhtp.org/abortion/mifepristone/default.asp (accessed Jan. 29, 2013).

78. Planned Parenthood, *Health Info & Services*, *Abortion*, *The Abortion Pill (Medication Abortion)*, "What is the Abortion Pill?" http://www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.asp (accessed Jan. 29, 2013).

79. The Henry J. Kaiser Family Found., *Mifepristone: An Early Abortion Option* 1 (July 2001) (available at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13809).

women seeking to terminate an early pregnancy, specifically within the first forty-nine days of pregnancy.[80]

A. Development and FDA Approval

Although adverse political pressure initially delayed mifepristone's approval in the United States,[81] Europe has used mifepristone successfully for more than twenty years.[82] Roussel Uclaf, the French pharmaceutical developer of mifepristone, gave the United States' patent rights for the drug to the Population Council, which conducts research as a private, nonprofit entity.[83] After clinical trials were conducted in the United States to study the safety and efficacy of mifepristone-misoprostol treatment, the FDA granted the regimen "approvable" status in 1996.[84] Then, in September 2000, the FDA approved mifepristone (under the brand name Mifeprex) for use in conjunction with the drug misoprostol to end an early pregnancy.[85] The Population Council granted Danco Laboratories, LLC, a women's health pharmaceutical company, an exclusive license to manufacture, market, and distribute mifepristone in the United States.[86]

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80. U.S. Food & Drug Administration, *Mifeprex (mifepristone) Tablets, 200mg for Oral Administration Only* 5, http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/020687s013lbl.pdf (July 19, 2005).

81. Nat'l Abortion Fed'n, *Professional Education*, *Education Resources*, *Medical Abortion*, *History and Overview*, "Bringing Mifepristone to the United States," http://www.prochoice.org/education/resources/med_history_overview.html (accessed Jan. 29, 2013).

82. Danco Laboratories, *Mifeprex in the United States*, http://www.earlyoptionpill.com/section/what_is_mifeprex/mifeprex_in_united_states (accessed Jan. 29, 2013). Mifepristone was developed and licensed for use as an abortifacient in combination with the drug misoprostol, a prostaglandin analogue. Nat'l Abortion Fed'n, *supra* n. 81. Misoprostol was originally developed to treat peptic ulcers but has become an important medication in the field of obstetrics and gynecology. O.S. Tang, K. Gemzell-Danielsson & P.C. Ho, *Misoprostol: Pharmacokinetic Profiles, Effects on the Uterus and Side-Effects*, 99 Int'l J. Gynecology & Obstetrics S160, S160 (2007). Originally considered to be side effects, misoprostol causes the cervix to soften and the uterus to contract. *Id.* at S163.

83. Nat'l Abortion Fed'n, *supra* n. 81.

84. Kaiser Found., *supra* n. 79, at 4. The FDA relied on the efficacy and safety data that the Population Council gathered during its clinical trials in the United States, in addition to data gathered during clinical trials conducted in France. Nat'l Abortion Fed'n, *supra* n. 81.

85. U.S. Food & Drug Administration, *Mifeprex (mifepristone) Information*, http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm111323.htm (updated July 19, 2011).

86. Nat'l Abortion Fed'n, *supra* n. 81. Danco Laboratories had difficulty finding a manufacturer that was willing to step into the politically charged abortion arena, causing the final FDA approval of the drug to be delayed. *Id.*

B. How Mifepristone Works and How It Is Administered

Mifepristone is taken orally in conjunction with misoprostol, a prostaglandin analogue, to terminate early pregnancies.[87] Mifepristone is administered first and acts as an anti-progestin, blocking the body's reception of the hormone progesterone, which is needed for a woman's body to sustain a pregnancy.[88] Then, misoprostol[89] is administered up to three days later to cause uterine contractions and complete the procedure.[90] Because mifepristone is an early method of abortion, the more traditionally used surgical-aspiration procedure is still available as a safe option in the rare three percent of cases in which a complete abortion is not achieved.[91]

Though a mifepristone abortion requires a woman to make more than one visit to her physician, it affords her the opportunity to complete the abortion procedure in private.[92] During her initial visit, a woman will discuss the medication-abortion option with her physician and undergo various laboratory and physical tests, including an ultrasound.[93] Then, upon determining that the woman is a candidate for the procedure, the physician will give the woman the mifepristone and watch her take it in the office.[94] During that visit, the physician will also provide her with instructions for how and when to take the misoprostol to complete the abortion process.[95] Many women choose the privacy and control of a medication abortion over the surgical alternative.[96] For many women, being able to undergo what is already a stressful process in the privacy of their own homes, in the company of friends or family if they so choose, provides a tremendous amount of com-

87. *Id.*
88. Kaiser Found., *supra* n. 79, at 2.
89. When prescribed in small doses, misoprostol causes uterine contractions. *Id.*
90. Reprod. Health Techs. Project, *supra* n. 77.
91. Planned Parenthood, *supra* n. 78, at "How Effective is the Abortion Pill?"
92. *Id.* at "Why Do Women Choose the Abortion Pill?"
93. *Id.* at "What Happens during a Medication Abortion?"
94. *Id.*; U.S. Food & Drug Administration, *supra* n. 80, at 13. The woman is also required to read the Mifeprex Medication Guide at this time and must read and sign the Mifeprex Patient Agreement before the physician provides the mifepristone. *Id.*
95. Planned Parenthood, *supra* n. 78, at "What Happens during a Medication Abortion?"
96. *Id.* at "Why Do Women Choose the Abortion Pill?"

fort.[97] Finally, it is very important that the woman visit her physician again for a follow-up appointment to verify that the pregnancy was successfully terminated and ensure there were no complications.[98]

C. Safety

Mifepristone has been widely used by women seeking an early abortion in both the United States and the international community, and has achieved a high level of success and safety.[99] As of 2008, mifepristone had been approved for use in thirty-eight countries.[100] In the United States, an estimated 1.52 million women have used mifepristone,[101] and the FDA has only received 2,207 reported cases in which the woman experienced any adverse effect.[102] Thus, only about 0.145% of women who have used mifepristone in the United States reported experiencing an adverse reaction.[103]

Further, only fourteen cases of fatalities have been reported to the FDA.[104] Eight of these deaths were associated with fatal septic shock,[105] but no causal relationship has been established between the rare occurrence of this severe bacterial infection

97. *See* EarlyOptions, *Abortion Methods*, *Abortion Pill*, "Frequently Asked Questions about the Abortion Pill," http://www.earlyabortionoptions.com/abortion-method/abortion-pill/ (accessed Jan. 29, 2013) (explaining that many women choose medication abortion to avoid enduring uncomfortable medical offices and can instead complete the abortion process in the comfort of their own homes). Many women have said that this method of abortion more closely resembles a miscarriage and therefore seems more "natural." *Id.*

98. *Id.* at "What Happens during a Medication Abortion?"; U.S. Food & Drug Administration, *supra* n. 80, at 14.

99. Ass'n of Reprod. Health Prof'ls, *What You Need to Know: Mifepristone Safety Overview* 1 (Apr. 2008) (available at http://www.arhp.org/uploaddocs/mifepristonefactsheet.pdf).

100. *Id.*

101. U.S. Food & Drug Administration, *Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011* (Apr. 30, 2011) (available at http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf).

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.* Sepsis is a severe bacterial pelvic infection that very rarely occurs following abortion (medical or surgical), childbirth (vaginally or via cesarean section), or other gynecologic or non-gynecologic conditions. Danco Laboratories, *Mifeprex (Mifepristone) Tablets, 200 mg, Infection and Sepsis* 10 (July 19, 2005) (available at http://www.earlyoptionpill.com/userfiles/file/Mifeprex%20Labeling%204-22-09_Final_doc.pdf). All but one of the eight cases of fatal sepsis reported vaginal use of misoprostol; the FDA protocol calls for only oral administration of the drug. U.S. Food & Drug Administration, *supra* n. 101.

and mifepristone use.[106] Mifepristone's fatality rate and risk of adverse effects is lower than that of many common medications, including several over-the-counter anti-inflammatory drugs and antihistamines.[107]

D. Potential and Actual Effect on Early Abortion Access

When the FDA approved mifepristone for use in the United States, pro-choice activists and women's healthcare professionals alike hoped it would bring women greatly increased access to safe, early abortion care.[108] For many reasons, medication abortion is much more amenable to being widely accessible than is surgical abortion. First, a wider range of physicians can prescribe mifepristone than are permitted to perform surgical abortions and it does not require a surgical center.[109] Further, medication-abortion patients are afforded increased privacy and have more control over the abortion care they receive.[110] Moreover, because pregnancies can be terminated at an earlier gestational age than is possible with a surgical abortion,[111] some of the risks associated with obtaining an abortion later in the pregnancy can be avoided by using medication-abortion procedures.

Although mifepristone has improved access to early abortion procedures, it has not had the profound effect that many hoped it would have. A 2005 study found that mifepristone use is heavily concentrated in urban areas, with healthcare providers in only ninety-three counties (about three percent of all United States

106. *Id.*

107. Ass'n of Reprod. Health Prof'ls, *supra* n. 99, at 1. Acetaminophen causes 150 deaths per year due to catastrophic liver failure. *Id.* Nonsteroidal anti-inflammatory drugs (NSAIDs, including ibuprofen and aspirin) cause 100,000 hospitalizations and 16,000 deaths per year. Timothy J. Wiegand, *Nonsteroidal Anti-Inflammatory Agent Toxicity, Overview, Epidemiology*, "Mortality/Morbidity," http://emedicine.medscape.com/article/816117-overview#a0199 (updated May 20, 2010). Five deaths result for every 100,000 prescriptions of Viagra. Ass'n of Reprod. Health Prof'ls, *supra* n. 99.

108. *See* Jordan & Shields, *supra* n. 63, at 219 (explaining that the FDA's approval of mifepristone for use in the United States brought with it a promise of "increased access to early, safe, noninvasive abortion and the potential mainstreaming of abortion services into the larger scope of routine comprehensive women's [healthcare]").

109. *Id.*

110. *Id.*

111. *Id.*

counties) providing mifepristone abortions.[112] Thus, the provision of both abortion services in general and medication abortions specifically are largely overlapping in urban areas. This redundant phenomenon is expected, to an extent, but also shows that mifepristone availability has not indiscriminately increased access to abortion services as it has the potential to do. While FDA approval of mifepristone has increased abortion options available at existing providers' offices, geographical barriers have prevented mifepristone from increasing rural women's access to abortion services.[113] Telemedicine technology provides a means by which abortion providers can remotely consult with patients and dispense mifepristone—uninhibited by existing geographical barriers.

In addition to being limited by geographical barriers, mifepristone has also been limited in its ability to increase access to abortion services by restrictive state legislation. Both existing abortion laws and newly proposed legislation pose obstacles to increasing abortion access. Existing "physician-only laws" also apply to medication abortions.[114] These laws make it illegal for anyone other than a physician to perform an abortion,[115] even if a state's law generally allows other medical professionals to prescribe medications. These laws present an unnecessary barrier to mifepristone's potential to increase access to abortion services; under existing state laws, more healthcare providers are qualified to prescribe medication than are licensed to perform surgery.[116] While legislation restricting the provision of surgical abortion services to licensed physicians may be well-placed, it is likely a step too far in the context of early medical abortions. Further,

112. *Id.* About ninety-five percent of both medical and surgical-abortion providers are located in metropolitan areas. *Id.*

113. *See generally id.* (describing how mifepristone access is generally concentrated around urban areas, leaving rural areas largely without the medication abortion option).

114. Ctr. for Reprod. Rights, *Laws and Regulations Affecting Medical Abortions*, http://reproductiverights.org/en/document/laws-and-regulations-affecting-medical-abortion (July 1, 2003). Some other healthcare providers, such as nurse practitioners, nurse midwives, and registered nurses, currently have the authority to prescribe and dispense prescription medication under existing state laws. *Id.*

115. *Id.*

116. *See id.* (providing that physician-only laws, when transposed to the medication-abortion context, are much more restrictive than they originally were for surgical abortions because several non-physician healthcare practitioners are able to prescribe medications under existing state laws).

women obtaining medication abortions must also comply with state legislation imposing mandatory waiting periods and counseling requirements.[117] Many states have also redefined their existing abortion laws to include medication abortions within the definition of the term "abortion" so as to make all existing abortion laws apply to that procedure.[118]

V. TELEMEDICINE: MODERN TECHNOLOGY PROVIDES GREATER ACCESS TO EXISTING MEDICAL SERVICES

"Telemedicine" is a broad concept that the American Telemedicine Association defines as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."[119] In layman's terms, it is the medical field's way of "keeping up with the Joneses"[120] by using and adapting modern technology for use in the healthcare context. Telemedicine allows healthcare professionals to use telecommunications technology to evaluate, diagnose, and treat patients in remote locations who may not otherwise have access to a healthcare provider.[121] Further, telemedicine allows patients in remote, rural areas access to medical expertise quickly and without having to travel extensive distances, as may have been the case otherwise.[122] Additionally, medical experts can utilize telemedicine technology to consult remotely with their peers and engage in continuing-education opportunities without ever having to leave their offices.[123]

117. *Id.*

118. *Id.*

119. Am. Telemedicine Ass'n, *What is Telemedicine?* http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333 (accessed Jan. 29, 2013).

120. American Culture Explained, *American Culture, Idioms, and Idiosyncrasies*, *Keeping up with the Joneses*, http://americaexplained.wordpress.com/2010/11/01/keeping-up-with-the-joneses/ (Nov. 1, 2010).

121. AMD Global Telemedicine, *Telemedicine Defined*, http://www.amdtelemedicine.com/telemedicine-resources/telemedicine-defined.html (accessed Jan. 29, 2013).

122. *Id.*

123. *Id.* NASA used its telemedicine technology to record and monitor certain physiological features of the astronauts from the spacecraft and from the astronauts' spacesuits. Teresa Smith Welsh, *Telemedicine*, "Brief History of Telemedicine," http://ocean.st.usm.edu/~w146169/teleweb/telemed.htm (updated June 20, 1999).

A. Development and Present-Day Use

NASA can be credited with the first use of what can be called "telemedicine" in the early 1960s.[124] Today, telemedicine technology is used in several ways, including specialist referral services,[125] patient consultations,[126] remote patient monitoring,[127] medical education,[128] and consumer medical and health information.[129] Particularly of interest for this Article is the use of telemedicine technology for patient consultations.[130] This phenomenon allows physicians to increase their reach into the rural community and bring medical care to people who may not have access to it otherwise.[131] For example, obstetricians in Tennessee recently began using telemedicine technology to monitor women with high-risk pregnancies in rural areas of the state.[132] A nurse practitioner and a sonographer evaluate the high-risk patient at her location and then transmit the ultrasounds and the patient's history to an obstetrician in Knoxville or Chattanooga.[133] By employing this remote method of patient consultation, the Tennessee obstetricians have found that women are much less likely

124. Welsh, *supra* n. 123.

125. Am. Telemedicine Ass'n, *supra* n. 119. Specialist referral services involve a general practitioner using a specialist's remote assistance in reaching a diagnosis. *Id.*

126. *Id.* Patient consultations involve using telecommunications to communicate medical data between a physician and a patient. *Id.* Physicians use a similar process to communicate to patients in the telemedicine-abortion setting. Women's L. Project Blog, *Planned Parenthood Telemedicine Program Update*, http://womenslawproject.wordpress.com/2011/01/19/planned-parenthood-telemedicine-program-update/ (Jan. 19, 2011, 2:57 p.m.).

127. Am. Telemedicine Ass'n, *supra* n. 119. Remote patient monitoring involves using devices that collect and send data to a monitoring station, allowing a healthcare professional to remotely monitor a patient's vital signs. *Id.*

128. *Id.* This involves a healthcare professional using telecommunications technology to complete continuing-education requirements or to acquire specialized training remotely. *Id.*

129. *Id.* Consumers use the Internet to obtain health information and support. *Id.*

130. *See* Women's L. Project Blog, *supra* n. 126 (describing how telemedicine technology is used for the provision of medication-abortion services).

131. Am. Telemedicine Ass'n, *What Is Telemedicine*, *What Are the Benefits of Telemedicine?* http://www.americantelemed.org/learn/what-is-telemedicine (accessed Jan. 29, 2013).

132. Cynthia Johnson & HealthLeaders Media, *Telemedicine Trialed for Obstetric Consultations*, http://www.healthleadersmedia.com/page-1/TEC-253489/Telemedicine-Trialed-for-Obstetric-Consultations (July 7, 2010).

133. *Id.* at "Have Specialist, Don't Travel."

to miss their appointments—something that would otherwise regularly happen due to travel time.[134]

In addition to being used in a variety of ways, telemedicine technology is also used across a wide variety of medical practices. Radiology is the practice area that makes the greatest use of telemedicine technology today by using this technology to view thousands of radiographs and other images every year.[135] Nearly fifty medical specialty areas and subspecialties have successfully integrated telemedicine into their practices.[136]

Because the term "telemedicine" encompasses such a broad range of procedures, and with new medical discoveries taking place every day, it seems that the future for telemedicine is boundless.

B. Use as a Remote Means of Providing Medication-Abortion Services

In July 2008, Planned Parenthood of the Heartland in Iowa began providing rural women with early medication-abortion services via telemedicine.[137] By using telemedicine technology, physicians are able to remotely counsel patients and dispense mifepristone at the patient's location.[138] Currently, Planned Parenthood of the Heartland is the only location offering telemedicine-abortion services;[139] but if its success is any indication, the practice is almost certainly going to expand to providers in more locations.

1. How It Works

To obtain a medication abortion via telemedicine, women (currently only in Iowa) must first visit their local Planned

134. *Id.*

135. Am. Telemedicine Ass'n, *supra* n. 119. Other major specialty areas that significantly benefit from the use of telemedicine technology include dermatology, ophthalmology, mental health services, cardiology, and pathology. *Id.*

136. *Id.*

137. Planned Parenthood of the Heartland, *Who We Are*, *Our History*, "2008," http://www.plannedparenthood.org/heartland/history-29880.htm (accessed Jan. 29, 2013).

138. Women's L. Project Blog, *supra* n. 126.

139. *Id.* Currently, sixteen clinics associated with Planned Parenthood of the Heartland provide telemedicine-abortion services. *Id.*

Parenthood clinic.[140] Once there, a woman will undergo various tests and counseling procedures before speaking to a physician, regardless of whether she will be meeting with her physician remotely or in person.[141] A licensed technician always performs an ultrasound to determine gestational age.[142] The patient then consults with a physician via teleconference and is asked the same questions and provided with the same information as those women who choose to have a face-to-face meeting with their physicians.[143] If the physician determines that the patient is a candidate for medical abortion, the physician can then remotely provide the patient with the mifepristone and misoprostol, watching as the patient takes the former and providing her with instructions on when and how to take the latter.[144] The only difference between this procedure and the standard medication-abortion routine is the fact that the woman consults with her physician via webcam instead of in person.[145]

2. Reception

Although it has only been used in a concentrated area for a relatively short period of time, the telemedicine-abortion method has generally been well received by patients and healthcare prac-

140. Linda Carroll, *Abortions via 'Telemedicine' Are Safe, Effective, Iowa Study Finds*, http://www.msnbc.msn.com/id/43828311/ns/health-womens-health/t/abortions-telemedicine-are-safe-effective-iowa-study-finds/ (July 20, 2011).

141. *Id.*

142. *Id.*; Amy Norton, *Abortion Pill via Telemedicine Seen Safe, Effective*, http://www.reuters.com/article/2011/07/26/us-abortion-pill-idUSTRE76P78E20110726 (July 26, 2011).

143. Norton, *supra* n. 142.

144. *Id.* The physician is able to remotely dispense the medication by pushing a button or turning a key at his or her location, which then opens a "lock-box" at the patient's location revealing a single dose of the medication. *Id.*; Ibis Reprod. Health, *Medication Abortion, Brief 2: Strategies for Improving Service Delivery and Access to Services* (Nov. 2010) (available at http://www.ibisreproductivehealth.org/downloads/IbisMedAbBrief2FINAL08Nov10.pdf).

145. The Gazette, *Telemed Abortions Are Safe, Iowa Study Finds*, http://thegazette.com/tag/telemedicine-abortion-method/ (accessed Jan. 29, 2013). Regardless of the consultation method, a woman will receive an ultrasound by a trained technician, receive information about medication abortion, and undergo standard informed-consent requirements for abortion. *Id.* In both an in-person medication abortion and a telemedicine abortion, the physician will determine if the woman is a candidate for medication abortion. *Id.* If the physician determines that the woman is a candidate for mifepristone treatment, then the physician will give the woman the mifepristone and the misoprostol, watch her take the former, and provide her with instructions for how to take the medication. *Id.*

titioners alike.[146] By 2005, medication abortions via mifepristone accounted for about one-fifth of all abortions.[147] As described above, there are many reasons that women may prefer medication abortions over the surgical alternative.[148] By providing medication abortions via telemedicine, Planned Parenthood of the Heartland is merely bringing this option to rural women as well as those living in more urban locations.

A recent study in the journal *Obstetrics and Gynecology* examined the effectiveness and acceptability of using telemedicine for the provision of early medication abortion.[149] The study followed the experiences of 449 women at Iowa Planned Parenthood clinics who chose to have a medication abortion.[150] Of those women, 223 of them opted to consult with a physician via teleconference, while the remaining 226 women chose to see a physician in person.[151] Ninety-nine percent (220 of 223) of the telemedicine patients had a successful abortion, compared to ninety-seven percent (219 of 226) of the patients who saw a physician in person.[152] Further, the same small percentage of women (just over one percent) in both groups experienced serious side effects.[153] When asked about the procedure, ninety-one percent of the total number of women studied reported being "very satisfied" with the procedure,[154] but those who received care via telemedicine were more likely to recommend the procedure to others.[155]

146. NARAL Pro-Choice Am. Found., *supra* n. 71.
147. *Id.*
148. Jordan & Shields, *supra* n. 63, at 219.
149. Abortion Rev., *USA: Effectiveness and Acceptability of Medical Abortion Provided through Telemedicine*, http://www.abortionreview.org/index.php/site/article/1032 (Sept. 30, 2011).
150. Norton, *supra* n. 142.
151. *Id.*
152. *Id.*
153. *Id.*
154. *Id.*
155. Abortion Rev., *supra* n. 149.

VI. GOVERNMENT RESPONSE

A. In Iowa, the Host State

In October 2010, Operation Rescue[156] led a protest against the telemedicine abortion procedure, claiming that it violated an existing Iowa law requiring all abortions to be performed by a physician and demanding that the Iowa Board of Medicine sanction Dr. Susan Haskell.[157] After investigating the matter, the Board sent a letter to Operation Rescue's Cheryl Sullenger indicating it would be closing the file without taking disciplinary action against Dr. Haskell.[158] As is customary, the Board did not provide reasoning for its decision.[159]

B. Preemptive State Restrictions

Out of anticipation (and perhaps fear) that the telemedicine-abortion procedure may soon be coming to their states, several state legislatures have enacted, or are attempting to enact, preemptive restrictions on the procedure.[160] Nebraska has amended its law to require physical presence of the physician performing the abortion.[161] Nebraska's approach is largely repre-

156. Operation Rescue describes itself as "one of the leading pro-life Christian activist organizations in the nation." Operation Rescue, *Who We Are*, http://www.operationrescue.org/about-us/who-we-are/ (accessed Jan. 29, 2013).

157. Ltr. from Mark Bowden, Exec. Dir., Iowa Bd. of Med., to Cheryl Sullenger, Senior Policy Advisor, Operation Rescue, *Notice of Findings Regarding Complaint Against Dr. Susan C. Haskell* (Jan. 11, 2011) (available at http://www.desmoinesregister.com/section/documentcloud&dckeyword=26167-jan-11-letter-from-iowa-board-of-medicine-to-operation-rescue-activist-cheryl-sullenger). The argument that the telemedicine-abortion procedure is unsafe because women do not consult with their doctor in person is one that is echoed by others opposing this procedure, including Representative Steve King of Iowa. *See* Consideration of H.R. Amend. 436, 112th Cong. (June 15, 2011) (amendment to H.R. 2112) (available at http://thomas.loc.gov/home/thomas.php; *select* Try the Advanced Search, *select* Select Congress: 112, *select* Bill Number, *search* "h.amdt.463," *select* consideration: CR H4268-4269, *select* Printer Friendly Display, *scroll down to* Time 23:40 (June 15, 2011). Representative King expressed his concern to the House of Representatives that the telemedicine-abortion procedure allows "circumventing the requirement in Iowa that [patients] be seen by a doctor." *Id.*

158. Ltr. from Mark Bowden, *supra* n. 157.

159. Nat'l P'ship for Women & Fams., *The Daily Report*, *Iowa Medical Board Rejects Challenge to Telemedicine Abortion System*, http://www.nationalpartnership.org/site/News2?abbr=daily2_&page=NewsArticle&id=27404 (Jan. 14, 2011).

160. Guttmacher Inst., *supra* n. 76, at 1.

161. Neb. Rev. St. § 28-335 (WL current through 2011 First Reg. Sess.).

sentative of that taken by other states seeking to preemptively prohibit telemedicine abortions. Instead of an outright ban on using telemedicine for the provision of medication-abortion services, most state legislatures choose to effectively ban the procedure.[162] Similar to Nebraska, a Tennessee law that goes into effect in 2013 requires physical presence of the physician for all abortions.[163] Along those same lines, North Dakota[164] and Kansas[165] require mifepristone to be administered in the physical presence of the physician prescribing the drug.[166] South Dakota law requires the acting physician to "physically and personally meet[ ]" with the patient before a medication or surgical abortion is performed.[167] Finally, Oklahoma requires mifepristone to be administered in the same room and in the physical presence of the prescribing physician.[168]

While most state legislatures seeking to preemptively prohibit the use of telemedicine for the provision of medical abortions take the approach of effectively banning the procedure, Arizona goes one step further. In Arizona, the use of telemedicine for abortion is expressly prohibited.[169] This ban is in place even though the Arizona legislature recognizes that "[t]elemedicine makes it possible to deliver health care to distant or remote locations using modern technology."[170]

Currently, seven states have enacted laws restricting the provision of medication abortions via telemedicine,[171] while other

162. Guttmacher Inst., *Monthly State Update: Major Developments in 2012*, https://www.guttmacher.org/statecenter/updates/index.html (updated Aug. 1, 2012).

163. Tenn. Code Ann. § 63-6-241 (WL current through 2011 First Reg. Sess.) (effective Jan. 1, 2013).

164. N.D. Cent. Code § 14-02.1-03.5(5) (WL current through 2011 Reg. Sess.). This law is currently enjoined by court order and is therefore not in effect, pending the litigation's outcome. Guttmacher Inst., *supra* n. 76, at 2.

165. Kan. Stat. Ann. § 65-4a10 (WL current through 2011 Reg. Sess.).

166. *Id.*; N.D. Cent. Code § 14-02.1-03.5(5).

167. S.D. Codified Laws § 34-23A-56 (2011).

168. Okla. Stat. Ann. tit. 63, § 1-729a (WL current through 2011 First Reg. Sess.). This law is not in effect as it is currently enjoined by court order and not enforced, pending the litigation's outcome. Guttmacher Inst., *supra* n. 76, at 2.

169. Ariz. Rev. Stat. Ann. § 36-3604 (WL current through 2011 First Reg. Sess. & Third Spec. Sess.).

170. Ariz. Sen. Fact Sheet for H. 2416, 1st Reg. Sess. (Mar. 30, 2011) (providing background information for A.R.S.).

171. Rachel Benson Gold & Elizabeth Nash, *Troubling Trend: More States Hostile to Abortion Rights as Middle Ground Shrinks*, 15 Guttmacher Policy Rev. (Winter 2012) (available at http://www.guttmacher.org/pubs/gpr/15/1/gpr150114.html).

states have also proposed legislation to this effect.[172] The responses of state legislatures using telemedicine technology in the abortion context strongly indicate that this procedure is not going away. Proposed legislation in Michigan would require a physician prescribing a medication abortion to first personally conduct a physical examination of the patient.[173] Wisconsin has also proposed legislation to this effect.[174] This law would successfully make performing telemedicine abortions illegal because the physical exam is usually performed by a licensed technician at the patient's physical location.[175] Thus, it is impossible for a physician providing a medication abortion via telemedicine to personally conduct a physical examination of the patient via remote telecommunication. Further, if that requirement were not enough, the law prohibits a physician from using "other means including, but not limited to, an [I]nternet web camera, to diagnose and prescribe a medical abortion."[176]

C. Proposed Federal Restrictions

Legislation has also been submitted at the federal level that would prohibit using federal appropriations for mifepristone. House Amendment 463 to House Resolution 2112,[177] sponsored by Representative Steve King (R-Iowa), would prohibit the use of federal funds under this appropriation for mifepristone, for any purpose.[178] In support of this amendment, Representative King argued that telemedicine abortions sidestep the requirement in

172. *Id.*

173. Mich. H. 4688, 96th Legis., Reg. Sess. (May 31, 2011) (available at http://www.legislature.mi.gov/documents/2011-2012/billintroduced/House/htm/2011-HIB-4688.htm).

174. Wis. Sen. 306, 2011–2012 Sess. § 10 (Nov. 25, 2011). This law would also require a physician to consult with the patient to confirm that the request for an abortion is voluntary. *Id.* at § 2.

175. *See* Carroll, *supra* n. 142 and accompanying text (explaining that a licensed technician always performs an ultrasound prior to receiving an abortion to determine the fetus' gestational age).

176. Mich. H. 4688, 96th Legis., Reg. Sess. (May 31, 2011) (available at http://www.legislature.mi.gov/documents/2011-2012/billintroduced/House/htm/2011-HIB-4688.htm).

177. Lib. Cong., *Bill Summary & Status: 112th Congress (2011–2012): H.AMDT.463*, http://thomas.loc.gov/home/thomas.php; *select* Try the Advanced Search, *select* Select Congress: 112, *select* Bill Number, *search* "h.amdt.463" (accessed Jan. 29, 2013).

178. *Id.* This bill passed through the House of Representatives in June 2011. *Id.*

Iowa that women obtaining an abortion be seen by a doctor.[179] Specifically in support of this amendment to the appropriations bill, Representative King maintained that none of the $15 million line item appropriated for telemedicine should be used for mifepristone, for any purpose.[180] Representative Sam Farr rose in opposition to this amendment and stated that he did not believe the use of telemedicine was "illegal[ ] or ill-wise."[181] Representative Farr emphasized the fact that mifepristone is an FDA-approved drug that has been used effectively in all fifty states since 2000 when it was approved, and therefore that any controversy surrounding mifepristone's use was settled years ago.[182]

A proposed amendment to Senate Bill 1572,[183] sponsored by Senator Jim DeMint (R-S.C.), would effectively prohibit physicians and patients from discussing abortion via telemedicine.[184] According to Nancy Keenan, President of NARAL Pro-Choice America, Senator DeMint's amendment would require a woman and her physician to enter a separate communication if the topic of abortion came up during an unrelated teleconference.[185]

As the success of telemedicine technology for the provision of early medication-abortion services grows and the procedure continues to gain notoriety, the Author predicts that legislatures will increasingly enact restrictions aimed at banning this procedure, whether it be at the state or federal level.

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179. *Id.*; *select* consideration: CR H4268-4269, *select* Printer Friendly Display, *scroll down to* Time 23:40 (June 15, 2011).

180. *Id.* Representative King argued that even those who disagree over the abortion issue should see that taxpayer dollars should not be used to fund telemedicine abortions. *Id.*

181. *Id.*

182. *Id.* Representative Farr stated that there was "no reason for this amendment other than to stir up the controversy over the reproductive rights of women." *Id.*

183. Sen. Amend. 1572, 112th Cong. (Sept. 15, 2011) (available at http://www.gpo.gov/fdsys/pkg/BILLS-112s1572pcs/pdf/BILLS-112s1572pcs.pdf). This Amendment is also referred to as the "Commerce, Justice, Science, and Related Agencies Appropriations Act, 2012." *Id.* at 126.

184. Ted Miller, *Sen. DeMint Injects Anti-Choice Politics into Appropriations Bill*, http://www.prochoiceamerica.org/media/press-releases/2011/pr10182011_demint.html (Oct. 18, 2011). Measures such as these could give rise to First Amendment concerns even though setting standards for communication between physicians and patients is within state authority to regulate the medical field. Gregory D. Curfman et al., *Physicians and the First Amendment*, 359 N. Engl. J. Med. 2484, 2484–2485 (2008). The Supreme Court has ruled that "the right of freedom of thought protected by the First Amendment . . . includes both the right to speak freely and the right to refrain from speaking at all." *Wooley v. Maynard*, 430 U.S. 705, 714 (1977).

185. Miller, *supra* n. 184.

VII. LEGAL ANALYSIS: ABORTION-SPECIFIC TELEMEDICINE BANS FAIL THE UNDUE BURDEN TEST

"Progress [d]oes [n]ot [a]lways [c]ome [e]asy."[186] Thus, even though advancements in medical technology aim to bring a renewed hope toward the achievement of universal access to safe, early abortion services, opposition and restrictive legislation stifle the mission. Although legislation has been aimed at quashing the use of telemedicine in the abortion context,[187] these restrictions do not stand on solid ground. Selective, abortion-specific restrictions on telemedicine technology should be viewed as unconstitutional under the Fourteenth Amendment of the United States Constitution.[188]

A. Overview of the Analysis

As discussed above,[189] the undue burden test requires a specific inquiry into the facts of the case at hand.[190] The Court begins its two-fold inquiry by first determining whether the state restriction at issue is reasonably related to a legitimate state interest. Such interests that qualify as "legitimate" generally include a government preference for childbirth over abortion,[191] a desire for the woman's decision to be an informed one,[192] or a concern for maternal health.[193]

Once it has been determined that the legislation at issue is reasonably related to a legitimate state interest, one must consider the specific group of people that the legislation effects and begin the "substantial obstacle" inquiry from there.[194] Then, one

186. Jimmy Carter, *Always a Reckoning and Other Poems: Progress Does Not Always Come Easy* 69 (Random H. 1995).

187. Guttmacher Inst., *State Policy Trends: Abortion and Contraception in the Crosshairs* 1, http://www.guttmacher.org/media/inthenews/2012/04/13/index.html (Apr. 13, 2012).

188. U.S. Const. amend. XIV.

189. *Supra* n. 29 and accompanying text (explaining the specifics of applying *Casey*'s undue burden test).

190. *Casey*, 505 U.S. at 894–895.

191. *Id.* at 886.

192. *Id.* at 885.

193. *Roe*, 410 U.S. at 163.

194. *Casey*, 505 U.S. at 894.

must consider whether, for that specific group of people, the legislation would serve as a substantial obstacle.[195] This can be answered in the affirmative when the legislation would be outcome-determinative as to whether the woman will seek an abortion for a significant number of the targeted group.[196] Examination of both the purpose and the effect of the specific legislation being considered is necessary.[197] Even if the legislature did not have the express purpose of placing a substantial obstacle in the path of a woman's choice to have an abortion, if the effect of the legislation is to do so, then that is sufficient, and the law is still unconstitutional.[198]

As the Court did in *Casey*, one must begin the undue burden analysis of abortion-specific restrictions on telemedicine by first determining whether these restrictions are reasonably related to a legitimate state interest.[199]

B. Abortion-Specific Restrictions on Telemedicine Are Not Reasonably Related to a Legitimate State Interest

Unlike mandatory waiting periods and informed consent laws, abortion-specific restrictions on telemedicine do not address a legitimate state interest and therefore cannot withstand constitutional scrutiny under the undue burden test.[200]

Restrictions on telemedicine abortion cannot survive constitutional scrutiny pursuant to an advanced state interest in maternal safety. As discussed in detail above,[201] mifepristone is a safe method of early abortion.[202] It has been FDA approved since 2000[203] and has been safely used for over twenty years.[204] In fact, studies have shown that early medical abortion via mifepristone

195. *Id.* at 895.
196. *Id.*
197. *Id.* at 877.
198. *Id.*
199. *Id.* at 878; *Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999).
200. *Supra* nn. 190–192 and accompanying text (noting that restrictions must first address a legitimate state interest to withstand the undue burden test).
201. *Supra* pt. IV (detailing the history and safety of mifepristone).
202. *Supra* pt. IV(C) (providing safety information for mifepristone, including the number of cases of adverse reactions that have been reported to the FDA).
203. *Supra* n. 85 and accompanying text (discussing the FDA's approval of the use of mifepristone in conjunction with misoprostol to end an early pregnancy).
204. *Supra* n. 99 and accompanying text (explaining that mifepristone is approved for the provision of early medication abortions in thirty-eight countries).

is one of the safest procedures in any medical practice today.[205] Mifepristone is also widely used, both in the United States and internationally.[206]

Moreover, telemedicine abortions are merely a means of prescribing mifepristone.[207] The only difference between the in-person medication-abortion method and the telemedicine-abortion method is the physician's physical presence.[208] Otherwise, women in both settings undergo the same procedure and receive the same quality of care.[209] The medication-abortion method is no less safe when provided via telemedicine. Regardless of whether a woman consults with her physician in person or via webcam, she is surrounded by a trained staff of medical experts during the consultation and, before leaving, is provided with emergency contact information and instructions.[210] States have not gone so far as to place an outright ban on the use of mifepristone for the provision of abortion.[211] This is most likely because a ban on mifepristone would surely be held unconstitutional, largely due to mifepristone's longstanding history of use and safety,[212] in addition to its federal approval and oversight.[213]

Because telemedicine is merely a means of prescribing mifepristone remotely, this abortion procedure is available only for early pregnancies.[214] The Court in *Roe* and *Casey* supported the notion that the state has a strong interest in the mother's health

205. *See* Grimes et al., *supra* n. 59, at 1908 (explaining that legal abortion is one of "the safest procedures in contemporary medical practice").

206. *Supra* n. 99 and accompanying text.

207. *See supra* pt. V(B)(1) (describing how telemedicine works in the abortion context as a means of remotely prescribing mifepristone to rural patients).

208. This distinction between the two procedures, namely, whether the physician is physically present to dispense the medication, is what those opposing the telemedicine-abortion method claim makes it illegal. *Supra* n. 157.

209. *See* The Gazette, *supra* n. 145 (providing that women receiving a medication abortion via telemedicine similarly meet with a Planned Parenthood staff member and receive an ultrasound before consulting with their physician).

210. *See id.* (explaining that regardless of the physician-consultation method, women receive information about medication abortion, undergo standard informed consent, and receive an ultrasound from a trained physician).

211. *See* Guttmacher Inst., *supra* n. 76, at 1–2 (stating that several states have enacted restrictions targeting mifepristone since its FDA approval in 2000, but demonstrating that no state has enacted an outright ban on the procedure).

212. Danco Laboratories, *supra* n. 82.

213. U.S. Food & Drug Administration, *supra* n. 85.

214. *Supra* pt. V(B) (explaining the mechanism of using telemedicine for the provision of mifepristone).

during the early stages of her pregnancy.[215] Because the safety risks associated with an abortion increase exponentially with gestational age, the earlier in a woman seeking an abortion obtains one, the safer it is for her.[216] Thus, it does not follow logically that a state, acting in accordance with its interest in maternal health, would restrict the telemedicine procedure given that it is a means of providing one of the safest abortion procedures available to a woman. Absent a legitimate interest to be advanced by specifically placing restrictions on telemedicine abortion, it seems that the more likely purpose behind these restrictions is to impose a substantial obstacle on a woman's right to choose.

Finally, abortion-specific restrictions on telemedicine cannot survive constitutional scrutiny under a claimed interest in the state's preference for childbirth over abortion. Although the Court has held that such an interest is indeed a valid one,[217] it has noted that such an interest can only prevail so long as the state does not deprive a woman from the ability to make the ultimate decision of whether to terminate her pregnancy.[218] Parts C and D will explain that abortion-specific restrictions on telemedicine effectively prevent rural women from making that ultimate decision.

C. Group Targeted by Abortion-Specific Restrictions on Telemedicine

One must begin the substantial-obstacle analysis by identifying the group that the legislation targets.[219] Because the appropriate group for analysis is isolated to those people who feel the law's effects,[220] women who have regular access to abortion services are excluded from the specific target group. Restrictive telemedicine-abortion laws present an issue for women who did not have access to abortion services until the use of telemedicine

215. *Casey*, 505 U.S. at 840; *Roe*, 410 U.S. at 163.

216. FamilyDoctor.org, *supra* n. 67.

217. *Casey*, 505 U.S. at 872–873.

218. *See id.* (describing that the woman has the right to decide whether to terminate her pregnancy, but the state may take steps to make sure that her decision is "thoughtful and informed").

219. *Id.* at 894.

220. *Id.*

technology made early medication abortion a realistic option for them.[221]

Assuming that a court would conclude that abortion-specific restrictions on telemedicine were reasonably related to a legitimate state interest, the legislation would still have to survive a substantial obstacle inquiry to survive constitutional scrutiny. This inquiry begins with a specific determination of the group of women targeted by the legislation.[222] To specifically determine the group of women affected by abortion-specific telemedicine bans, it is necessary to consider the statistics available for accessibility of abortion. As explained in Part III above, eighty-seven percent of United States counties do not have an abortion-services provider.[223] In the most general sense, the group of women targeted by the legislation would be the thirty-five percent of women who live in those counties lacking an abortion provider.[224]

Because the Court intended the definition of the target group to be *specific*,[225] an accurately defined group is likely even more narrow. The Court in *Casey* stressed the specificity to be attained when it defined Pennsylvania's spousal notification law's target group as married women seeking an abortion who do not want to tell their spouse about their intention.[226] In that case, the targeted group of women amounted to only one percent of women seeking an abortion.[227] Because this was the group of women for whom the spousal notification law would be an issue, the Court made it clear that the undue burden inquiry should be made specifically from the perspective of these women.[228]

Perhaps a better indication of the women affected by restrictions on telemedicine abortion is the distance that they would

221. *See* Women's L. Project Blog, *supra* n. 126 (providing that as of January 2011, over two thousand women have utilized the available telemedicine abortion technology since it became available in 2008—a number that is representative of the rural need for such services). While some of the women have used the telemedicine abortion method merely out of preference, the Court is unlikely to consider this "preference" group as part of the group of women specifically targeted by the legislation; the Court has stated that "[w]hen standard medical options are available, mere convenience does not suffice to displace them." *Gonzales*, 550 U.S. at 166.

222. *Casey*, 505 U.S. at 894–895.

223. Jones & Kooistra, *supra* n. 49, at 46.

224. *Supra* n. 50 and accompanying text.

225. *Casey*, 505 U.S. at 894.

226. *Id.* at 894–895; *supra* n. 29.

227. *Casey*, 505 U.S. at 894; *supra* n. 30 and accompanying text.

228. *Casey*, 505 U.S. at 894; *supra* n. 31.

have to otherwise travel to reach an abortion provider. The Court in *Casey* upheld Pennsylvania's mandatory waiting period as constitutional even after acknowledging that it would have the effect of imposing an incredible inconvenience on some women who would have to travel long distances to reach an abortion provider.[229] The avenue for future challenges regarding the effects of a restrictive-abortion law, however, should not be considered foreclosed.[230]

A recent survey by the Abortion Access Project[231] of women's healthcare providers in five of its seven initiative states[232] helps to reveal healthcare providers' mindsets regarding the accessibility of abortion services for rural women. To this effect, the survey asked providers for their opinion as to how many miles a woman would have to travel to access an abortion provider.[233] As reported, only about one-fourth of the providers surveyed perceived accessible abortion care as being within fifty miles.[234] Further, about half of the providers surveyed in the five states reported that women would have to travel over a hundred miles to reach the nearest provider of abortion services,[235] while one-fourth of the Colorado providers and half of the Wyoming providers perceived that women would have to travel more than one

229. *Casey*, 505 U.S. at 886–887.

230. *See Karlin*, 188 F.3d at 484 (holding that the plaintiffs were not precluded from bringing a facial challenge to a law imposing a mandatory waiting period that was nearly identical to the law upheld as constitutional in *Casey*).

231. Abortion Access Project, *Abortion Access and Opportunity in Rural Communities: A Survey of Clinicians* 3 (Aug. 2009) (available at http://www.abortionaccess.org/images/stories/Rural20Survey20Report20200920Final1.pdf) [hereinafter Abortion Access Project Survey]. The Abortion Access Project's (AAP) mission is to make safe abortion care accessible for all women in the United States. Abortion Access Project, *About Us*, *Mission*, http://www.abortionaccess.org/about-us/mission (accessed Jan. 29, 2013). To carry out this goal, the AAP collects data on the accessibility of abortion services and educates local communities and practitioners for the purpose of catalyzing a positive change in abortion accessibility on the local level. *Id.*

232. After noticing the disparity in abortion service accessibility between rural communities and metropolitan communities, the AAP launched the Rural Abortion Provider Initiative in 2007, which is currently the only national project with the specific goal of stimulating the development of rural abortion providers. Abortion Access Project Survey, *supra* n. 231, at 3. To effectuate this goal, the project operates in seven initiative states: Colorado, Iowa, Maine, Washington, West Virginia, Wisconsin, and Wyoming. *Id.*

233. *Id.* at 11.

234. *Id.* This is in stark contrast to the clinicians' perceptions about the accessibility of general obstetrical care, which seventy-six percent of providers perceived as being accessible within fewer than fifty miles. *Id.*

235. *Id.*

hundred and fifty miles to access abortion care.[236] With this being representative of the perceived accessibility of abortion services in states that, as of yet, do not have abortion-specific restrictions on telemedicine,[237] one can speculate that clinicians in those states that do have these restrictions in place view abortion accessibility as being in an even more dire state.

The income level of rural women is another factor to consider, along with the distance that women must travel in order to access an abortion provider, when determining the specific group of women targeted by abortion-specific restrictions on telemedicine. Rural populations are generally underserved by primary healthcare providers and have limited access to healthcare services.[238] Moreover, and not surprisingly, rural low-income women are more likely to fare much worse regarding quality of health and healthcare than urban, middle-class women.[239]

The group of women targeted by abortion-specific restrictions on telemedicine has two common characteristics: rural and low-income. It is those women who are located a significant distance away from any abortion-services provider and are unable to afford the costs of traveling and missing work (and everything that entails) who feel the harmful effects of telemedicine-abortion bans.[240]

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236. *Id.*

237. *See supra* pt. VI(B) (explaining that Nebraska, Arizona, North Dakota, Tennessee, Kansas, and Oklahoma currently have legislation imposing abortion-specific restrictions on telemedicine, while Michigan and Wisconsin have proposed legislation to the same effect).

238. Unite for Sight, *Global Health University*, *Urban Versus Rural Health*, "Rural Context," http://www.uniteforsight.org/global-health-university/urban-rural-health (accessed Jan. 29, 2013).

239. Leigh Ann Simmons, Elizabeth M. Dolan & Bonnie Braun, *The State of Rural Women's Economic and Health Status: KY, MD, NH*, 47, 48 (2006 Conf., E. Fam. Econ. & Resource Mgt. Ass'n) (available at http://mrupured.myweb.uga.edu/conf/6.pdf). This study collected state and county data in Kentucky, Maryland, and New Hampshire, paying particular attention to health and economic indicators. *Id.* at 47. These three states were selected because they ranked overall as one of the worst, middle, and best states, respectively, by the Institute for Women's Policy Research's (IWPR) economic and health status reports. *Id.* The IWPR conducts its reports by using data from the United States Census Bureau, the United States Department of Health and Human Services, and the United States Department of Labor, Bureau of Labor Statistics. *Id.*

240. *See supra* pt. III (discussing the overwhelming lack of abortion-services providers in rural areas).

D. Abortion-Specific Restrictions on Telemedicine Impose a Substantial Obstacle in a Significant Number of Cases

One must then determine whether, for the rural women affected by restrictions on the use of telemedicine concerning early medication abortions, such legislation is outcome-determinative in a significant number of cases as to whether they will seek an abortion.[241] This analysis calls for speculation because telemedicine restrictions are so new—with some not even on the books yet. Determining the extent to which the legislation affects rural women's ability to consider early medication abortion an option is a bit difficult. This can still be done, however, by analogizing to the route taken in *Casey* when determining whether Pennsylvania's spousal notification law presented an undue burden. In *Casey*, the Court examined the statistics and circumstances surrounding the women in the targeted group to determine the law's true effect.[242]

Considering the statistics and circumstances surrounding rural women, the extent to which abortion-specific restrictions on telemedicine effectively make early medication abortion unattainable to them are evident. Rural women are often lower-income-earning women.[243] This reality, combined with the inevitable burdens imposed by geographical barriers and the dearth of healthcare providers in rural areas, exposes the true detrimental effect that telemedicine-abortion restrictions have on rural women.

The *Casey* Court held that a woman seeking a pre-viability abortion is not completely insulated in making that decision and that the state is permitted to enact mechanisms by which it can express "profound respect for the life of the unborn" so long as

241. *See Karlin*, 188 F.3d at 482 (explaining that the "challenged state regulation must have a strong likelihood of preventing women from obtaining abortions rather than merely making abortions more difficult to obtain") (emphasis removed).

242. *Casey*, 505 U.S. at 894–895. The Court considered the burdening effect that Pennsylvania's spousal notification law would have on women who do not want to tell their spouse that they are seeking an abortion because of, for example, domestic abuse. *Id.* at 893.

243. *See* Rural Poverty Portal, *Region and Country*, *Americas*, *Rural Poverty in Latin America*, "Northern America," http://www.ruralpovertyportal.org/region/home/tags/americas (accessed Feb. 5, 2013) (noting that thirty-seven percent of rural families headed by a woman lived under the poverty line in 2002).

those mechanisms do not amount to a substantial obstacle.[244] But abortion-specific restrictions on telemedicine do not merely provide a "structural mechanism" by which the state advances its preference for childbirth over abortion.[245] These restrictions do not fall into the same category as informed consent laws,[246] mandatory waiting periods,[247] or counseling requirements.[248] Abortion restrictions in that category serve as a "structural mechanism" by which the state can further its interest and ensure that women are making an informed decision. An outright ban on telemedicine abortion, however, cannot be justified under the heading of a legitimate state interest that women make an informed decision of whether to obtain an abortion.[249]

Telemedicine-abortion bans differ from the "structural mechanism" category of laws in both their purpose and their effect. The purpose of "structural mechanism" laws is to do just that: provide a "structural mechanism" by which the state can express its profound respect for the unborn by ensuring that a woman's decision to obtain an abortion is informed.[250] In contrast, the purpose of telemedicine-abortion restrictions is to completely ban an effective means of providing a safe, federally approved method of abor-

244. *Casey*, 505 U.S. at 877. The Court further held that the State may impose these "structural mechanisms" even when they do not advance a health interest. *Id.* at 886.

245. *See id.* (explaining that states are able to "enact persuasive measures which favor childbirth over abortion").

246. Informed consent laws embody three interrelated elements: (1) that patients have the capacity to make decisions regarding their care; (2) that patients voluntarily participate in making these decisions about their care; and (3) that patients are provided with adequate and appropriate information such that they can make an informed decision regarding their care. Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 Guttmacher Policy Rev. 6, 7 (Nov. 4 2007).

247. Currently, twenty-six states require women to wait at least twenty-four hours between receiving abortion counseling and undergoing the abortion procedure. Guttmacher Inst., *supra* n. 73.

248. Thirty-five states currently mandate that women receive pre-abortion counseling. *Id.* The Court in *Casey* held that because the state has an interest in the potential life of the unborn, the state may take steps to ensure that the woman's decision to undergo an abortion is informed. 505 U.S. at 882.

249. Although the state may have a legitimate interest in expressing profound respect for the unborn, this interest is insufficient to render an outright ban on telemedicine abortion services constitutional when such a ban effectively deprives women of the ultimate decision to obtain an abortion. *Id.* at 872–873; *supra* nn. 217–218 and accompanying text.

250. *Casey*, 505 U.S. at 877.

tion—early medication abortion via mifepristone.[251] "Structural mechanism" laws have the effect of slowing and complicating the abortion process, but do not ban the procedure, and therefore do not rise to the level of imposing a substantial obstacle on a woman's right to choose abortion.[252] Abortion-specific restrictions on telemedicine, however, have the effect of foreclosing a recently opened avenue of access to abortion services for rural women.[253] Prior to the advent of telemedicine abortion, geographical and income barriers prevented rural women from accessing early medication-abortion services.[254] Telemedicine technology has provided a mechanism by which women can now overcome such barriers. Legislation that re-closes this avenue of abortion access cannot withstand constitutional scrutiny where it operates as a substantial obstacle on the right to choose abortion for a significant number of women targeted by the legislation, as it does here.

VIII. CONCLUSION

With advances in medical technology come increases in the safety, affordability, and accessibility of modern healthcare. Women's healthcare services, including abortion, are no exception to this phenomenon. Over the last several years, the medical community has made great strides in the use of telemedicine to address accessibility issues and bring healthcare services to those who would otherwise not have them.[255] Although general advances in telemedicine have received widespread acclaim,[256] the use of this technology in the abortion context has not been similarly embraced.[257] Several states have enacted legislation prohib-

251. *See supra* pt. VI(B) (discussing the states' enacted or proposed preemptive restrictions on telemedicine abortion).

252. *Casey*, 505 U.S. at 877–878.

253. *See* Women's L. Project Blog, *supra* n. 130 (noting that over two thousand women have used telemedicine-abortion technology since its availability in 2008).

254. *See supra* n. 51 and accompanying text (noting that rural women confront the most difficulty in accessing abortion services).

255. *See supra* n. 122 and accompanying text (explaining how telemedicine allows physicians to remotely treat patients in rural areas who may not otherwise have access to healthcare services).

256. *See supra* nn. 135–136 and accompanying text (describing the wide number of medical practice areas in which telemedicine technology has been successfully implemented).

257. *See supra* pt. VI(B) (describing the states that have enacted or proposed preemptive restrictions on telemedicine abortion).

iting the use of telemedicine for the provision of medication abortions.[258]

The Author proposes that this legislation exceeds the state's regulatory authority by imposing an undue burden on a woman's right to choose to have an abortion. Abortion-specific restrictions on telemedicine are not reasonably related to a legitimate state interest. Telemedicine technology is widely used and endorsed in other areas of medicine.[259] Further, telemedicine abortions involve a physician prescribing mifepristone,[260] which has already been approved by the FDA and has been safely used for over twenty years.[261] Additionally, mifepristone is used only to terminate early gestational pregnancies (those before the seventh week of pregnancy) when it is safest to do so.[262] Telemedicine abortions merely involve using a pre-existing method of medical technology (webcams) as a delivery system to provide a pre-existing method of abortion (early medication abortion). It is illogical that a state, acting in accordance with its interest in maternal health, would prohibit a procedure that could not only bring rural women access to early abortion procedures that they otherwise would not have access to, but a procedure that would bring access to quite possibly the safest method of abortion. Because telemedicine abortion improves the quality and accessibility of an existing method of abortion, it is unlikely that states will be able to advance a valid interest that will be sufficient to survive a constitutional challenge to legislation banning, or effectively banning, telemedicine abortion.

Further, even if a court could find that abortion-specific restrictions on telemedicine are reasonably related to a legitimate state interest, these restrictions still cannot survive the substantial-obstacle inquiry. After considering the specific group of women affected by telemedicine abortion restrictions, it becomes clear that in a substantial number of cases, these restrictions are outcome-determinative as to whether a rural, lower-income

258. *See supra* pt. VI(B).

259. *See supra* nn. 135–136 (describing the wide variety of practice areas in which telemedicine has been implemented and in which this technology is successfully used today).

260. Ibis Reprod. Health, *supra* n. 144.

261. *See supra* pt. IV(A) (describing mifepristone's history of use and FDA approval in 2000).

262. *See supra* n. 85 and accompanying text (explaining how mifepristone is taken in conjunction with the drug misoprostol to terminate an early pregnancy).

woman will seek to obtain an abortion. Rural, lower-income women who are seeking an abortion compose the specific group of women who are targeted by this type of legislation.[263] In a significant number of cases, abortion-specific restrictions on telemedicine prevent these women from considering abortion as a realistic, attainable option.[264] Thus, abortion-specific restrictions on telemedicine cannot pass constitutional muster and should be held unconstitutional when a facial challenge[265] to any of these laws is brought before a court. The alternative (i.e., to uphold abortion-specific restrictions on telemedicine as constitutional) would be to set the Court on a slippery slope toward eroding the right to obtain an abortion, and ultimately, the rights to privacy and bodily integrity in general.

263. *See supra* pt. VII(C) (analyzing the specific group targeted by abortion-specific restrictions on telemedicine).

264. *See supra* pt. IV(D) (discussing how telemedicine technology could combat the geographical barriers limiting mifepristone's impact on rural women's access to abortion services).

265. To succeed in a facial challenge to an abortion restriction, a plaintiff must show that in a "large fraction of cases in which the [statute] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *McCormack v. Heideman*, 2011 WL 4436548 at *6 (D. Idaho 2011) (quoting *Casey*, 505 U.S. at 895).