

THE DOCTOR REQUIREMENT: *GRISWOLD*, PRIVACY, AND AT-HOME REPRODUCTIVE CARE

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INTRODUCTION

Privacy law has traditionally offered greater protection to activities exercised within the home. This is true in common law as well as across a broad range of constitutional claims. For example, common law privacy protection identifies the home as a location of solitude and repose and is often conceptualized as the “right to be let alone.”¹ Fourth Amendment protections against search and seizure and the notion of the reasonable expectation of privacy are enhanced when the defendant is within her or his home.² In contrast to other constitutional claims, however, I argue in this Article that reproductive self-care—care that takes place outside of the formal healthcare setting—receives *less* constitutional protection when exercised in the privacy of the home.³ Most frequently, restrictions on reproductive self-care in

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1. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 195 (1890) (arguing for the recognition in law of the right of privacy which they described as the “right to be let alone”).

2. See *infra* at notes 87–94 and accompanying text.

3. I use the term “home” because the home is where medication abortion is most frequently ingested. See Mitchell D. Creinin & Kristina Gemzell Danielsson, *Medical*

the home take the form of what I have termed a “doctor requirement”: laws that require reproductive care be performed in a formal healthcare setting, often requiring that a doctor be physically present. While the doctor requirement is imposed in a variety of reproductive self-care contexts—including self-insemination,⁴ miscarriage management,⁵ abortion, and home birth⁶—this Article will focus specifically on medication abortion.⁷

Abortion in Early Pregnancy, in MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCY: COMPREHENSIVE ABORTION CARE 114 (Paul et al. eds., 2009) [hereinafter MANAGEMENT OF UNINTENDED PREGNANCY]; *Medical Management of First-Trimester Abortion*, 143 AM. C. OBSTETRICIANS & GYNECOLOGISTS PRACTICE BULLETIN: CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN-GYNECOLOGISTS 3 (Mar. 2014) [hereinafter ACOG PRACTICE BULLETIN]. However, the critical aspect of the doctor requirement is that pregnant people are forced into public healthcare settings, and thereby necessarily out of private spaces of their choosing, whether it be the home or any other non-clinical setting. For a discussion of how the Court has extended the reach of zonal privacy beyond the home to include areas possessing the qualities of home, such as an office, store, hotel room, automobile, or taxicab, see Yvonne Lindgren, *Personal Autonomy: Towards a New Taxonomy of Privacy Law*, 31 WOMEN’S RTS. L. REP. 447, 454 n.31 (2010). I use the term home while acknowledging that pregnant people may choose other non-clinical settings to ingest medication abortion.

4. For example, the Uniform Parentage Act required a doctor’s supervision as a condition for releasing a sperm donor from the rights and obligations of paternity. While the doctor requirement was removed from the UPA in 2002, many states retain the doctor requirement in their statutory schemes. *See, e.g.*, Kansas Parentage Act, KAN. STAT. ANN. § 23-2208(f) (2014); *Jhordan C. v. Mary K.*, 224 Cal. Rptr. 530, 538–39 (Cal. Ct. App. 1986) (granting visitation over the mother’s objection based upon a conclusion that a sperm donor’s paternity rights are invalidated only if the insemination is conducted “under the supervision of a licensed physician” under state law); MELISSA MURRAY & KRISTIN LUKER, CASES ON REPRODUCTIVE RIGHTS AND JUSTICE 388 (2015).

5. Several states have recently introduced legislation requiring that all miscarriages be registered with a healthcare professional. *See e.g.*, Ohio Sub. S.B. 175, 127th General Assembly (Dec. 2015) (requiring women who suffer a miscarriage to file a form with the state of Ohio indicating that they suffered a miscarriage and providing for felony charges punishable with life in prison or death for any “prenatal murder,” including those in which there was “human involvement”); S.B. 962–098385288, (Va. 2009) (requiring all pregnant people in Virginia to report miscarriages to police or risk legal penalties, including as much as a year in jail).

6. *See, e.g.*, Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 874 (2005) (discussing the ways that privacy of the home is implicated by midwifery in the home-birth context); Jennifer J. Tachera, *A “Birth Right”: Home Births, Midwives and the Right to Privacy*, 12 PAC. L.J. 97, 103 (1980) (arguing that home birth is an aspect of the privacy right because it relates to family relationships); Barbara A. McCormick, Note, *Childbearing and Nurse-Midwives: A Woman’s Right To Choose*, 58 N.Y.U. L. REV. 661, 694–95 (1983) (arguing that the constitutional right of privacy protects a woman’s right to choose the site and method of delivery).

7. Medication abortion involves the use of medication rather than surgery to induce an abortion. *See, e.g.*, ACOG PRACTICE BULLETIN, *supra* note 3, at 1.

It considers a previously unaddressed question:⁸ Why is the home treated differently in cases of abortion-related self-care than in other constitutional moments and what does that difference reveal about this type of regulation? I conclude that laws imposing a doctor requirement are unconstitutional because medication abortion at home falls within privacy law's traditional protection of spatial, relational, and decisional privacy.⁹ I conclude that the doctor requirement reveals that rather than a realm of privacy, the home has become a site of increasing regulation of pregnant people's reproductive autonomy in the guise of benign medical protectionism.

The anomalous treatment in law of reproductive self-care at home, when compared with the law's treatment of other types of constitutional and common law privacy claims, offers a rich opportunity to consider how claims of reproductive autonomy, safeguarding the health of pregnant persons,¹⁰ and the privacy of the home coalesce in reproductive self-care to reveal underlying tensions in regulation in this area. I argue that medication abortion in the home falls squarely within the protections of privacy jurisprudence: First, in medication abortion the home functions in its traditional privacy role as a zone free from third-party intrusion and governmental surveillance for pregnant people accessing medication abortion. For example, medication

8. Previous scholarship has considered reproductive self-care primarily in the context of home-birth, with an emerging scholarship addressing the constitutional implications of self-abortion. *See, e.g.*, Suzanne M. Alford, *Is Self-Abortion a Fundamental Right?*, 52 DUKE L.J. 1011, 1029 (2003); Cohen, *supra* note 6; Stacey Tovino, *American Midwifery Litigation and State Legislative References for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61 (2004); McCormick, *supra* note 6.

9. These categories are used in Kendall Thomas, *Beyond the Privacy Principle*, 92 COLUM. L. REV. 1431, 1443 (1992). However, many scholars have used taxonomy to classify the complex subject of privacy law. *See, e.g.*, JUDITH W. DECEW, IN PURSUIT OF PRIVACY: LAW, ETHICS, AND THE RISE OF TECHNOLOGY 75–77 (1997) (identifying privacy as a cluster of rights relating to informational privacy, accessibility privacy, and expressive privacy); Gary L. Bostwick, Comment, *A Taxonomy of Privacy: Repose, Sanctuary, and Intimate Decision*, 64 CALIF. L. REV. 1447, 1448 (1976); Tom Gerety, *Redefining Privacy*, 12 HARV. C.R.–C.L. L. REV. 233, 236 (1977); Jerry Kang, *Information Privacy in Cyberspace Transactions*, 50 STAN. L. REV. 1193, 1202–03 (1998) (defining privacy to include three overlapping clusters of rights: physical space, choice, and flow of personal information); Daniel J. Solove, *A Taxonomy of Privacy*, 154 U. PA. L. REV. 477, 489 (2006).

10. I use the term pregnant “people” instead of “women” to acknowledge that trans men and other gender-non-conforming people may also seek abortion-related healthcare and may have even more difficulty accessing reproductive healthcare than cis-women seeking abortion. *See, e.g.*, Katha Pollitt, *Who Has Abortions?*, NATION (Mar. 13, 2015), <https://www.thenation.com/article/who-has-abortions/>.

abortion at home protects pregnant people in violent intimate relationships from surveillance and further violence from intimate partners that can be triggered by pregnancy; the home protects individuals from harassment and surveillance by anti-abortion protesters at clinics; and the home protects those with compromised immigration status from state surveillance at immigration checkpoints along the southern border of the United States when travelling long distances to access abortion-related healthcare at clinics. Second, the doctor requirement in medication abortion infringes on privacy as a right related to intimacy and autonomy of reproductive decision-making that the Court has recognized at the core of the Fourteenth Amendment.¹¹ Finally, medication abortion at home is encompassed by privacy's protection of intimate association as abortion at home allows pregnant people to end their own pregnancies in the privacy of their homes with the support of their chosen company, or alone, rather than in a clinical setting. I conclude that restrictions on reproductive self-care in the home are incongruous with privacy law's traditional articulation in both common law and constitutional law.

Next, I consider more generally whether privacy is an adequate legal framework to identify the interests involved in restrictions on medication abortion at home. While medication abortion at home falls within privacy's framework of zonal, relational, and decisional privacy,¹² I draw upon critical and feminist legal scholarship to argue that the harms imposed on pregnant people ending their pregnancies at home are not adequately captured or conceptualized by privacy's conceptual framework of individuals exercising rights in the privacy of the home. The Court's privacy analysis that identifies the home as a critical zone of protection against state surveillance and intrusion fails to acknowledge the ways in which medication abortion at home implicates private violence, third party harassment and surveillance, and state-sponsored surveillance and regulation in the lives of pregnant people. What is more, the privacy analysis

11. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) (“Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.” (citations omitted)).

12. Thomas, *supra* note 9, at 1443.

fails to consider the ways in which state policies that deny access to abortion-related healthcare create the conditions under which pregnant people turn to medication abortion in the home, due to clinic closures, immigration enforcement, intimate partner violence, and harassment at clinics, to name only a few. This is especially true for pregnant people who are living in poverty,¹³ of color,¹⁴ or with compromised immigration status¹⁵ because pregnancies for these vulnerable groups are disproportionately subjected to surveillance.¹⁶ In short, the doctor requirement

13. While the rate of unintended pregnancies and abortion has declined among people with resources and college graduates, it has increased among people living in poverty and with less education. Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL REPROD. HEALTH 90–96 (2006); see also *id.* at 93 tbl. 1. As a result, those with the least resources bear a disproportionate burden of unintended pregnancies and abortion. Allan Rosenfield, *Foreword*, in MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3, at x.

14. See PATRICIA HILL COLLINS, BLACK FEMINIST THOUGHT: KNOWLEDGE, CONSCIOUSNESS AND THE POLITICS OF EMPOWERMENT 18 (2d ed. 2000) (describing a “matrix of domination” to refer to the way intersection systems of oppression function to discipline the lives of marginalized and oppressed populations); see also Kimberlé W. Crenshaw, *From Private Violence to Mass Incarceration*, 59 UCLA L. REV. 1418, 1449 (2012) (“The interplay between structures and identities are key elements in understanding the ways that [women of color] are situated within and affected by the various systems of social control.”). A rich body of scholarship has highlighted the intersection of reproductive oppression and racial control in a variety of contexts including forced sterilization, family caps on public support, lack of access to culturally sensitive birth control, and criminalizing women for negative birth and pregnancy outcomes. See, e.g., DOROTHY E. ROBERTS, KILLING THE BLACK BODY: RACE REPRODUCTION AND THE MEANING OF LIBERTY 250–254 (1997); SILLMAN ET AL., UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE 127 (2004); Elena R. Gutiérrez, Issue Brief, *Bringing Families Out of ‘Cap’tivity: The Need To Repeal the Calworks Maximum Family Grant Rule*, CTR. ON REPROD. RTS. & JUST (April 2013), https://www.law.berkeley.edu/files/bccj/CRRJ_Issue_Brief_MFG_Rule_FINAL.pdf (last visited Apr. 11, 2017); Rebekah J. Smith, *Family Caps in Welfare Reform*, 29 HARV. J.L. & GENDER 151, 152–154 (2006). By contrast, wealthier women’s pregnancies are less likely to be subject to surveillance, as they rely on private physicians, midwives and home care.

15. See *infra* notes 103–08 and accompanying text.

16. See Brief for National Asian Pacific American Women’s Forum (NAPAWF) and Center for Reproductive Rights and Justice at the University of California, Berkeley School of Law et al. as Amici Curiae Supporting Appellant, *Patel v. State*, No. 71A04-1504-CR-00166 (Ind. Ct. App. filed Oct. 2, 2015) [hereinafter *Patel Amicus Brief*]; see also KHIARA M. BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 41–73 (2011); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 25–46 (2002) [hereinafter *CHILD WELFARE*] (discussing the impact of state surveillance on communities of color); Dorothy Roberts & Jeffrey Vagle, Opinion, *Racial Surveillance Has a Long History*, HILL (Jan. 4, 2016), <http://thehill.com/opinion/op-ed/264710-racial-surveillance-has-a-long-history> (noting that wide-ranging welfare surveillance disproportionately strips recipients of color’s dignity and privacy).

reveals how a myriad of political, structural, and economic forces work in tandem to deny the right of privacy in its traditional sense to pregnant people exercising reproductive self-care in the home. Thus, while the doctor requirement falls within privacy's framework, it simultaneously reveals how insubstantial the privacy analysis is in articulating the interests at stake with respect to the right of dignity and autonomy of pregnant people seeking to exercise abortion-related self-care in the home.

It is a critical time to consider doctor-requirement restrictions on medication abortion as these laws are gaining momentum. In the last four years, nineteen states have passed laws requiring that the two-pill regimen for medication abortion be taken in the presence of a doctor,¹⁷ despite guidelines by the Food and Drug Administration (FDA),¹⁸ the American College of Obstetricians and Gynecologists (ACOG), and the World Health Organization (WHO), which do not require that *either* of the pills be ingested in a doctor's presence.¹⁹ The doctor requirement restricts pregnant people's ability to engage in abortion-related self-care in the privacy of their homes and effectively prohibits the use of telemedicine for abortion care.²⁰

This Article proceeds in three parts. Part I describes the two-pill medication abortion regimen and its uses both within and outside of the clinical context. This section details state law restrictions on at-home use of medication abortion and their impact on the widespread practice of using telemedicine to deliver abortion-related healthcare to people living in areas without

17. *Telemedicine Introductory Brief: Provision of Medication Abortion*, IBIS REPROD. HEALTH (Jan. 2016), <https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Telemedicine%20introductory%20brief%20Jan%202016.pdf>.

18. The new FDA guidelines require that the first drug, mifepristone, be "dispensed" by a doctor, but does not require that the pills be ingested in the presence of a doctor. Because the guidelines do not require that either drug, mifepristone or misoprostol, be taken in the presence of a doctor, they can be taken at home. ACOG PRACTICE BULLETIN, *supra* note 3, at 2.

19. See MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3; WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 44 (2d. ed. 2012) [hereinafter SAFE ABORTION] ("Home use of misoprostol is a safe option for women."); ACOG PRACTICE BULLETIN, *supra* note 3, at 2.

20. Telemedicine is a method of providing abortion care at a distance using technology. The doctor requirement restricts the use of telemedicine both for home based and clinic based telemedicine abortion care. See *infra* notes 33–37 and accompanying text.

access to clinics, especially rural areas.²¹ It considers the claims that these restrictions are designed to protect women's health in light of the undue burden standard of *Planned Parenthood of Southeastern Pennsylvania v. Casey*,²² and its recent articulation in *Whole Woman's Health v. Hellerstedt*.²³ Part II argues that state restrictions on medication abortion are unconstitutional because medication abortion at home falls within the purview of privacy law's traditional protection of zonal, relational, and decisional privacy. It concludes that the privacy interest at stake in medication abortion at home involves matters of personal significance related to procreation, within the physical confines of the home, as well as the right to exercise control over one's body that go beyond mere location of the medical procedure in a healthcare setting. Part III critiques the limitations of the privacy analysis in the context of medication abortion at home and considers how larger systems and structures deny access to privacy for pregnant people seeking to exercise reproductive self-care in the home.

I. THE HOME AND REPRODUCTIVE SELF-CARE

Medication abortion involves the use of medication rather than surgery to induce an abortion.²⁴ A pregnant person may end a pregnancy at home using medication abortion under two circumstances: within the clinical context facilitated by a doctor or outside of the clinical context by self-inducing abortion. This section details the ways that medication abortion is used to end pregnancy both inside and outside of the clinical setting. In each of these instances, some part of the medication abortion regimen occurs at home.

A. MEDICATION ABORTION AND THE HOME

Medication abortion is commonplace in the United States through medical facilities.²⁵ In this clinical context, a pregnant

21. R.J. Gomperts et al., *Using Telemedicine for Termination of Pregnancy with Mifepristone and Misoprostol in Settings Where There Is No Access to Safe Services*, 115 INT'L J. OBSTETRICS & GYNECOLOGY 1171, 1173 (2008).

22. 505 U.S. 833 (1992).

23. 136 S. Ct. 2292 (2016).

24. See, e.g., ACOG PRACTICE BULLETIN, *supra* note 3, at 1.

25. Gomperts et al., *supra* note 21, at 1173; see also Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 17–27(2014).

person takes a two-drug protocol—mifepristone and misoprostol—approved by the FDA.²⁶ The FDA protocol requires that the first medication, mifepristone, be dispensed at a clinic,²⁷ but does not indicate where either of the two drugs must be ingested. Studies reveal that most pregnant people who end their pregnancies using abortion medication choose to do so at home.²⁸ Medication abortion using the two-drug regimen under a doctor’s supervision is considered to be safe and effective, with a ninety-two to ninety-five percent success rate, comparable to that of surgical abortion.²⁹ As I will discuss in more detail below,³⁰ numerous studies have confirmed the safety and efficacy of the at-home administration not only of the second pill, but of the entire regimen of medication abortion through telemedicine.³¹ These studies concluded that in-home administration was as safe, effective, and as acceptable to pregnant persons as clinic administration.³²

Telemedicine³³—virtual consultation with a physician by video—has been an effective way to provide abortion-related

26. The FDA-approved regimen is detailed in the mifepristone package label. ACOG PRACTICE BULLETIN, *supra* note 3, at 2. Since FDA approval, medication abortion has been used by almost two million women in the United States to end early pregnancies, about 200,000 a year. Linda Greenhouse, Opinion, *The Next Abortion Case Is Here*, N.Y. TIMES (Sept. 4, 2013), https://opinionator.blogs.nytimes.com/2013/09/04/the-next-abortion-case-is-here/?_r=0.

27. Mifepristone must be dispensed by a licensed medical office by the terms of the licensing agreement. See *Mifeprex Prescriber’s Agreement*, DANCO LABS., <https://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111364.pdf> (last visited Apr. 11, 2017).

28. See MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3; ACOG PRACTICE BULLETIN, *supra* note 3, at 3.

29. Christian Fiala & Kristina Gemsell-Danielsson, *Review of Medical Abortion Using Mifepristone in Combination with a Prostaglandin Analogue*, 74 CONTRACEPTION 66, 69 (2006); Gomperts et al., *supra* note 21, at 1171.

30. See *infra* notes 65–74 and accompanying text.

31. See, e.g., Thoai D. Ngo et al., *Comparative Effectiveness, Safety, and Acceptability of Medical Abortion at Home and in a Clinic: A Systemic Review*, 89 BULLETIN WORLD HEALTH ORG. 360, 370 (2011).

32. *Id.* at 360–70.

33. The doctor requirement also presumptively bans mid-level providers such as nurse-midwives, nurse-practitioners, and physicians-assistants from administering medication abortion, despite recommendations from WHO, the American College of Obstetricians and Gynecologists, the American Public Health Association, and the American Medical Women’s Association to increase training and use of mid-level providers for medication abortions. Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, 19 GUTTMACHER POL’Y REV. 1 (2013).

healthcare to pregnant people in rural areas.³⁴ When telemedicine is used in a clinical setting, a doctor talks with patients on-screen, reviews test results, and then the doctor dispenses the dosage of the pills remotely.³⁵ The pills are dispensed in the clinic and the patient takes the pills at home.³⁶ A current study underway is examining the effectiveness of providing abortion medication by mail using telemedicine, thereby entirely foregoing the need for a clinic visit.³⁷

When pregnant people end their own pregnancies using medication without medical supervision, they generally take misoprostol alone.³⁸ Gynuity Health Projects and WHO have developed guidelines for self-induction using misoprostol alone.³⁹ This single medication method can safely induce an abortion and is eighty-five percent effective.⁴⁰ The side effects of using the one-drug regimen of misoprostol on its own are generally minimal and are similar to those associated with spontaneous miscarriage.⁴¹ Much research has pointed to the safety and efficacy of the single-drug regimen for medication abortion using misoprostol.⁴²

34. Gomperts et al., *supra* note 21, at 1173. Telemedicine has been an effective way to provide abortion-related healthcare to rural women as evidenced by Planned Parenthood in Iowa's successful program to use videoconferencing to provide abortion medications to more than 6,500 women in rural clinics. See Emily Bazelon, *The Dawn of the Post-Clinic Abortion*, N.Y. TIMES MAG. (Aug. 28, 2014), <https://www.nytimes.com/2014/08/31/magazine/the-dawn-of-the-post-clinic-abortion.html>.

35. Bazelon, *supra* note 34.

36. *Id.*

37. After consulting with an abortion provider by videoconference, the patient is sent the necessary abortion medication by overnight mail. See *TelAbortion Study FAQ*, TELABORTION, <http://telabortion.org/faq/> (last visited Apr. 7, 2017).

38. The self-induction regimen is a one-pill regimen because mifepristone is expensive and must be distributed at a licensed medical office. See *Mifeprex Prescriber's Agreement*, *supra* note 27. This protocol is often referred to as "miso-alone." See, e.g., SAFE ABORTION, *supra* note 19, at 45.

39. *Instructions for Use*, GYNUITY HEALTH PROJECTS, http://gynuity.org/downloads/clinguide_ifu_pphprevention_en.pdf (last visited Apr. 7, 2017); see also SAFE ABORTION, *supra* note 19, at 44.

40. See R. Kulier et al., *Medical Methods for First Trimester Abortion*, 2011 COCHRANE DATABASE SYS. REV. at 11.

41. *Id.*

42. Helena von Hertzen et al., World Health Org. Res. Grp. on Postovulatory Methods of Fertility Regulation, *Efficacy of Two Intervals and Two Routes of Administration of Misoprostol for Terminating Pregnancy: A Randomized Controlled Equivalence Trial*, 396 LANCET 1938, 1938–46 (2007); N.L. Moreno-Ruiz et al., *Alternatives to Mifepristone for Early Medical Abortion*, 96 INT'L J. OBSTETRICS & GYNECOLOGY 212, 216–18 (2007); *Consensus Statement: Instructions for Use – Abortion Induction with Misoprostol in Pregnancy Up to 9 Weeks LMP*, Expert Meeting on Misoprostol Sponsored

Research conducted under the auspices of WHO examined the prospect of permitting women to self-administer misoprostol rather than requiring a doctor visit and recommended the use of misoprostol alone in those settings where mifepristone is not available.⁴³

The home is central in all three contexts in which a pregnant person may choose to end a pregnancy using medication abortion: clinical supervision, telemedicine, and self-induction. Despite the proven safety, efficacy, and prevalence of at-home administration of medication abortion—both within and outside of the formal healthcare system—in the United States there is increasing pressure by anti-abortion groups to limit access to medication abortion within the formal healthcare context. The next section will examine restrictions on medication abortion through doctor requirements which also result in prohibitions on the use of telemedicine.

B. RESTRICTIONS ON HOME-USE OF MEDICATION ABORTION

In the last four years, nineteen states have passed legislation that requires pregnant people who take medication abortion to have both pills dispensed in the physical presence of a doctor.⁴⁴ This doctor requirement is contrary to FDA, ACOG and WHO protocols which provide that only the first pill, mifepristone, be dispensed by a medical facility.⁴⁵ Laws that require the physical presence of the physician also preemptively ban the use of telemedicine.⁴⁶ In states with a doctor requirement, a pregnant person seeking a medication abortion may have to travel long distance to visit a clinic attended by a physician, and attend in-person counseling or undergo enforced ultrasound examinations that necessitate multiple trips to the clinic. These laws require pregnant persons to complete every step of the procedure in the physical presence of a physician, rather than in the privacy of the

by Reproductive Health Technologies Project and Gynuity Health Projects, July 28, 2003, Washington, D.C.

43. Gomperts et al., *supra* note 21, at 1174.

44. IBIS REPROD. HEALTH, *supra* note 17.

45. See MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3, at 114; ACOG PRACTICE BULLETIN, *supra* note 3, at 2.

46. Francine Coeytaux & Victoria Nichols, *Plan C: The Safe Strategy for a Missed Period When You Don't Want To Be Pregnant*, REWIRE (Feb. 7, 2014), <https://rewire.news/article/2014/02/07/plan-c-safe-strategy-missed-period-dont-want-pregnant/>.

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home pursuant to approved guidelines.⁴⁷ Justice Sotomayor highlighted this element of the issue of medication abortion during her questioning at recent oral arguments in *Whole Woman's Health v. Hellerstedt*:

Justice Sotomayor: The medical abortion, that doesn't involve any hospital procedure. A doctor prescribes two pills, and the women take the pills at home, correct?

Ms. Toti: Under Texas law, she must take them at the facility, but that's otherwise correct.

Justice Sotomayor: I'm sorry. What? She has to come back two separate days to take them?

Ms. Toti: That's correct, yes.

Justice Sotomayor: All right. So now, from when she could take it at home, now she has to travel 200 miles or pay for a hotel to get these two days of treatment?⁴⁸

These state laws that require abortion medications be dispensed in a healthcare setting contravene FDA labelling and ACOG protocols for medication abortion.⁴⁹ These regulations also necessarily infringe on the right to exercise abortion-related self-care in the home by forcing pregnant people out of the home and into public healthcare settings. Justice Sotomayor's questioning also highlighted that these requirements restrict access to abortion-related healthcare by adding difficulty, cost, distance, and time required to access a procedure that could otherwise be obtained after one visit—either virtual by telemedicine or in-person—to a healthcare provider. The next section will examine whether the added cost and difficulty of accessing medication abortion imposed by the doctor requirement creates an undue burden on abortion under *Planned Parenthood of Southeastern Pennsylvania v. Casey*⁵⁰ and *Whole Woman's Health v. Hellerstedt*.⁵¹

47. See MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3, at 114; ACOG PRACTICE BULLETIN, *supra* note 3.

48. Transcript of Oral Argument at 20–21, *Whole Woman's Health et al. v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274).

49. See MANAGEMENT OF UNINTENDED PREGNANCY, *supra* note 3; ACOG PRACTICE BULLETIN, *supra* note 3.

50. 505 U.S. 833 (1992).

51. 136 S. Ct. 2292 (2016).

C. THE DOCTOR REQUIREMENT AND THE UNDUE BURDEN STANDARD

The Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*⁵² held that the right of abortion encompasses a woman's right to have an abortion before viability "without undue interference from the State."⁵³ The state may express its interest in potential life by regulating abortion, so long as those regulations do not pose an "undue burden" on a woman's ability to seek an abortion before viability.⁵⁴ The undue burden standard was defined as "a state regulation [that] has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."⁵⁵ While the state may seek to ensure that a woman's choice is informed and protect the health and safety of a woman, the state may not prohibit the woman from making the ultimate decision to undergo an abortion.⁵⁶ This "undue burden" standard downgraded the standard for judicial review from the strict scrutiny that had been applied by the courts in previous abortion cases based on the view that abortion was a fundamental right.⁵⁷ Opponents of the abortion right argued that the standard was little more than rational basis review.⁵⁸

In 2015 the Supreme Court clarified the undue burden standard in *Whole Woman's Health v. Hellerstedt*.⁵⁹ In that case, the Court considered a Texas law, H.B. 2, that required abortion providers to secure admitting privileges at nearby hospitals and required that abortion clinics meet the requirements of

52. 505 U.S. 833 (1992).

53. *Id.* at 846.

54. *Id.* at 874.

55. *Id.* at 877.

56. *Id.* at 878–79.

57. See MURRAY & LUKER, *supra* note 4, at 775–76 (explaining that the undue burden standard replaced the strict scrutiny standard and was originally proposed by Justice O'Connor in her dissent in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)).

58. See Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman's Health*, 126 YALE L.J. FORUM 149, 152 (2016), <http://www.yalelawjournal.org/forum/the-difference-a-whole-woman-makes> (describing how the "undue burden" standard in the recent decision provided more than mere rational basis deference, but rather that the Court "balance[d] benefits and burdens [to] call into question myriad health-justified restrictions on abortion"); see, e.g., Brief for Respondents at 21–23, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274).

59. 136 S. Ct. 2292 (2016).

ambulatory surgical centers.⁶⁰ The Court required that states offer an evidentiary basis to substantiate its claim that abortion restrictions protected women's health.⁶¹ Under the new analysis, it is the role of the courts to interrogate the veracity of healthcare claims underlying abortion restrictions. Next, the courts must balance the purported health benefits of an abortion regulation against the burdens placed upon women's access to abortion-related healthcare.⁶² The Court found a "virtual absence of any health benefit"⁶³ from the Texas law and detailed the law's detrimental effect on women's access to abortion-related healthcare.⁶⁴

Medication abortion using the two-drug regimen under a doctor's supervision is considered to be safe and effective.⁶⁵ Studies have confirmed the safety and efficacy of the at-home administration not only of the second pill, but of the entire regimen of medication abortion through telemedicine.⁶⁶ These studies concluded that in-home administration was as safe, effective and as acceptable to pregnant persons as clinic administration.⁶⁷ ACOG reviewed the medical literature on at-home medication abortion and concluded that pregnant persons can "safely and effectively" use telemedicine to have medication abortion at home.⁶⁸ An analysis of pooled data from nine studies conducted by WHO found home-based medication abortions to be as effective as those administered in clinics, noting that "home-based medication abortions may have several advantages over clinic-based protocols, including allowing for greater privacy and lessening the burden on both women and service providers by reducing the number of clinic visits."⁶⁹

60. See Act of July 12, 2013, ch. 1, §§ 1-12, 2013 Tex. Sess. Law Serv. 4795-4802 (West) (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 171.0031, 171.041-048, 171.061-064, 245.010-011 (West 2015) and TEX. OCC. CODE ANN. §§ 164.052, 055 (West 2015)).

61. *Hellerstedt*, 136 S. Ct. at 2310.

62. *Id.* at 2309 (stating that *Casey* "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer").

63. *Id.* at 2313.

64. *Id.* at 2311-12, 2315.

65. Fiala & Gemsell-Danielsson, *supra* note 29.

66. Ngo et al., *supra* note 31.

67. *Id.*

68. Bazelon, *supra* note 34.

69. *Medication Abortion May Be Equally Safe Whether Done at Home or Clinic*, 37 INT'L PERSP. ON SEXUAL & REPROD. HEALTH 160 (2011). In light of its safety and efficacy, some researchers are calling for miso-alone to be available over-the-counter and

Research has revealed that self-induced abortion using the single-drug regimen for medication abortion using misoprostol is safe and effective.⁷⁰ WHO examined the safety of self-administered medication abortion using misoprostol alone, as opposed to the two-drug regimen that requires a doctor visit, and recommended the use of misoprostol alone in those settings where mifepristone is not available.⁷¹ The WHO safe abortion guidelines provide that misoprostol can be used alone to safely end a pregnancy through twelve weeks after the first day of the last menstrual period.⁷² Medication abortion via telemedicine has also been studied and found to be safe and effective. WHO reviewed the medical literature and concluded that pregnant persons “can safely and effectively” use telemedicine to have an abortion, including taking misoprostol at home.⁷³ Despite the consistent findings of safety and efficacy of telemedicine, Arkansas and Idaho have recently adopted new restrictions on telemedicine for medication abortion, joining sixteen other states in barring use of telemedicine for abortion-related healthcare.⁷⁴

Further, the *Whole Woman’s Health* decision is significant because it calls into question onerous health regulations that single out abortion for regulation that do not apply to other procedures that pose much greater risk. The *Whole Woman’s Health* Court found that health care claims asserted in H.B. 2 were called into question when the state did not similarly regulate more dangerous procedures, such as colonoscopy, liposuction, and childbirth.⁷⁵ Similarly, the doctor requirement in medication

have suggested calling it “Plan C” in reference to the morning-after pill, RU486, that is sold under the name “Plan B.” See Coeytaux & Nichols, *supra* note 46.

70. See, e.g., von Hertzen et al., *supra* note 42; Moreno-Ruiz et al., *supra* note 42; *Consensus Statement*, *supra* note 42.

71. Coeytaux & Nichols, *supra* note 46, at 2 (noting that pregnant people throughout much of the world ingest misoprostol to end pregnancies without medical supervision). Misoprostol is readily available over the counter elsewhere in the world and is commonly used to induce abortion outside of clinical settings. *Id.* Indeed, in an effort to reduce the number of deaths due to illegal abortions throughout much of Latin America, Africa, Asia and the Persian Gulf, WHO recently put mifepristone and misoprostol on its Essential Medicines List. Gomperts et al., *supra* note 21, at 1171.

72. Coeytaux & Nichols, *supra* note 46; Bela Ganatra et al., *From Concept to Measurement: Operationalizing WHO’s Definition of Unsafe Abortion*, 92 *BULLETIN WORLD HEALTH ORG.* 153, 155 (2014).

73. Ngo et al., *supra* note 31; see also Gomperts et al., *supra* note 21.

74. *IBIS*, *supra* note 17.

75. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016). Indeed, in her concurrence, Justice Ginsberg stated that, “Given those realities, it is beyond rational belief that H.B. 2 could genuinely protect the health of women, and certain that the law

abortion singles out abortion at home for regulation at the same time that other types of self-care at home are being expanded in an effort to lower healthcare costs. For example, Medicare is now taking steps to make it easier for people to do their own kidney dialysis at home.⁷⁶ Not only does at-home use save money, but federal Medicare authorities as well as doctors recognize that patients do better when they are active participants in their own care, while at the same time improving patient's experience and lowering medical costs.⁷⁷

Like other forms of home-based care such as dialysis, medication abortion significantly lowers the cost and difficulty of accessing abortion. For this reason, anti-abortion groups are particularly focused on restricting the use of medication abortion. The doctor requirement's mandate that the medication abortion regimen must be performed in the physical presence of a doctor infringes upon a pregnant person's ability to engage in reproductive self-care in the privacy of the home, without any cognizable health care benefits, thus calling into question the claim that these restrictions seek to protect women's health. What is more, like H.B. 2 in *Whole Woman's Health*, it is clear that the doctor requirement is motivated by opposition to abortion rather than by concern for protecting women's health. As scholar and journalist Linda Greenhouse summed it up, "if you think about it, it's evident why opponents of abortion have begun to focus on the early nonsurgical procedure. Medical abortion is the ultimate in women's reproductive empowerment and personal privacy."⁷⁸

At least two courts have overturned doctor requirement restrictions based on the undue burden analysis because of lack of purported healthcare benefits for requiring that pregnant people be in a doctor's physical presence to end their own pregnancies. The Ninth Circuit, in *McCormack v. Herzog*,⁷⁹ held that an Idaho provision that required that all second trimester abortions be performed in a hospital violated the rights of women who wished to obtain pre-viability abortions from a physician prescribing

'would simply make it more difficult for them to obtain abortions.'" *Id.* at 2321 (quoting *Planned Parenthood of Wis. v. Schimel*, 806 F.3d 908, 910 (7th Cir. 2015)).

76. Eric Whitney, *Feds Say More People Should Try Dialysis at Home*, NPR NEWS (Oct. 4, 2016), <http://www.npr.org/sections/health-shots/2016/10/04/492932675/feds-say-more-people-should-try-dialysis-at-home>.

77. *Id.*

78. Greenhouse, *supra* note 26.

79. 788 F.3d 1017 (9th Cir. 2015).

FDA-approved medication abortions.⁸⁰ Jeanne McCormack chose to end her own pregnancy using misoprostol that she obtained online, because there were no licensed abortion providers in southeastern Idaho where she lived and the nearest abortion clinic in Salt Lake City would cost between four hundred and two thousand dollars.⁸¹ She obtained the pills online for two hundred dollars and successfully ended her own pregnancy at home.⁸² Similarly, the Iowa Supreme Court in *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine*, struck down a regulation banning the use of telemedicine for medication abortion, arguing that the imposition posed an undue burden on women's access to abortion without sufficient evidence that it protected women's health.⁸³ The case involved a program set up by Planned Parenthood in Iowa in 2008 that used videoconferencing to provide abortion medications to more than 6,500 pregnant people in rural clinics.⁸⁴ In 2010, the Iowa Medical Board conducted a study of the program and found that the telemedicine program was safe and met the prevailing standard of care.⁸⁵ Despite these findings, the Iowa Right to Life organization put pressure on Governor Terry Brandstad, who then replaced the board. The new board voted to halt telemedicine for abortions in Iowa.⁸⁶

II. MEDICATION ABORTION AS ZONAL, RELATIONAL, AND DECISIONAL PRIVACY

This section considers the extent to which medication abortion at home falls within privacy's traditional framework of zonal, relational, and decisional privacy. First, this section argues that medication abortion at home falls within the right of privacy

80. *Id.* at 1029–30.

81. *Id.* at 1022 n.3.

82. *Id.*

83. *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 269 (Iowa 2015).

84. Bazelon, *supra* note 34; Eric Wicklund, *Abortion-by-Telemedicine Pilot Launches in Four States*, MHEALTH INTELLIGENCE (Apr. 1, 2016), <http://mhealthintelligence.com/news/abortion-by-telemedicine-pilot-launches-in-4-states>.

85. Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 OBSTETRICS & GYNECOLOGY 295, 296–303 (2011) [hereinafter Grossman, *Telemedicine*] (finding that abortion via telemedicine was safe and effective with comparable clinical outcomes to face-to-face provision of medication abortion and a very high patient satisfaction rate).

86. *Id.*

of the home as a physical zone free from governmental surveillance and third party intrusion. I highlight that the Constitution protects against government intrusions into the home and the common law protects individuals against invasions into the solitude and repose in their home by third parties who are not governmental actors. In both contexts—surveillance by governmental actors and intrusion by non-governmental actors—the Supreme Court affords heightened protection of the home against surveillance and the home acts as a refuge that protects the right to be let alone. Second, this section argues that the nature of the privacy right in medication abortion at home falls within privacy as a substantive right related to decisional autonomy. Finally, it argues that self-induced abortion at home, whether inside or outside of medical supervision, represents privacy of intimate association that engages important notions of dignity and autonomy that take place in the context of intimate relationships.

A. MEDICATION ABORTION AND ZONAL PRIVACY WITHIN THE HOME

The home has long served an important role in the Supreme Court’s privacy analysis in both common law and constitutional law. As early as colonial times there existed a strong principle that a “man’s house is his castle; and while he is quiet, he is well guarded as a prince in his castle.”⁸⁷ Both constitutional law and common law delineate the home as privileged space for heightened privacy protection.⁸⁸ The constitutional right of privacy that identifies the home as a physical zone free from governmental intrusion can be found in the Third Amendment prohibition against the quartering of soldiers in the home;⁸⁹

87. *Paxton’s Case of the Writ of Assistance*, in JOSIAH QUINCY, JR., REPORTS OF CASES ARGUED AND ADJUDGED IN THE SUPERIOR COURT OF JUDICATURE OF THE PROVINCE OF MASSACHUSETTS BAY BETWEEN 1761 AND 1772, at 51 (Boston, Little, Brown & Co., 1865); see also *Seymayne’s Case*, 77 Eng. Rep. 194, 195 (K.B. 1605) (“[T]he house of every one is to him as his . . . castle and fortress.”); Note, *The Right to Privacy in Nineteenth Century America*, 94 HARV. L. REV. 1892, 1894 (1981).

88. See e.g., *Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (describing the “fundamental right” to be free from governmental intrusions into the privacy of the bedroom); see also *Rowan v. U.S. Post Office Dep’t*, 397 U.S. 728, 738 (1970) (arguing that the mailbox fit within the zone of privacy of repose within the home).

89. The Third Amendment provides: “No soldier shall, in times of peace, be quartered in any house, without consent of the owner, nor in time of war, but in a manner to be prescribed by law.” U.S. CONST. amend. III.

however, it is the Fourth Amendment that guarantees the most extensive privacy rights against governmental intrusion into the home.⁹⁰ With respect to the protection against surveillance, the Supreme Court has stated that “[w]e have said that the Fourth Amendment draws ‘a firm line at the entrance of the house.’”⁹¹ This zonal paradigm of privacy protects against third party and governmental surveillance into “the sanctity of a man’s home and the privacies of life.”⁹² In *Stanley v. Georgia*, Justice Marshall described the “fundamental right” to be free from governmental intrusions into the privacy of the bedroom.⁹³ Louis Brandeis has argued that both the common law right of privacy in tort regarding the flow of information, and the Fourth Amendment right of privacy of physical space, flow from the same source: “the right to be let alone.”⁹⁴

Medication abortion in the home, both self-induced and under a doctor’s supervision, falls squarely within privacy law’s traditional framework of zonal privacy. The home offers enhanced privacy protection from third-party intrusion and governmental surveillance for pregnant people accessing medication abortion. This is especially true for pregnant people who are living in poverty, of color,⁹⁵ and with compromised immigration status, because pregnancies for these vulnerable groups are disproportionately subjected to surveillance through public health insurance, public support agencies, and immigration check-points.⁹⁶ Much scholarship has explored the intersection of reproductive rights and state surveillance of communities of

90. The Fourth Amendment provides, in part, for “[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures” U.S. CONST. amend. IV. Privacy in the context of constitutional law first appeared in cases involving the Fourth Amendment. *See* *Gouled v. United States*, 255 U.S. 298, 304 (1921); *Boyd v. United States*, 116 U.S. 616, 630 (1886).

91. *Kyllo v. United States*, 533 U.S. 27, 40 (2001) (quoting *Payton v. New York*, 445 U.S. 573, 590 (1980)) (holding that the police could not use thermal imaging to detect heat patterns emanating from the defendant’s house because even though the surveillance was conducted outside the defendant’s home, the thermal-imaging device was gathering information about activities within the home); *see also* Andrew E. Taslitz, *The Fourth Amendment in the Twenty-First Century: Technology, Privacy, and Human Emotions*, 65 L. & CONTEMP. PROBS. 125, 144 (2002).

92. *Boyd*, 116 U.S. at 630.

93. *Stanley*, 394 U.S. at 565.

94. Warren & Brandeis, *supra* note 1, at 90 (quoting THOMAS M. COOLEY, COOLEY ON TORTS 29 (2d ed. 1888)).

95. Patel Amicus Brief, *supra* note 16, at 15, 22.

96. *See generally* BRIDGES, *supra* note 16.

color.⁹⁷ For these communities subjected to heightened surveillance, the ability to engage in abortion-related self-care in the home offers a sanctuary against governmental surveillance. Restrictions on medication abortion, both as self-induction through misoprostol alone and restrictions on ingesting medication at home under doctor supervision, increase the scrutiny of pregnant people, including those suffering poor pregnancy outcomes unrelated to the use of medication abortion.⁹⁸ As I will describe below, the repercussions of such surveillance and policing will disproportionately impact immigrant communities, low-income individuals, and communities of color.⁹⁹

Immigrant communities, communities living in poverty, and communities of color who disproportionately live in poverty due to barriers resulting from historic discrimination and lack of economic opportunity¹⁰⁰ are under greater scrutiny by police and governmental agencies, making them more likely to have their pregnancies subject to surveillance.¹⁰¹ This heightened scrutiny results from a greater likelihood that people living in poverty and people of color will be under governmental surveillance as the result of receiving public assistance, being supervised by parole officers, and under the care of public health systems.¹⁰² For pregnant people in these communities, abortion self-induction in the home offers greater protection from governmental surveillance that particularly targets communities of color living

97. See, e.g., *id.* at 41–71; see also CHILD WELFARE, *supra* note 16, at 25–46; ROBERTS, *supra* note 14, at 294–312; Roberts & Vagle, *supra* note 16.

98. People who live in poverty are more likely to suffer poor pregnancy outcomes due to socioeconomic factors and systemic problems. Patel Amicus Brief, *supra* note 16 at 20; see also Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States (1973-2005): The Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL'Y & L. 299, 310–12 (2013) (discussing the criminalization of women for negative birth or pregnancy outcomes and the connection between poverty and negative birth outcomes).

99. See, e.g., ROBERTS, *supra* note 14; SILLIMAN ET AL., *supra* note 14; Gutiérrez, *supra* note 14; Paltrow & Flavin, *supra* note 98; Smith, *supra* note 14.

100. See, e.g., Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1773 (2013) (“Classifications of race, ethnicity, and [social economic status] . . . reflect larger systems of structural inequality, including racism and systematic inequalities in both opportunities and power.”).

101. BRIDGES, *supra* note 16; ROBERTS, *supra* note 14; CHILD WELFARE, *supra* note 16; Roberts & Vagle, *supra* note 16.

102. See, e.g., Patel Amicus Brief, *supra* note 16, at 27; BRIDGES, *supra* note 16; ROBERTS, *supra* note 14; CHILD WELFARE, *supra* note 16; Paltrow & Flavin, *supra* note 98; Roberts & Vagle, *supra* note 16.

in poverty. What is more, lack of abortion clinic access, lack of health insurance coverage for abortion-related healthcare, and lack of resources to pay out of pocket for clinic-based care push people living in poverty towards medication abortion self-induction, because it is less expensive and more accessible than clinic-based care.

The role of the home as shield against governmental surveillance is critical in the context of medication self-induction abortion for pregnant people who are undocumented.¹⁰³ Pregnant people with compromised immigration status often turn to medication self-induction outside of the formal healthcare system because their ability to travel long distances to obtain reproductive healthcare is limited by the threat of apprehension, detention, and deportation, which severely restricts their travel and movement.¹⁰⁴ There has been an increase in immigration enforcement in the last ten years, which has resulted in a dramatic rise in detentions and deportations as well as increased policing of communities along the southern border of the United States.¹⁰⁵ For these pregnant people, the best choice for accessing abortion is often by obtaining medication from one of the border *mercados* or at a pharmacy across the border in Mexico where misoprostol is sold over the counter without a prescription.¹⁰⁶ At-home abortion for these pregnant people allows them to end their own

103. See COLLINS, *supra* note 14, at 18 (describing a “matrix of domination” to refer to the way intersection systems of oppression function to discipline the lives of marginalized and oppressed populations); see also ROBERTS, *supra* note 14; SILLIMAN, *supra* note 14; Crenshaw, *supra* note 14, at 1449 (“The interplay between structures and identities are key elements in understanding the ways that [women of color] are situated within and affected by the various systems of social control.”); Gutiérrez, *supra* note 14; Paltrow & Flavin, *supra* note 98.

104. See Madeline M. Gomez, *Intersection at the Border: Immigration Enforcement, Reproductive Oppression, and the Policing of Latina Bodies in the Rio Grande Valley*, 30 COLUM. J. GENDER & L. 84, 86 (2015) (noting that the intersection of immigration enforcement and reproductive oppression results in acute lack of access to reproductive healthcare for women who lack legal immigration status).

105. *Id.* at 91–92; see also Ana Gonzalez-Barrera & Jens Manuel Krogstad, *U.S. Deportations of Immigrants Reach Record High in 2013*, PEW RES. CTR. (Oct. 2, 2014), <http://www.pewresearch.org/fact-tank/2014/10/02/u-s-deportations-of-immigrants-reach-record-high-in-2013/>.

106. See Daniel Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, TEX. POL’Y EVALUATION PROJECT, at 1 (Nov. 17, 2015) [hereinafter *TexPEP Policy Brief*] (finding that in the wake of Texas’ passage of H.B. 2, one of the most restrictive abortion laws in the country, there has been an increase in the use of self-induction abortion through medication). See also Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014), <https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/>.

pregnancies safely, at low cost, in the comfort of their homes, and without the threat of detention by immigration enforcement.¹⁰⁷ A study published last year found that in 2013 after the Texas legislature passed the controversial state law, H.B. 2, which shuttered thirty of the state's forty-eight abortion clinics, somewhere between 100,000 and 240,000 women of reproductive age living in Texas tried to end their pregnancy entirely on their own, without any medical assistance.¹⁰⁸ Against the backdrop of immigration enforcement, the home features as a classic refuge from state surveillance, as described in the privacy case law related to Fourth and Fifth Amendment protections.

There is a significant privacy interest for pregnant people to choose medication abortion at home for purposes of ensuring privacy's elements of secrecy, anonymity, and solitude against intrusion by non-governmental third parties. For example, at-home use of medication abortion protects pregnant people against third party surveillance by anti-abortion activists. Permitting an individual to take medication to end their own pregnancy in the privacy of their home spares them the aggressive harassment and public shaming that occurs when a pregnant person attempts to enter an abortion facility in many cities.¹⁰⁹ In this way, the home serves its traditional function in privacy case law, of shielding individuals from intrusion by third parties. Further, new technology called "geo-fencing" has allowed anti-abortion groups to use mobile phone surveillance techniques to identify "abortion-minded women" via their cell phone's

107. Hellerstein, *supra* note 106.

108. TexPEP Policy Brief, *supra* note 106, at 2.

109. See generally DAVID S. COHEN & KRISTEN CANNON, *LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM* (2015). For descriptions by the Supreme Court of aggressive tactics used by anti-abortion protesters at clinics, see *McCullen v. Coakley*, 134 S. Ct. 2518, 2527 (2014) (describing protesters "who express their moral or religious opposition to abortion through sign and chants or, in some cases, more aggressive methods such as face-to-face confrontation"); *Hill v. Colorado*, 530 U.S. 703, 708 (2000) (describing demonstrations in front of abortion clinics that impeded access to the clinics and were often confrontational and included counselors who sometimes used strong and abusive language in face-to-face encounters); *Schenck v. Pro-Choice Network of Western New York*, 519 U.S. 357, 358 (1997) (invalidating the use of "floating buffer zones"); *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 772 (1994) (upholding thirty-six-foot buffer zone around clinic entrances and driveways); see also Brief for Planned Parenthood League of Massachusetts & Planned Parenthood Federation of America as Amici Curiae Supporting Respondents at 1, *McCullen v. Coakley*, 2014 WL 2882079 (2014) (No. 12-1168) (describing "thirty years of violent protests and patient harassment" at abortion clinics including the murder of two clinic employees).

proximity to an abortion clinic. The technology allows anti-abortion groups to collect data on persons at abortion clinics and to send anti-abortion propaganda directly to their cell phones as they sit in abortion clinic waiting rooms.¹¹⁰ The technology also has the ability to collect data from cell phones such as the names and addresses of persons seeking abortion-related healthcare if they have visited a clinic.¹¹¹ While it is beyond the scope of this project, it is important to note that this type of surveillance and data collection violates individuals' privacy over the flow of information as a common law right against third parties in tort for public disclosure of private facts.¹¹² This type of surveillance by non-governmental actors is largely unregulated and is only possible when a pregnant person enters an abortion clinic. As these examples highlight, the home thus serves its traditional function as a shield that protects pregnant people accessing abortion-related healthcare from surveillance and harassment by anti-abortion protesters, either in person or through electronic surveillance.

For pregnant people in abusive relationships, home-based abortion care may offer the safety and privacy necessary to protect them from further violence. The Supreme Court recognized the relationship between abortion and domestic violence in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹¹³ The *Casey* opinion struck down Pennsylvania's spousal consent requirement for abortion based on the findings that such notification would expose battered partners to further abuse.¹¹⁴

110. Sharona Coutts, *Anti-Choice Groups Use Smartphone Surveillance to Target "Abortion-Minded Women" During Clinic Visits*, REWIRE (May 25, 2016), <https://rewire.news/article/2016/05/25/anti-choice-groups-deploy-smartphone-surveillance-target-abortion-minded-women-clinic-visits/>.

111. *Id.*

112. See William Prosser, *Privacy*, 48 CALIF. L. REV. 383, 389 (1960). Jerry Kang has identified this type of privacy as "an individual's claim to control the terms under which personal information — information identifiable to the individual — is acquired, disclosed, and used." Jerry Kang, *Information Privacy in Cyberspace Transactions*, 50 STAN. L. REV. 1193, 1205 (1998). Much scholarship has addressed concerns with this type of data collection and the ability of individuals to control the flow of information about themselves with respect to information technology and cyberspace. See generally FRED H. CATE, *PRIVACY IN THE INFORMATION AGE* (1997); OSCAR H. GANDY, JR., *THE PANOPTIC SORT: A POLITICAL ECONOMY OF PERSONAL INFORMATION* (1993); PRISCILLA M. REGAN, *LEGISLATING PRIVACY: TECHNOLOGY, SOCIAL VALUES, AND PUBLIC POLICY* (1995).

113. 505 U.S. 833 (1992).

114. *Id.* at 892–93.

Violence by intimate partners increases in pregnancy both in frequency and in intensity.¹¹⁵ The *Casey* Court noted that, “[m]ere notification of pregnancy is frequently a flashpoint for battering and violence within the family.”¹¹⁶ The *Casey* Court concluded:

[T]he District Court’s findings reinforce what common sense would suggest. . . . [T]here are millions of women in this country who are the victims of regular physical and psychological abuse at the hands of their husbands. Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion.¹¹⁷

In light of the risk of violence associated with pregnancy and abortion, it is often critical for pregnant people in abusive relationships who seek abortions to find a way to end their own pregnancies. Abortion self-induction mimics miscarriage and is undetectable when the pills are taken orally.¹¹⁸ Clinic-based abortion care often requires taking time off work to go to clinics, this is especially true in those states where taking the two pills for medication abortion requires two separate trips to the abortion

115. Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 INT’L J. WOMEN’S HEALTH 183 (2010); Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 J. AM. MED. ASS’N 667, 672 (1996); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006). Indeed, in the United States, homicide is the leading cause of death among pregnant women. Jeani Chang et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999*, 95 AM. J. PUB. HEALTH 471, 473 (2005). A survivor of domestic violence who is forced to carry the pregnancy to term is less able to leave the abusive relationship because abusers often use threats of abuse against children as a means of coercion and control and the birth of children is more likely to make mothers economically dependent on their abusers. See Brief for Experts and Organizations Supporting Survivors of Intimate Partner Violence as Amici Curiae Supporting Petitioners at 15–20, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) [hereinafter *Intimate Partner Violence Amicus Brief*].

116. *Casey*, 505 U.S. at 889. As the *Casey* Court recognized, “Many may fear devastating forms of psychological abuse from their husbands, including verbal harassment, threats of future violence, the destruction of possessions, physical confinement to the home, the withdrawal of financial support, or the disclosure of the abortion to family and friends.” *Id.* at 893; see also *id.* at 889 (noting the district court findings that abusive partners may “threaten to (a) publicize her intent to have an abortion to family, friends or acquaintances; (b) retaliate against her in future child custody or divorce proceedings; (c) inflict psychological intimidation or emotional harm upon her, her children or other persons; (d) inflict bodily harm on other persons such as children, family members or other loved ones; or (e) use his control over finances to deprive of necessary monies for herself or her children”).

117. 505 U.S. at 892–93.

118. Kulier et al., *supra* note 40.

clinic on two different days, often at long distance.¹¹⁹ When survivors of domestic violence are required to take pills in clinics; they run the risk of being seen entering a clinic; this is especially true because a common aspect of the coercion and control cycle of domestic violence involves abusive partners monitoring the movements of their victims.¹²⁰ Abortion at home may offer safety and privacy for abused pregnant people to end their own pregnancies without giving notice to abusive partners.

B. MEDICATION ABORTION AND PRIVACY OF DECISIONAL AUTONOMY

Privacy's second broad category is decisional autonomy which has been recognized in a series of cases, from *Eisenstadt v. Baird*¹²¹ to *Roe v. Wade*¹²² and its progeny. The *Eisenstadt* case extended the right of unmarried people to access contraception. The Court articulated the right by saying, "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."¹²³ In 1973 the Supreme Court in *Roe v. Wade* recognized that the right of privacy as decisional autonomy extended to encompass the abortion decision. There, the Court held that, "This right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."¹²⁴ Justice Stevens, in *Whalen v. Roe*, expressed the

119. Justice Sotomayor raised this issue during questioning at oral argument in *Whole Woman's Health*. See *supra* notes 48–51 and accompanying text.

120. Intimate partner violence involves coercion and control, and violence is just one way that abusive partners use to exert control. As the amici experts in intimate partner violence in *Whole Woman's Health* explain, these tactics of coercive control also involve isolating the abused person from family and friends and monitoring her whereabouts and relationships by "track[ing] their use of transportation, and catalog[ing] their time spent out of the home." Intimate Partner Violence Amicus Brief, *supra* note 115, at 7–8 (citing Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 S.M.U. L. REV. 2117, 2126–27 (1993); LEIGH GOODMARK, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 42 (2011)).

121. 405 U.S. 438 (1972).

122. 410 U.S. 113 (1973).

123. *Eisenstadt*, 405 U.S. at 453.

124. *Roe*, 410 U.S. at 153. The Court framed the decisional right as the right to decide to terminate a pregnancy in consultation with a "responsible physician." *Id.* This conceptualization has been widely criticized for subordinating the constitutional rights of pregnant people to the judgment of their doctors. See Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L. Q. 183, 197–201 (1985); Reva B. Siegel, *Roe's*

privacy right in abortion cases as an “interest in independence in making certain kinds of important decisions.”¹²⁵

Laws that restrict at-home use of medication abortion necessarily limit the right of pregnant people to make choices about the care they will receive. While abortion opponents may argue that the doctor requirement does not restrict abortion itself, only the way that abortion-related healthcare is delivered, this argument fails to recognize that decisions over medical care are at the heart of decisional autonomy. For example, Justice Blackmun’s concurring opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹²⁶ identified abortion as a right of reproductive choice, stating: “Just as the Due Process Clause protects the deeply personal decision of the individual to *refuse* medical treatment, it also must protect the deeply personal decision to *obtain* medical treatment, including a woman’s decision to terminate a pregnancy.”¹²⁷ In his concurring opinion in *Roe v. Wade*, Justice Douglas argued that abortion was a right of health that was related to privacy, describing the medical privacy right as “the right to care for one’s health and person and to seek out a physician of one’s own choice.”¹²⁸ His concurrence identified abortion specifically as a right of privacy related to healthcare, rather than as a right of privacy related to procreation, marriage, and childrearing.¹²⁹ He described this right of healthcare by stating, “The right to seek advice on one’s health and the right to place reliance on the physician of one’s choice are basic to Fourteenth Amendment values.”¹³⁰ He argued in *Roe* that the term “liberty” in the Fourteenth Amendment included “the freedom to care for one’s health and person, freedom from bodily restraint or compulsion, freedom to walk or stroll or loaf.”¹³¹ This

Roots: The Women’s Rights Claims That Engendered Roe, 90 B.U. L. REV. 1875, 1879 (2010) (arguing that *Roe v. Wade* gave only “confused expression” to women as constitutional rights holders in the abortion decision and gave greater protection to doctors’ rights to make medical decisions than to women’s rights to control reproduction); Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–79 (1992); see also Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–1200 (1992).

125. 429 U.S. 589, 599–600 (1977).

126. 505 U.S. 833 (1992).

127. *Id.* at 928 n.3 (Blackmun, J. concurring).

128. *Roe*, 410 U.S. at 219 (Douglas, J. concurring).

129. *Id.*

130. *Id.* at 219–20.

131. *Id.* at 213 (emphasis omitted).

characterization of the abortion right highlights that the ability to make healthcare decisions about abortion, like the decision to end one's own pregnancy at home, is integral to the right of decisional autonomy. Prohibitions on the use of medication abortion within the home through the doctor requirement infringe on the liberty and autonomy of reproductive decision-making that the Court has recognized at the core of the Fourteenth Amendment.¹³²

For many pregnant people, self-directed abortion care may be an expression of values and belief systems and reflects notions of autonomy and liberty that go beyond mere healthcare.¹³³ Researchers have found that many pregnant people prefer medication abortion in the privacy of their homes over clinic-based care because they view it as more natural to expel the product of conception by miscarriage than through surgery.¹³⁴ Further, many prefer medication abortion at home because it offers greater privacy than a clinical setting.¹³⁵ A review of twelve published studies on patient attitudes and reactions to early first-trimester pregnancy termination by medication showed consistently that when given a choice between medication and surgical abortion, sixty to seventy percent of patients chose the medication method.¹³⁶ The most common reasons cited for choosing medication over surgery were greater privacy and autonomy, less invasiveness, and greater naturalness than surgery.¹³⁷ Thus, the decision to self-induce abortion, inside or outside of the healthcare context, may express deeply held values and beliefs about health, nature, feminist values, or religion.¹³⁸

132. See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) (“Our law affords constitutional protection to personal decision relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.” (citations omitted)).

133. Greenhouse & Siegel, *supra* note 58, at 14.

134. Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, in *REPRODUCTIVE HEALTH MATTERS* 142, 142 (2010); Gomperts et al., *supra* note 21, at 1173; Beverly Winikoff et al., *Acceptability of Medical Abortion in Early Pregnancy*, 27 *FAMILY PLANNING PERSPS.* 142, 142–48 (1995).

135. Gomperts et al., *supra* note 21, at 1171; Grossman et al., *supra* note 134, at 142; Winikoff et al., *supra* note 134, at 142–48.

136. Gomperts et al., *supra* note 21, at 1173 (noting that studies have shown that a majority of women prefer at-home use of medication to clinic-based care); Grossman, *Telemedicine*, *supra* note 85, at 296–303.

137. *Id.*

138. This argument has been set forth in the context of home birth but in many ways parallels to at-home abortion. See Cohen, *supra* note 6, at 855 (describing that childbirth

Medication abortion at home should be understood as more than simply a medical decision or personal preference. The decision to end a pregnancy at-home through use of medication engages the very values expressed by the *Casey* Court in its description of abortion as a protected part of the fundamental right of privacy: “These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”¹³⁹ The decision to exercise reproductive autonomy within the privacy of the home relates to bodily integrity and the right to exercise autonomy within the sacred precinct of the home.¹⁴⁰ Abortion self-induction in the home involves reproductive autonomy which the Supreme Court has deemed as a protected interest under the Fourteenth Amendment.¹⁴¹ Indeed, the Court has described reproductive autonomy as being integral to the very core of human identity.¹⁴²

C. MEDICATION ABORTION AND PRIVACY OF INTIMATE ASSOCIATION

Finally, the right of privacy has been recognized to include privacy of intimate relationships. Most notably, the decisions in *Griswold v. Connecticut*¹⁴³ and *Lawrence v. Texas*¹⁴⁴ drew upon the privacy case law related to protection of the physical boundaries of the home, and extended it to emphasize that it is not merely the physical confines of the home, but the deeply personal activities that occur within the home, that are protected by the right of privacy. The *Griswold* Court relied upon privacy

choice expresses deeply held beliefs and values); Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 549 (1994) (“[E]fforts to employ this alternative approach [of home birth] can be seen as acts of resistance to the dominant order, acts informed by an alternative set of understandings of the world that medicine purports to know.”).

139. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992).

140. There is a growing recognition of the importance of self-directed care at home in many contexts. *See supra* notes 76–77 and accompanying text.

141. *See supra* notes 121–26 and accompanying text.

142. *Casey*, 505 U.S. at 851 (“These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.”).

143. 381 U.S. 479, 485–86 (1965) (holding unconstitutional a portion of a Connecticut statute that prohibited the *use* of contraceptives).

144. 539 U.S. 558 (2003).

cases that related to physical zones of privacy in the Third, Fourth, and First Amendments to conclude that the guarantees in the Bill of Rights “have penumbras, formed by emanations from those guarantees that help give them life and substance.”¹⁴⁵ This substantive right of privacy overlaps with both spatial privacy of the marital bedroom and substantive privacy in reproductive decisions that take place within intimate relationships. The *Griswold* decision addressed the intrusion into the physical confines of the home, specifically the marital bedroom, but also the “privacy surrounding the marriage relationship.”¹⁴⁶ The Court stated that the case involved “a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the *use* of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship.”¹⁴⁷

The *Lawrence* Court, like the *Griswold* Court, expanded the right of privacy of physical space within the home to include the private activities and relationships that take place and find refuge in the home. The *Lawrence* Court described the right of intimate association as:

Liberty protects the person from unwarranted government intrusions into a dwelling or other private places. In our tradition, the State is not omnipresent in the home. And there are other spheres of our lives and existence, outside the home, where the State should not be a dominant presence. Freedom extends beyond spatial bounds. Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct. The instant case involves liberty of the person both in its spatial and in its more transcendent dimensions.¹⁴⁸

145. *Griswold*, 381 U.S. at 484.

146. *Id.* at 485–86.

147. *Id.* at 485.

148. 539 U.S. 558, 562 (2003).

Thus, under the Supreme Court's privacy analysis, the home has become a sanctuary for the exercise of the most personal rights related to humanity¹⁴⁹ and dignity.¹⁵⁰

The doctor requirement is a governmental intrusion into intimate personal activity that makes it incongruous with privacy of intimate association. Medication abortion at home allows a pregnant person to end a pregnancy in the comfort of home, surrounded by family and support of friends, rather than in a clinical setting.¹⁵¹ Others may choose a medical abortion at home because it offers privacy and solitude that is not available in a clinical setting. Thus, it is important to recognize that privacy interest at stake in medication abortion at home may involve matters of personal significance related to procreation within the context of the home as a location of intimacy and support that goes beyond merely a location for healthcare delivery.¹⁵²

III. THE DOCTOR REQUIREMENT AND THE LIMITATIONS OF PRIVACY

While medication abortion at-home falls within privacy's traditional analysis as a zonal, relational, and decisional right, this section argues that privacy is inadequate to encompass the interests at stake in medication abortion at home. As the foregoing discussion reveals, a myriad of economic, political, and social forces influence a pregnant person to choose medication abortion at home. The forces that push people toward ending their own pregnancies at home include poverty, inaccessibility of

149. Kenneth Karst has written on the privacy right of intimate association that flows from the First Amendment. Kenneth L. Karst, *The Freedom of Intimate Association*, 89 YALE L.J. 624, 692 (1980) ("The freedom to choose our intimates and to govern our day-to-day relations with them . . . is the foundation for the one responsibility among all others that most clearly defines our humanity.").

150. See, e.g., *Poe v. Ullman*, 367 U.S. 497, 551 (1961) (Harlan, J., dissenting) ("[H]ere we have not an intrusion into the home so much as on the life which characteristically has its place in the home.").

151. See Patel Amicus Brief, *supra* note 16, at 14; see also Grossman et al., *supra* note 134, at 142.

152. For the parallels between home-birth and abortion at-home, see Cohen, *supra* note 6, at 868–77; McCormick, *supra* note 6, at 682–93. Personal empowerment and autonomy are values that have long animated the practice of reproductive self-care in a variety of contexts from home birth to at-home miscarriage management. See Patel Amicus Brief, *supra* note 16, at 14 (citing Josee Lafrance & Lyne Mailhot, *Empowerment: A Concept Well-Suited for Midwifery*, 4 CAN. J. MIDWIFERY RES. & PRAC. 2 (2005)); Yvonne Lindgren, *From Rights to Dignity: Drawing Lessons from the Movements for Aid in Dying and Reproductive Rights*, 5 UTAH L. REV. 779 (2016).

clinics and waiting periods, immigration policy, family violence, and failure to protect against and police clinic harassment, to name only a few. As I will describe in this section, the doctor requirement reveals that public, private, and state-sponsored harm are imposed on pregnant people ending their pregnancies at home that are not adequately captured or conceptualized in privacy's conceptual framework of individuals exercising rights in the privacy of the home. Identifying medication abortion at home as a right of privacy fails to acknowledge the ways in which third party and state actions and policies come to bear upon—and ultimately circumscribe—the ability of individuals to make reproductive decisions in the home. In other words, privacy law's traditional analysis fails to acknowledge the myriad of political, economic, and social systems that influence and effect decision-making in this context.

Privacy jurisprudence reinforces a liberal notion of what has been described as the “atomistic man,” or the conceptual framework that views individuals as separate, atomistic individuals competing for legal rights rather than recognizing individuals as interconnected, dependent, and existing within a community.¹⁵³ The Court in *Stanley v. Georgia* described that right of privacy in relation to the “man sitting alone in his house.”¹⁵⁴ This idealized liberal notion of the individual embodies a distinctively masculine perspective that fails to account for the lived experiences of women whose lives are often marked by interdependence, caregiving, connection, and responsibility.¹⁵⁵ As the preceding section highlighted, rather than “atomistic” individuals exercising rights in the privacy of their homes, pregnant people who choose medication abortion may be individuals whose choices are necessarily affected by where they are situated within social, political, and economic systems. Poverty, immigration status, and violence in the home are but a

153. See Linda C. McClain, “Atomistic Man” Revisited: *Liberalism, Connection, and Feminist Jurisprudence*, 65 S. CAL. L. REV. 1171, 1174–76 (1992).

154. In *Stanley v. Georgia*, Justice Marshall wrote, of the “fundamental right” to be free from governmental intrusions into the privacy of the bedroom: “If the First Amendment means anything, it means that a State has no business telling a man, sitting alone in his own house, what books he may read or what films he may watch.” 394 U.S. 557, 565 (1969).

155. McClain, *supra* note 153, at 1174; see also CAROL GILLIGAN, IN A DIFFERENT VOICE 87–89 (1982); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 21 (1988).

few of the factors that may push pregnant people toward medication abortion at home. In light of these realities, the privacy analysis fails to recognize the ways that public forces impact private decision-making.

A central focus of feminist theorizing has been to critique the right of privacy, especially as it has been conceptualized as a zone free from governmental regulation.¹⁵⁶ The liberal conception of the constitutional protection of personal or family privacy—often centered within the home—fails to take into account that the home is a realm in which women have unequal power and are physically vulnerable.¹⁵⁷ For example, familial privacy has historically been used as a rationale to shield the private abuse of domestic violence from public scrutiny and prosecution.¹⁵⁸ Courts and police agencies often refused to arrest and prosecute batterers because of their reluctance to intrude upon the privacy of the home and family.¹⁵⁹ Thus, the private sphere of the home free of unwanted governmental and community interference must be understood in the context of social and sexual inequality.¹⁶⁰ As scholar Anita Allen has argued, the liberal conception of the private realm free of state interference “undervalues private inequality and overstates individual agency.”¹⁶¹

156. Carole Pateman, *Feminist Critiques of the Public/Private Dichotomy*, in PUBLIC AND PRIVATE IN SOCIAL LIFE 281, 281 (Stanley I. Benn & Gerald F. Gaus eds., 1983) (“The dichotomy between the private and the public is central to almost two centuries of feminist writing and political struggle; it is, ultimately, what the feminist movement is about.”); Tracey E. Higgins, *Reviving the Public/Private Distinction in Feminist Theorizing*, 75 CHI.-KENT L. REV. 847, 847–48 (2000) (explaining that attacking the public/private line has been one of the primary concerns of feminist theorizing for over two decades).

157. See, e.g., ROBIN WEST, PROGRESSIVE CONSTITUTIONALISM: RECONSTRUCTING THE FOURTEENTH AMENDMENT 119 (1994); Catherine A. MacKinnon, *Reflections on Sex Equality Under the Law*, 100 YALE L.J. 1281, 1311 (1991) (“[T]he law’s privacy is a sphere of sanctified isolation, impunity, and unaccountability.”).

158. See, e.g., WEST, *supra* note 157, at 119 (“[I]f patriarchal control of women’s choices and patriarchal domination of women’s inner and public lives occur in the very private realm of home life[,] then the Constitution, above all else, protects the very system of power and control that constrains us.”); MacKinnon, *supra* note 157, at 1318.

159. See, e.g., Reva B. Siegel, “*The Rule of Love*”: *Wife Beating as Prerogative and Privacy*, 105 YALE L.J. 2117, 2154–61 (1996).

160. See, e.g., ANITA L. ALLEN, UNEASY ACCESS: PRIVACY FOR WOMEN IN A FREE SOCIETY 54–56 (1988); CATHARINE A. MACKINNON, *Privacy v. Equality: Beyond Roe v. Wade*, in FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW 101–02 (1987); Nadine Taub & Elizabeth M. Schneider, *Women’s Subordination and the Role of Law*, in THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE 328–55 (David Kairys ed., 3d ed. 1990); Kathryn Abrams, *From Autonomy to Agency: Feminist Perspectives on Self-Direction*, 40 WM. & MARY L. REV. 805, 813–23 (1999).

161. Higgins, *supra* note 156, at 851.

Similarly, it is critical to understand the privacy interest in medication abortion within the context of social and sexual inequality. Pregnant people do not come to the abortion decision with a full range of rights and privileges. Rather, they turn towards medication abortion because of systems of oppression, both private, such as intimate partner violence, as well as public, in the case of immigration surveillance, clinic harassment, and the cost and distance involved in accessing clinic-based abortion care. The unique burdens placed on individuals seeking to end their pregnancies because they are living in poverty, undocumented, living in rural areas far from an abortion clinic, or living in abusive relationships, are not captured by the privacy analysis. Scholar and activist Jael Silliman has described that

conception of choice is rooted in the neoliberal tradition that locates individual rights at its core, and treats the individual's control over her body as central to liberty and freedom. This emphasis on individual choice, however, obscures the social context in which individuals make choices, and discounts the ways in which the state regulates populations, disciplines individual bodies, and exercises control over sexuality, gender, and reproduction.¹⁶²

Therefore, despite the fact that medication abortion technically falls within the four corners of privacy's doctrine, it is critical to acknowledge the political, social, and economic forces at play in private decision-making that takes place within the home.

Private violence, third party surveillance and harassment, and governmental regulation all work in tandem to influence decision-making in the context of medication abortion at home. These structural systems and their influence on private decision-making are not accounted for by privacy's analysis, which conceptualizes the right in necessarily individualistic, isolated terms. Professor Kendall Thomas has described the combination

162. Jael Silliman, *Introduction*, in *POLICING THE NATIONAL BODY* x–xi (Jael Silliman & Anannya Bhattacharjee eds., 2002). The movement for reproductive justice contextualizes decision-making to consider how lack of social support, access to healthcare, poverty, race, disability, age and rural location, for example, affect decision-making. For more information on “reproductive justice,” see *Reproductive Justice Virtual Library*, CTR. ON REPROD. RTS. & JUST., <https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/library.php> (last visited Apr. 11, 2017). See generally Silliman et al., *supra* note 14; ASIAN COMMUNITIES FOR REPROD. JUSTICE, *A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS, AND REPRODUCTIVE JUSTICE* (2005); SISTERSONG WOMEN OF COLOR REPROD. HEALTH COLLECTIVE, *REPRODUCTIVE JUSTICE BRIEFING BOOK* (2007).

of social interests and forces at work that bear upon constitutional rights as “body politics” that exist beyond the narrow conceptualization of privacy.¹⁶³ He uses the term body in its corporeal sense, as the actual harm wrought upon the physical bodies of individuals as a result of public and private harm, violence, and governmental complicity that is not captured by the traditional privacy framework.¹⁶⁴ He argues that privacy’s narrow articulation fails to acknowledge or account for the public and private practices that affect access to constitutional rights. He describes that, “This constellation of prohibitive practices . . . enlists the unauthorized, unofficial, disciplinary powers of private actors *and* the authorized, official police power of state institutions Given this complexity, the question becomes whether the factual predicates of the issues presented in *Hardwick* can be cleanly or comprehensively contained within the constitutional category of privacy.”¹⁶⁵

Similarly, privacy in the context of medication abortion fails to account for the myriad of state and private forces that bear upon decision-making and autonomy in the realm of the home. For example, as described above, intimate partner violence may drive some pregnant people to medication abortion at home to avoid detection by abusive partners for ending a pregnancy. Pregnancy is a common flashpoint for intimate partner violence and abusers frequently restrict access to reproductive care and contraception to coerce and control their victims.¹⁶⁶ In this context, the private violence of intimate partners would cast serious doubt as to whether a pregnant person has true access to either decisional autonomy or privacy in its traditional sense when considering whether medication abortion at home falls within privacy’s legal boundaries. As described in Professor Thomas’ work, it may be argued that private violence and state complicity in violence in the home through lack of enforcement form part of the body politic that influences decisional autonomy in the home, but is not recognized in the narrow conscripts of the right of

163. Thomas, *supra* note 9, at 1435–36; *see also id.* at 1461–62. Professor Thomas’ work considers the limits of the privacy analysis in *Bowers v. Hardwick*, arguing that the privacy analysis fails to acknowledge the role that sodomy laws play in encouraging private homophobic violence and governmental complicity in violence toward the LGBTQ community.

164. *Id.* at 1436.

165. *Id.* at 1441 (emphasis added).

166. *See supra* notes 113–21 and accompanying text.

privacy. Privacy fails to acknowledge the public aspect of abortion access and fails to address the necessity of a governmental commitment to the right. Instead, situating medication in the home in terms of a right of privacy fails to acknowledge the ways that economic, political, and social systems bear upon medication abortion in the home.

In addition to intimate partner violence, the privacy analysis also fails to account for the ways in which public actors such as clinic protestors, and State policies that restrict access to clinics, require waiting periods and long travel, are integral to—or should be integral to—the privacy analysis. The doctor requirement restricts pregnant people’s access to care in the privacy and protection of their homes and forces them into a public setting of a clinic. In addition to the impact on the dignity and decisional autonomy of all pregnant people who are denied access to medication abortion at home, the doctor requirement subjects those who are most vulnerable to the potential of increased risk of private violence, public harassment and surveillance, and state surveillance and detention. Limiting the analysis to privacy of the home limits the analysis of the public and private implications of the doctor requirement. In short, the limited nature of the privacy analysis fails to acknowledge the public dimensions and the private harm of the doctor requirement.

CONCLUSION

Medication abortion at-home falls squarely within zonal, relational, and decisional privacy. Common law privacy protects the home as a sanctuary of solitude and repose free of intrusions by third parties. Constitutional privacy law protects the home as a location free of governmental surveillance and intrusion. Further, the Court has recognized the right of privacy to encompass more than merely spatial privacy within the physical confines of the home. Rather, the Court has held that the privacy right encompasses deeply personal decisions related to marriage, child rearing, reproduction and intimacy of relationships. Medication abortion, both inside and outside of the clinical context, engages the right of pregnant persons to protections against third party and governmental surveillance within the privacy of the home as well as protection of pregnant people’s liberty and autonomy to exercise reproductive decision-making. In the context of medication abortion at home, the home

functions in the traditional way set forth in privacy jurisprudence, as a shield against state surveillance and as a location of solitude and repose, especially for marginalized communities. People living in poverty, in rural areas, of color, or with compromised immigration status may be more likely to turn to self-induction abortion outside of the formal healthcare system because of fears of immigration surveillance, structural barriers such as cost, distance of clinics, and waiting periods. The higher rate of abortion self-induction among these marginalized groups leaves them open to greater surveillance and therefore in greater need of the protection of the home as a shield against state and third party surveillance.

More broadly, however, analyzing medication abortion within privacy law's framework of zonal, decisional, and relational privacy highlights the limitations of the privacy analysis in this context. The Court's conceptualization of an individualized privacy right, or what has been described as the "atomistic man," fails to account for social, political, and economic forces that work in tandem to deprive pregnant people of meaningful privacy in the home. Much feminist scholarship has criticized privacy as a legal concept and questioned whether privacy is a right that is available to women. The doctor requirement suggests that privacy continues to be elusive and largely unavailable to pregnant people. Rather, while privacy case law has centered the home as a zone free from governmental intrusion, for pregnant people the home has become a site of increasing regulation in the benign guise of protecting women's health.