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Authors
Eichner, Maxine
Buchbinder, Mara
Schultz, Abby
et al.

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The Inevitable Vagueness of Medical Exceptions to Abortion Bans

Maxine Eichner,* Mara Buchbinder,** Abby Schultz,*** Cambray Smith,**** & Amy G. Bryant*****

In the aftermath of the 2022 U.S. Supreme Court ruling in Dobbs v. Jackson Women's Health Organization *removing federal constitutional protection for abortion, twenty states currently significantly restrict access to abortion. These state laws all include exceptions for the life of the pregnant person; most also exempt significant impairments to the pregnant patient's health. Despite these exceptions, repeated accounts in the press and in court cases have shown pregnant patients in significant medical need being denied abortion care, resulting in serious injuries and, in some cases, death. The reasons for this denial of care, though, are disputed. Physicians have contended that the language of medical exceptions is so unclear that they are difficult to apply. Meanwhile, legislators who favor strict restrictions have blamed attending doctors for failing to apply what they say are clear exceptions, either because of negligence or because physicians are seeking to discredit restrictive regulations.*

This Article explores the controversy over application of medical exceptions through analyzing the results of a new empirical study involving in-depth, qualitative interviews with maternal fetal medicine physicians providing patient-facing care post Dobbs. *Physicians' responses in these interviews, we demonstrate, pinpoint recurring gaps between the ways that physicians make abortion decisions in standard medical practice and the language of medical exceptions. These create uncertainty regarding whether, among other issues, the level of risk to life or health experienced by the patient rises to the threshold required by state law, and whether and when the patient's medical risk meets the exception's requirements regarding timing of the abortion. The disjuncture between medical practice and the statutory language physicians are expected to apply, we show, creates indecision regarding whether medical*

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* J.D., Ph.D., Graham Kenan Distinguished Professor of Law, UNC School of Law.
** Ph.D., Professor, Department of Social Medicine, UNC School of Medicine.
*** M.D., Assistant Professor, Department of Obstetrics and Gynecology, UNC School of Medicine.
**** Ph.D., M.D. Candidate, Department of Health Policy and Management, UNC School of Global Public Health and UNC School of Medicine.
***** M.D., M.S.C.R., Associate Professor, Department of Obstetrics and Gynecology, UNC School of Medicine. The authors thank members of the Reproductive Rights/Reproductive Justice Roundtable, as well as Kerry Abrams, Meghan Boone, Naomi Cahn, Greer Donley, Marie-Amélie George, Meredith Harbach, Jessie Hill, Heather Kolinsky, Laura Lane-Steele, Laura Matthews-Jolly, Gregg Strauss, and Katie Watson for helpful comments on earlier drafts. Special thanks to Casey Buttke, Carolyn Calder, Sarah Carver, Robert Fensom, and Ben Stroud for excellent research assistance.

exceptions will shield doctors from liability and severe penalties in most cases involving medical risk.

We then argue that physicians' uncertainties in applying medical exceptions implicate the constitutional "void-for-vagueness" doctrine. Under that doctrine, laws that do not allow those persons subject to them to determine whether their conduct is legal cannot be enforced. We contend that physicians' inability to determine whether and when existing medical exceptions apply in the cases presented to them requires that courts strike down abortion restrictions. Finally, although we believe that pregnancy is too complicated to allow abortion to be regulated in a manner that adequately protects the lives and health of pregnant patients in all cases, we offer an example of a "least-vague" medical exception that would provide better guidance to physicians about when abortions for medical reasons are lawful. Such an exception, we believe, would clear the void-for-vagueness bar.

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INTRODUCTION

In August 2022, Amanda Zurawski of Texas, eighteen weeks pregnant after a year and a half of fertility treatments, was dismayed when her water broke.[1] Her physician told her it was too early for the baby to survive. But although she was at high risk for a life-threatening infection, physicians refused to terminate the pregnancy because the fetus still had a heartbeat. They sent her home instead. Zurawski and her husband contemplated leaving the state to get an abortion but remained home, fearing that a fast-developing infection could kill her during the eight-hour drive. Three days later, Zurawski's temperature spiked and physicians finally decided an abortion was warranted. By then, though, she was so sick that antibiotics wouldn't stop the infection. After her infection became life-threatening, she was admitted to the intensive care unit where her blood pressure plummeted. Physicians finally managed to stabilize her condition, but her uterus was so scarred that, even after surgery, it is unclear if she can have more children.[2]

That same month, Nancy Davis, a Louisiana resident who was ten weeks pregnant, was denied an abortion at her local hospital.[3] Davis's doctors had diagnosed her fetus with acrania, a rare, lethal disorder in which the fetus develops without a complete skull, and which results in miscarriage, stillbirth, or a very short lifespan if the child is born. Yet, despite an exception for medical futility in Louisiana's abortion ban, the hospital refused to perform an abortion. Instead, Davis said, doctors told her she would have to "carry [her] baby to bury [her] baby."[4] She ultimately traveled to New York to obtain an abortion.[5] The Louisiana hospital that had denied Davis care, in response to press inquiries, stated that navigating medical exceptions to state abortion laws is "extremely complex" for hospitals who seek to ensure physicians are safe from prosecution.[6]

Zurawski and Davis are two of the many cases in which pregnant patients experiencing medical problems were refused care in states that have restricted abortions before viability since the Supreme Court issued *Dobbs v. Jackson Women's*

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1. *See* Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN (June 20, 2023, 7:17 AM), https://www.cnn.com/2022/11/16/health/abortion-texas-sepsis/index.html [perma.cc/W6LN-6NSV].

2. *Id.* Similarly, Kyleigh Thurman of Texas presented with all of the symptoms of an ectopic pregnancy but was sent home from her local hospital repeatedly. She eventually had to undergo emergency surgery and lost part of her reproductive system. Amanda Seitz, *Texas Hospital That Discharged Woman with Doomed Pregnancy Violated the Law, A Federal Inquiry Finds*, AP (June 4, 2025, 12:22 PM), https://apnews.com/article/abortion-texas-hospital-doomed-pregnancy-discharge-308ea695a17f72500cbf31622fdb521a [perma.cc/E69C-JHJU].

3. *See* Nadine El-Bawab, *"I Had to Carry My Baby to Bury My Baby": Woman Says She Was Denied Abortion for Fetus Without Skull*, ABC NEWS (Aug. 26, 2022, 4:49 PM), https://abcnews.go.com/US/carry-baby-bury-baby-woman-denied-abortion-fetus/story?id=88890813 [perma.cc/S2PJ-NQ6G].

4. *Id.*

5. Lola Fadulu, *New York City Welcomes Growing Number of Out-of-State Abortion Patients*, N.Y. TIMES (Apr. 12, 2023), https://www.nytimes.com/2023/04/12/nyregion/abortions-out-of-state-nyc.html [perma.cc/EXF3-A7VH].

6. Amanda Musa, *Louisiana Woman Claims She Was Denied an Abortion After Fetus Was Diagnosed with a Fatal Condition*, CNN (Aug. 20, 2022, 12:09 AM), https://www.cnn.com/2022/08/20/us/louisiana-abortion-fatal-condition/index.html [perma.cc/XZD2-LBA4].

Health in June 2022.[7] In the aftermath of *Dobbs* reversing *Roe v. Wade*,[8] and declaring that the right to abortion is not protected by the U.S. Constitution, twenty states now ban or significantly restrict access to legal abortions before viability.[9] All these state statutes include exceptions for the life of the pregnant person.[10] Most also provide exceptions for significant impairments to the health of the pregnant person.[11] Although statutes regulating abortion in the *Roe* era also contained medical exceptions, those exceptions were generally less relevant because pregnant patients previability could obtain abortions as a matter of right.

Today, repeated accounts of pregnant patients denied abortion in cases of medical need in states with previability abortion bans have appeared in the press and in court cases.[12] In one Texas case, twenty women with medical complications who were denied abortions, including Amanda Zurawski, sued to seek clarification

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7. Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (overruling Roe v. Wade, 410 U.S. 113 (1973)).

8. *Roe*, 410 U.S. 113.

9. As of April 28, 2026, twenty states restrict abortion to before viability. Complete citations to all these statutes are listed in the Appendix. *See infra* Appendix. Thirteen states—Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia—have near total bans on abortion. *Id.* Another four—Florida, Georgia, Iowa, and South Carolina—have banned abortion after or about the first six weeks of pregnancy. *Id.* Two more—Nebraska and North Carolina—have banned abortion after twelve weeks of pregnancy. *Id.* Utah has banned abortion after eighteen weeks of pregnancy. *Id.* Three other states, until recently, had been on the list of restrictive states: Ohio banned abortion from when cardiac activity is detected, as early as six weeks of pregnancy. OHIO REV. CODE § 2919.195 (2023). Missouri banned abortion from conception. MO. REV. STAT. § 188.017(2) (2022). Arizona banned abortion after fifteen weeks of pregnancy. ARIZ. REV. STAT. § 36-2322(B) (2023). However, voters in Ohio's 2023 election voted to provide protection for abortion in their state's constitution. *See* OHIO CONST. art. 1, § 22 (effective Dec. 7, 2023); *see* Jo Ingles, *Ohio Votes in Favor of Amending the State Constitution to Enshrine Abortion Rights,* NPR (Nov. 7, 2023, 9:41), https://www.npr.org/2023/11/07/1209092670/2023-results-key-ohio-elections. A year later, voters in the 2024 elections chose to amend Missouri and Arizona's constitutions to do the same. *See* ARIZ. CONST. art. II, § 8.1 (effective Nov. 5, 2024); MO. CONST. amend. I, § 36 (effective Dec. 5, 2024); *see* Katherine Davis-Young, *Arizona Voters Pass Constitutional Amendment Guaranteeing Abortion Access*, NPR (Nov. 6, 2024, 4:20 AM), https://www.npr.org/2024/11/06/g-s1-32937/arizona-abortion-amendment-results [perma.cc/MF8Q-SMFT]; Anna Spoerre, *Missouri Voters Approve Amendment 3, Overturn State's Abortion Ban*, MO. INDEP. (Nov. 5, 2024, 10:37 PM), https://missouriindependent.com/2024/11/05/missouri-voters-overturn-states-near-total-abortion-ban [perma.cc/87LZ-KPHY].

10. *See infra* Appendix.

11. Those states include Alabama, Florida, Georgia, Indiana, Kentucky, Louisiana, Nebraska, North Carolina, North Dakota, South Carolina, Tennessee, Utah, and West Virginia. *See infra* Appendix. Texas's medical exception requires a "life-threatening physical condition" that "places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function ." TEX. HEALTH & SAFETY CODE ANN. § 170A.002 (b)(2) (West 2023). Read carefully, that language should properly be construed as a life-only exception. *Id.*

12. In an Oklahoma case, Jaci Statton sought treatment for her cancerous molar pregnancy from a nearby hospital. She was told by the staff to sit in the hospital parking lot until her condition worsened. "[W]e cannot touch you unless you are crashing in front of us or your blood pressure goes so high that you are fixing to have a heart attack." Selena Simmons-Duffin, *In Oklahoma, a Woman Was Told to Wait Until She's 'Crashing' for Abortion Care*, NPR (Apr. 25, 2023, 10:10 AM), https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals [perma.cc/E26Q-EDST].

of the law's exception for medical risks.[13] In Tennessee, seven women who were denied abortions, along with two physicians, brought suit to challenge the vagueness of the state's abortion ban.[14] In Idaho, four women sued claiming that they were denied medically necessary abortion care.[15] After initially accepting review of the case on the ground that it involved interpretation of the federal Emergency Medical Treatment and Labor Act (EMTALA), the U.S. Supreme Court dismissed review as improvidently granted, in part because the state had changed its position regarding whether abortions in particular circumstances were permitted by the state's medical exceptions.[16]

The pregnant patients described so far were more fortunate than others who experienced medical problems following the enactment of abortion restrictions. In September 2021—a few days after Texas passed its law banning abortion after six weeks of pregnancy[17]—Josseli Barnica died following physicians' refusal to treat her miscarriage. Barnica had been seventeen weeks pregnant when she began to miscarry. Because her fetus still had a heartbeat, doctors delayed treating her for forty hours, even though her cervix was so dilated that it left her vulnerable to fast-acting infections. Only after the fetal heartbeat stopped did a doctor intervene to administer abortion medication. A few days later, Barnica died of sepsis—a death that experts later deemed preventable.[18] Nevaeh Crain, a pregnant eighteen-year-old from Texas, also died from sepsis after making three trips to emergency rooms, waiting twenty hours before physicians agreed to admit her. During the second visit, she was diagnosed with sepsis, but physicians refused to treat her because her fetus still had a heartbeat. She was finally admitted at her third hospital visit, but physicians refused to treat her until two ultrasounds showed her fetus had died. In the meantime, according to reports, "sepsis had spread throughout her body and

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13. Plaintiffs' Original Petition for Declaratory Judgment & Application for Permanent Injunction at 1, Zurawski v. Texas, D-1-GN-23-000968 (Tex. Dist. Ct. Travis Cty. Mar. 6, 2023). In 2024, the Texas Supreme Court denied the challenge. State v. Zurawski, 690 S.W.3d 644 (Tex. 2024).

14. Plaintiffs' First Amended Complaint for Declaratory Judgment & Permanent Injunction at 2-4, Blackmon v. State, No. 23-1196-I (Chancery Court of Tenn. for the Twentieth Jud. Dist. Jan. 8, 2024); *see Blackmon v. State of Tennessee*, CTR. FOR REPROD. RTS. (Sept. 11, 2023), https://reproductiverights.org/case/emergency-exceptions-abortion-bans-idaho-tennessee-oklahoma/blackmon-v-state-of-tennessee [perma.cc/S3CW-CH4S]. A ruling from a Tennessee Chancery Court on Oct. 17, 2024, temporarily blocked civil but not criminal enforcement of the Tennessee law based on the vagueness of its medical exception, as well as included particular medical conditions within the medical exception. *See Ruling Temporarily Blocking Tennessee's Abortion Ban Means Doctors Can Treat Patients Facing Dangerous Pregnancy Complications*, CTR. FOR REPROD. RTS. (Oct. 18, 2024), https://reproductiverights.org/blackmon-v-tennessee-abortion-ban-temporarily-blocked [perma.cc/AJ2U-DGGF].

15. Complaint for Declaratory Judgment & Injunctive Relief, Adkins v. State, No. CV01-23-14744 (Dist. Ct. of the Fourth Jud. Dist. of Idaho Sep. 11, 2023); *see Adkins v. State of Idaho*, CTR. FOR REPROD. RTS. (Sep. 11, 2023), https://reproductiverights.org/case/emergency-exceptions-abortion-bans-idaho-tennessee-oklahoma/adkins-v-state-of-idaho [perma.cc/ZGV9-7GKU].

16. Moyle v. United States, 603 U.S. 324 (2024); *id.* at slip op. 5–6 (Barrett, J., concurring).

17. The state now bans abortion from conception. *See* TEX. HEALTH & SAFETY CODE §§ 171.001–171.212 (West 2003).

18. Carter Sherman, *Texas Woman Died After Being Denied Miscarriage Care Due to Abortion Ban, Report Finds*, GUARDIAN (Oct. 30, 2024, 1:17 PM), https://www.theguardian.com/us-news/2024/oct/30/texas-woman-death-abortion-ban-miscarriage [perma.cc/6LMZ-GSGM].

her organs failed."[19] Likewise, a *ProPublica* investigation found that a preventable pregnancy-related death occurred in Georgia after physicians discussed intervening, but then refused to do so, presumably for fear of violating the state's restrictive abortion law, despite Georgia's medical exception for life-threatening circumstances. When doctors finally decided to operate twenty hours later, it was too late.[20] Later data analysis by *ProPublica* revealed that, after Texas passed restrictive abortion laws, the rate of sepsis shot up more than 50 percent for Texas women hospitalized when they lost pregnancies in the second trimester.[21]

The prevalence of these cases demonstrates that life and health exceptions to previability abortion bans are not safeguarding the well-being of pregnant patients. As one headline in the *New York Times* succinctly put it, "*Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*."[22] Since *Dobbs*, physicians have repeatedly gone on record about their difficulty in determining whether statutory exceptions apply in particular cases.[23] "Medical emergency exceptions, the way they're written, don't work in real life," said Molly Meegan, chief legal officer at the American College of Obstetrics and Gynecologists.[24] The confusion surrounding these

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19. Cassandra Jaramillo, Kavitha Surana, Lizzie Presser & Ziva Branstetter, *Texas Lawmakers Push for New Exceptions to State's Strict Abortion Ban After the Deaths of Two Women*, PROPUBLICA (Nov. 20, 2024, 5:00 AM), https://www.propublica.org/article/texas-abortion-ban-exceptions-deaths [perma.cc/9R2Y-EC7N]; Lizzie Presser & Kavitha Surana, *A Pregnant Teenager Died After Trying to Get Care in Three Visits to Texas Emergency Rooms*, PROPUBLICA (Nov. 1, 2024, 6:00 AM), https://www.propublica.org/article/nevaeh-crain-death-texas-abortion-ban-emtala [perma.cc/2SSP-7NST]. Another Texas woman, Porsha Ngumezi, died due to blood loss after doctors refused to provide her with a dilation and curettage (D&C) after her miscarriage. Lizzie Presser & Kavitha Surana, *A Third Woman Died Under Texas' Abortion Ban. Doctors Are Avoiding D&Cs and Reaching for Riskier Miscarriage Treatments*, PROPUBLICA (Nov. 25, 2024, 6:00 AM), https://www.propublica.org/article/porsha-ngumezi-miscarriage-death-texas-abortion-ban [perma.cc/7XH4-V8A7].

20. Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable*, PROPUBLICA (Sept. 16, 2024, 5:00 AM), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death; John Yang & Ryan Connelly Holmes, *Investigation Links Georgia's Abortion Ban to Preventable Deaths of 2 Women*, PBS NEWS HOUR (Sept. 18, 2024, 6:30 PM), https://www.pbs.org/newshour/show/investigation-links-georgias-abortion-ban-to-preventable-deaths-of-2-women [perma.cc/X2XW-U6RX].

21. Lizzie Presser, Andrea Suozzo, Sophie Chou & Kavitha Surana, *Texas Banned Abortion. Then Sepsis Rates Soared*, PROPUBLICA (Feb. 20, 2025, 5:00 AM), https://www.propublica.org/article/texas-abortion-ban-sepsis-maternal-mortality-analysis [perma.cc/G9GC-L4T9].

22. Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*, N.Y. TIMES (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html [perma.cc/GP4B-C2BS].

23. *See, e.g.*, Caroline Kitchener & Dan Diamond, *Faced With Abortion Bans, Doctors Beg Hospitals for Help with Key Decisions*, WASH. POST (Oct. 28, 2023, 6:00 AM), https://www.washingtonpost.com/politics/2023/10/28/abortion-bans-medical-exceptions/ [perma.cc/V35F-ZKS9]; Eleanor Klibanoff, *Texas Medical Board Remains Silent on Abortion Laws, Despite Calls for More Guidance*, TEX. TRIBUNE (Dec. 21, 2023, 5:00 AM), https://www.texastribune.org/2023/12/21/texas-medical-board-abortion [perma.cc/XE3J-B4SX]; Nadine El-Bawab, *Termination Boards: How Physicians Are Providing Abortions Within Exceptions Allowed By Bans*, ABC NEWS (June 23, 2023, 2:01 AM), https://abcnews.go.com/US/termination-boards-physicians-providing-abortions-exceptions-allowed-bans/story?id=100167990 [perma.cc/UK99-YH6L].

24. Klibanoff, *supra* note 23; Alice Miranda Ollstein & Megan Messerly, *Patients Are Being Denied Emergency Abortions. Courts Can Only Do So Much*, POLITICO (April 23, 2024, 5:00 AM), https://www.politico.com/news/2024/04/23/doctors-abortion-medical-exemptions-00153317

exceptions has caused doctors and patients in restrictive states to call for clarification of their state's statutes.[25] Even some anti-abortion legislators have called for clarifying medical exceptions.[26]

Yet some supporters of previability abortion bans assert that medical exceptions are clear and have instead blamed doctors and hospitals for failing to apply them properly. After reports of the death of the two Texas women, Josseli Barnica and Nevaeh Crain, Texas State Senator Bryan Hughes, who authored the Texas abortion ban, wrote an op-ed claiming that the law "provides a clear exception for medical emergencies."[27] The problem, he wrote, was likely that "left-wing media have been relentless in their attempts to scare doctors, pregnant mothers and the general public into believing that Texas law prevents doctors from helping patients and saving lives."[28] Only several months later did he sign on to co-sponsor the bill clarifying Texas's medical exception.[29]

In response to press accounts that Nancy Davis had to travel to New York to obtain an abortion, three dozen Louisiana anti-abortion legislators issued a statement asserting that the hospital had "grossly misinterpreted" Louisiana's abortion policies.[30] It was "very clear," they asserted, that Davis met the criteria for Louisiana's "medical futility exception."[31] Tennessee Attorney General Jonathan Skrmetti asserted that the medical exceptions were not the problem harming

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[perma.cc/CF3G-ZGTT].

25. Klibanoff, *supra* note 23; Kitchener & Diamond, *supra* note 23; Ollstein & Messerly, *supra* note 24.

26. Kavitha Surana, *Some Republicans Were Willing to Compromise on Abortion Ban Exceptions. Activists Made Sure They Didn't*, PROPUBLICA (Nov. 27, 2023, 5:00 AM), https://www.propublica.org/article/abortion-ban-exceptions-trigger-laws-health-risks [perma.cc/W2E7-8NGV].

27. Bryan Hughes, *I Wrote Texas' Abortion Law. It's Plenty Clear About Medical Emergencies*, HOUSTON CHRON. (Nov. 8, 2024), https://www.houstonchronicle.com/opinion/outlook/article/texas-abortion-medical-emergencies-19900172.php [perma.cc/P64Q-EXSW].

28. *Id.* More than one hundred Texas OB-GYNs signed a public letter rebutting Hughes' letter and urging changes to the Texas statute. Jaramillo et al., *supra* note 19. Instead, the Texas Committee charged with reviewing pregnancy-related deaths decided to skip review of the years 2022 and 2023—the first years that its abortion ban was in place. *See* Caroline Kitchener, *Texas Committee Won't Examine Maternal Deaths in First Years After Abortion Ban*, WASH. POST (Nov. 26, 2024), https://www.washingtonpost.com/investigations/2024/11/26/texas-committee-wont-examine-maternal-deaths-first-years-after-abortion-ban [perma.cc/LL5V-TVFY]. A Florida Republican representative also blamed pro-choice messaging for her difficulty obtaining an abortion to end her ectopic pregnancy after Florida's abortion ban went into effect. Edward Helmore, *Republican Representative's Ectopic Pregnancy Clashes with Florida Abortion Law*, GUARDIAN (June 22, 2025, 6:21 PM), https://www.theguardian.com/us-news/2025/jun/22/kat-cammack-republican-florida-abortion-law-ectopic-pregnancy [perma.cc/V8XL-CGVA].

29. *Texas Senate Bill 31 (Adjourned Sine Die)*, LEGISCAN (June 20, 2025), https://legiscan.com/TX/bill/SB31/2025 [perma.cc/4JGQ-BQ7Q].

30. Sara Cline, *Louisiana Woman Denied Abortion Wants 'Vague' Ban Clarified*, AP NEWS (Aug. 26, 2022, 2:10 PM), https://apnews.com/article/abortion-health-legislature-john-bel-edwards-baton-rouge-217b965dcb28a77d4bc46054b351a76e [perma.cc/W8YH-49NV]; Julie O'Donoghue, *Louisiana Proposes Expanding List of Exceptions to Abortion Ban*, LA. ILLUMINATOR (Oct. 19, 2022, 5:43 PM), https://lailluminator.com/2022/10/19/louisiana-proposes-expanding-list-of-conditions-that-allow-for-abortion/#:~:text=By%3A%20Julie%20O'Donoghue%20%2D,19%2C%202022%205%3A43%20pm&text=Louisiana%20has%20proposed%20adding%20one,t%20terminate%20her%20compromised%20pregnancy [perma.cc/2JTB-TRHP].

31. *Id.*

women, but instead "other factors like doctors' independent choices not to provide permissible abortions."[32] Anti-abortion groups have charged the same, contending that doctors are willfully misinterpreting abortion laws because they oppose them. "[Abortion-rights groups] have sown confusion to justify their agenda for unlimited abortion," said Kelsey Pritchard, the director of state public affairs at Susan B. Anthony Pro-Life America.[33] Doctors who have acted "recklessly with women's safety" by denying care, she added, have committed "medical malpractice. That's not due to the pro-life laws."[34] Agreeing, legislators in many states have refused calls to clarify medical exceptions; Texas, which amended its medical exception to provide clarification on the issue of timing, albeit following a Texas Supreme Court ruling on this issue, became the rare state to reform its exception to provide somewhat more clarity.[35]

This Article explores the controversy over the application of medical exceptions in states that have instituted previability abortion bans by analyzing the results of a new University of North Carolina study involving in-depth, qualitative interviews with thirty-five maternal fetal medicine (MFM) physicians providing patient-facing care in the Southeast United States post *Dobbs*.[36] MFM physicians are obstetrician-gynecologists who specialize in diagnosing and treating high-risk medical conditions in pregnant people and fetuses, and therefore have particular insight into obstetric complications that might necessitate abortion. Physicians' responses in these interviews pinpoint recurring patterns that create indecision regarding whether statutory exceptions will shield doctors from suit. These patterns include medical cases in which the patient's life or health is at risk, but it is uncertain

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32. Kimberlee Kruesi, *Asked to Clear Up Abortion Bans, GOP Leaders Blame Doctors and Misinformation for the Confusion*, AP NEWS (Mar. 11, 2024, 8:50 AM), https://apnews.com/article/abortion-bans-exceptions-doctors-lawmakers-7cefca4a248076268c789ea05b367f1a [perma.cc/Q2VD-F5FD].

33. Ollstein & Messerly, *supra* note 24.

34. *Id.*

35 In 2023, the Texas Supreme Court, in a per curiam opinion, declared that the medical exception to the state's abortion band did not require "imminence," or that a patient be "about to die." In re State, 682 S.W.3d 890, 894 (Tex. 2023). Texas subsequently passed a law amending its medical exception to provide that a qualifying "life-threatening physical condition" need not be "imminent" or "actively injuring the patient," and that an abortion may be performed before the mother suffers any effects from the life-threatening risk. *Life of the Mother Act*, S.B. 31, 89th Leg., Reg. Sess. (Tex. 2025). Few similar reforms to medical exceptions have cleared other state legislatures. *See* Surana, *supra* note 26. In 2025, Tennessee lawmakers amended the state's medical exception, apparently to clarify it in response to litigation. The revised exception mentioned a number of conditions that presented serious risks to pregnant women including previable premature rupture of membranes (PPROM), severe preeclampsia, and mirror syndrome. However, the language of the amendment provided that these conditions "may" be included under the state's medical exception, not that they must be, and therefore fail to definitively clarify these conditions. *See* Phillips v. Tennessee, No. 23-1196-IV(I), Memorandum and Order on Defendants' Motion for Judgment on the Pleadings, Oct. 16, 2025, at 8–9. Anti-abortion attorneys general have provided little more clarification. A 2022 memorandum from the Oklahoma attorney general told prosecutors and police that doctors should have "substantial leeway" to provide abortions in case of medical emergencies, adding in 2022 that patients need not be "septic, bleeding profusely, or otherwise close to death," but also stated that physicians should be prosecuted if a woman's life was not actually in danger. *See* Kruesi, *supra* note 32; Surana, *supra* note 26.

36. Interviews were conducted by Abby Schultz, M.D., Division of Complex Family Planning, UNC School of Medicine, Department of Obstetrics and Gynecology.

if the level of risk rises to the threshold required by state law; cases in which the patient's life or health is at risk, but it is not clear if and when the medical risk meets the exception's requirements regarding timing of the abortion; cases in which physicians' calculations of medical risk do not neatly comport with designations of legal risk laid out in medical exceptions because the condition is caused by multiple factors; and cases in which the stark penalties associated with violation of abortion statutes, as well as the fear that an aggressive prosecutor could bring suit, dissuade physicians from performing abortions even when they believe that the patient's case likely meets the terms of the statutory exceptions.

Physicians' uncertainty in applying medical exceptions, we argue, implicates the constitutional "void-for-vagueness doctrine" that both federal and state courts apply. Under that doctrine, laws that do not provide sufficient guidance to those subject to them regarding whether their conduct is legal cannot be enforced. Succinctly put, "[i]n our constitutional order, a vague law is no law at all."[37] We contend that physicians' inability to determine whether and when medical exceptions will authorize abortions in the medical cases presented to them requires that courts strike down state abortion laws as overly vague.

This Article makes four significant contributions to the legal literature. First, it is the first to use detailed empirical research to explain why physicians' attempts to apply statutory medical exceptions to abortion bans produce indecision and inhibit physicians from performing abortions necessary to support the lives and health of their patients. This research leads us to our second contribution: demonstrating that physicians following the usual standards of practice make determinations regarding whether and when to perform abortions in a manner significantly different from the language in which abortion exceptions are framed. This causes considerable dissonance for those seeking to practice good medicine while still obeying the law. Third, this Article is the first to describe in detail why the indeterminacy resulting from the clash between medical and legal standards should cause courts to strike down abortion bans based on vagueness. A few other articles consider the issue of vagueness as generally applied to medical exceptions to abortion bans;[38] none yet, however, have more than glancingly considered the vagueness that results from the disjuncture between the way that physicians make decisions about medical risk and the way that abortion ban exceptions are framed.[39]

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37. United States v. Davis, 588 U.S. 445, 447 (2019).

38. *See* Alan Morrison, *Abortion Ban Exceptions and the Problem of Vagueness*, NAT'L L.J. (Aug. 8, 2022, 10:00 AM), https://www.law.com/nationallawjournal/2022/08/08/abortion-ban-exceptions-and-the-problem-of-vagueness/ [perma.cc/4PDR-Q2B7] (discussing broadly how the vagueness problem under abortion bans became worse after *Dobbs*, because medical exceptions were relied on more heavily in order to grant women the ability to receive abortion care); Brian G. Slocum & Nadia Banteka, *Fair Notice and Criminalizing Abortions*, 113 J. CRIM. L. & CRIMINOLOGY 747, 747 (2024) (offering a new theory of the void-for-vagueness doctrine as it relates to abortion bans, proposing that "fair notice is a matter of degree, dependent on various factors.").

39. The published literature that comes closest is Greer Donley and Caroline Kelly's excellent article arguing that statutes banning abortion cannot adequately distinguish abortion from other types of reproductive care and therefore produce indeterminate and incoherent results. Greer Donley & Caroline Kelly, *Abortion Disorientation*, 4 DUKE L.J. 1 (2024). The authors consider the vagueness of

Fourth, and finally, while we believe that pregnancy is too complicated for legislators to craft a clear medical exception that never risks the lives and health of pregnant patients, we maintain that lawmakers who insist on regulating abortion could do far better at drafting a statute that provides real guidance to physicians. We therefore propose a "least-vague" abortion exception that, in contrast to existing medical exceptions, we believe would clear the bar on constitutional vagueness and would reduce harm to pregnant patients.

Part I sets the statutory stage by detailing the exceptions for pregnant patients' lives and health in states that have significantly restricted abortion post *Dobbs*. Part II turns to our empirical study and details the multiple ways that physicians' determinations regarding whether to perform abortions for medical reasons do not map onto the language of statutory exceptions to state abortion bans. We demonstrate that this is not a problem that can be completely cured by revising these statutes; the disjuncture is inherent between the medical system's mode of determining how much risk is too much based on the pregnant patient's own views, and medical exceptions' rejection of the patient's views as the standard for risk assessment. Part III pivots to describe existing law regarding the vague for voidness doctrine generally, and as it was applied to abortion statutes in the *Roe* era. Part IV assesses current medical exceptions to existing abortion statutes in the post-*Roe* era under the void-for-vagueness doctrine. We argue that physicians' lack of clarity regarding when the exceptions apply, in combination with the steep penalties imposed for their violation, render all abortion statutes in restrictive states overly vague. Finally, Part V presents what a "least-vague" medical exception might look like, for those states determined to regulate abortion procedures.

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the implications of this issue but do not drill down on the gap between medical exceptions and how physicians practice medicine. *Id.* at 82–88. Teneille Brown's thoughtful essay demonstrates that many aspects of abortion regulations, including medical emergency exceptions, treat biology as black-and-white, obscuring the ways that biological data are variable and complex. That essay examines the issue in the context of medical exceptions to abortion doctrine but does not address constitutional vagueness doctrine. Teneille R. Brown, *Abortion and the Extremism of Bright Line Rules*, 119 NW. U. L. REV. ONLINE 1, 5 (2024). Finally, Naomi Cahn and Sonia Suter also address the indeterminacy of the language of medical exceptions, but without exploring the legal doctrine of vagueness. Naomi Cahn & Sonia Suter, *Most State Abortion Bans Have Limited Exceptions—But It's Hard to Understand What They Mean*, CONVERSATION (Jan. 26, 2024, 8:21 AM), https://theconversation.com/most-state-abortion-bans-have-limited-exceptions-but-its-hard-to-understand-what-they-mean-221389 [perma.cc/P4U9-37J7].

Meanwhile, two other helpful pieces not yet published overlap with issues detailed in this Article, although they do not cover exactly the same territory. David Cohen and Greer Donley's manuscript, *The Broad Promise of Abortion Exception Litigation*, describes the many ways that litigation regarding abortion exceptions can aid the movement toward restoring abortion rights for all persons. While it considers vagueness doctrine, it does not focus on the disjuncture between the language of exceptions and medical practice. David S. Cohen & Greer Donley, *The Broad Promise of Abortion Exception Litigation* (unpublished manuscript) (on file with author). Further, Yvonne Lindgren and Michelle Oberman's article, *Recalibrating Risk under* Dobbs**,** explores whether and how the chilling effect of the vague language of abortion statutes, which deprive pregnant patients of adequate medical care, can be addressed through medical malpractice suits. Yvonne Lindgren & Michelle Oberman, *Recalibrating Risk under* Dobbs, 94 FORDHAM L. REV. 627 (2025).

I. THE STATUTORY FRAMEWORK OF MEDICAL EXCEPTIONS TO ABORTION BANS

Of the twenty states in post-*Roe* United States that restrict abortions before viability, thirteen bar abortion from the time of conception; seven others bar the procedure at some point between six weeks and eighteen weeks of pregnancy.[40] Every state with a previability abortion ban provides an exception relating to the pregnant person's life,[41] often framed in terms of allowing abortions "necessary" "to avert" or "to prevent" the death of a patient; a few state exceptions are framed in terms of permitting abortion to "save" or "preserve" the patient's life.[42] Most, but not all, states with abortion bans also provide a limited exception relating to the pregnant person's health, often phrased in terms of exempting abortions "necessary" to prevent "substantial and irreversible" impairment to a major bodily function.[43] Arkansas, Idaho, Iowa, Mississippi, Oklahoma, South Dakota, and Texas are the outliers, containing no exceptions for health when the pregnant person does not suffer a life-threatening condition.[44]

Exceptions in nine states with previability bans allow abortion for medical reasons only in the case of a "medical emergency."[45] Two of these states define "medical emergency" explicitly to require some immediacy of the medical threat.[46] For instance, North Carolina bans abortion after twelve weeks of pregnancy, but excepts from that ban cases involving a medical emergency, defined as:

> [a] condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the *immediate abortion* of her pregnancy to avert her death or for which *a delay will create serious risk* of substantial and irreversible physical impairment of a major

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40. *See* states cited *supra* note 9; *see infra* Appendix.

41. *See infra* Appendix.

42. *Id.*

43. *See supra* note 11. Nine states explicitly exclude mental health conditions or threats of self-injury from their life and health exceptions. Donley & Kelly, *supra* note 39, at 51. As Donley and Kelly point out, several states exempt abortion procedures when the pregnant patient experiences particular medical risks from the state's ban by defining these situations not to constitute abortions at all. These include Alabama, which defines abortion to exclude "deliver[ing] the unborn child prematurely to avoid a serious health risk to the unborn patient's mother." ALA. CODE § 26-23H-3 (2024). Louisiana also excludes from the definition of abortion "[t]he performance of a medical procedure necessary in medical judgment or reasonable medical judgment to prevent the death or substantial risk of death to the pregnant woman due to a physical condition, or to prevent the serious, permanent impairment of a life sustaining organ of a pregnant woman," LA. STAT. ANN. § 14:87.1 (2024). Montana, meanwhile, exempts from the definition of abortion "a separation procedure performed because of a medical emergency and prior to the ability of the unborn child to survive outside of the womb with or without artificial support." MONT. CODE. ANN. § 50-20-1002 (2023). *See* Donley & Kelley, *supra* note 39, at 51.

44. *See infra* Appendix; *see supra* note 11; GUTTMACHER, *supra* note 9.

45. These include Alabama, Arkansas, Georgia, Iowa, Louisiana, Nebraska, North Carolina, South Carolina, and West Virginia. *See infra* Appendix.

46. Nebraska's and North Carolina's statutes include time-contingency language. *See infra* Appendix. The only state explicitly to rule out time contingency in its medical exception is Texas, which recently passed a law providing that a qualifying "life-threatening physical condition" need not be "actively injuring the patient," and that an abortion may be performed before the mother suffers any effects from the life-threatening risk. *Life of the Mother Act*, S.B. 31, 89th Leg., Reg. Sess. (Tex. 2025); *see supra* at 35.

bodily function, not including any psychological or emotional conditions.[47]

Further, while pre-*Dobbs* abortion statutes generally required that the medical conditions in the exceptions need only be met according to the attending physician's "good-faith medical judgment," today, all but one restrictive state impose a more demanding standard that goes beyond what a physician honestly believes is required.[48] Fifteen states evaluate whether the terms of the exception apply under a "reasonable medical judgment" standard,[49] and which could therefore impose liability on physicians who lack knowledge that their conduct is wrongful.[50] Another four simply state that an abortion must be "necessary" to prevent specific health outcomes for the pregnant person, therefore also lacking a subjective good-faith standard to assess liability.[51] Even when a patient's condition falls into a life or health exception to the state's abortion ban, six states still require a procedure be performed in the manner that gives the fetus the best chance for life, except in an extremely limited range of circumstances.[52] This language has been construed to mean that an abortion procedure may be illegal even in many cases that meet life or health exceptions, instead requiring that a caesarean section be performed or birth induced.[53]

Only two states list specific medical conditions that might qualify for the medical exception. South Carolina lists eleven conditions that are "presumed" to constitute "a risk of death" or risk of "substantial and irreversible physical impairment" that would therefore qualify to meet its life and health exceptions.[54] Tennessee lists five conditions that it states "may" constitute a "serious risk of substantial and irreversible impairment of a major bodily function" that would satisfy the state's medical exception.[55] Neither state's statute clarifies how physicians may definitively determine whether these conditions meet the exception in a given case.

States that ban abortion altogether or limit the procedure before viability impose steep penalties for violating abortion restrictions. All these states have

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47. N.C. GEN. STAT. § 90-21.81(5) (through the 2024 Reg. Sess. of the Gen. Assemb.) (emphasis added).

48. The sole exception is Idaho. *See infra* Appendix.

49. These states are Alabama, Arkansas, Georgia, Indiana, Iowa, Kentucky, Louisiana, Nebraska, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, and West Virginia. *See infra* Appendix.

50. *See* Women's Med. Pro. Corp. v. Voinovich, 130 F.3d 187, 204 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998).

51. These include Florida, Mississippi, Oklahoma, and Utah. *See infra* Appendix.

52. Donley & Kelly, *supra* note 39, at 68.

53. *See* Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1203–05 (Idaho 2023); Donley & Kelly, *supra* note 39, at 68; CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST-CENTURY AMERICA 102 (2017).

54. S.C. CODE ANN. § 44-41-640(B)(1) (2023). The conditions listed are molar pregnancy, partial molar pregnancy, blighted ovum, ectopic pregnancy, severe preeclampsia, HELLP syndrome, abruptio placentae, severe physical maternal trauma, uterine rupture, intrauterine fetal demise, and miscarriage. S.C. CODE ANN. § 44-41-640(C)(2) (2023).

55. TENN. CODE ANN. §§ 39-15-213(a)(6) (2025). The statute lists "previable preterm premature rupture of membranes; inevitable abortion; severe preeclampsia; mirror syndrome associated with fetal hydrops; and an infection that can result in uterine rupture or loss of fertility." *Id.* For more on this statute, see *supra* note 35.

imposed criminal penalties—in Texas, that can include life in prison.[56] Tennessee and Utah provide for up to fifteen years in prison.[57] Violations in most states also carry severe civil penalties. Physicians can lose their license to practice medicine in fifteen states.[58] Seven states also allow an action for civil damages against a physician.[59] Some states permit all these penalties. In Texas, a physician commits a felony for performing an unlawful abortion and can face life in prison and up to a $100,000 civil penalty, as well as revocation of their medical license.[60]

II. MEDICAL DECISION-MAKING & ABORTION EXCEPTIONS

In this section, we use empirical data from a qualitative study of thirty-five MFM physicians providing patient-facing care post *Dobbs*. We undertook this study to characterize the professional experiences of MFM physicians in the Southeastern United States post *Dobbs*.[61] MFM physicians often counsel patients about pregnancy termination for both fetal and maternal indications.[62] We chose to focus on the Southeast as this region had high maternal morbidity and mortality even before *Dobbs*.[63] Almost all of these states implemented severe restrictions post *Dobbs*, further limiting access to care in the region and threatening to exacerbate maternal morbidity and mortality.[64]

Between February and June 2023, we interviewed MFMs from ten Southeastern states (Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi,

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56. TEX. HEALTH & SAFETY CODE ANN. §170A.004(b) (West 2023) (establishing if fetus dies as a first-degree felony); TEX. PENAL CODE ANN. § 12.32(a)-(b) (defining punishments for first-degree felony offenses).

57. TENN. CODE ANN. § 39-15-213(4)(b) (through Ch.1069 of the 2024 Reg. Sess.); TENN. CODE. ANN. § 40-35-112(c)(3) (2025) (defining felony classes); UTAH CODE ANN. § 76-7a-201(4) (LexisNexis 2023); UTAH CODE ANN. § 76-3-203(2) (LexisNexis 2023) (defining sentencing for felony offenses).

58. These states include Alabama, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Nebraska, North Carolina, Oklahoma, South Carolina, Texas, Utah, and West Virginia. *See infra* Appendix.

59. These include Alabama, Idaho, Kansas, North Carolina, Ohio, Oklahoma, and Texas. *See infra* Appendix.

60. TEX. HEALTH AND SAFETY CODE ANN. § 170A.002 (West 2023) (defining abortion restrictions); TEX. HEALTH AND SAFETY CODE ANN. § 170A.004 (West 2023) (defining criminal offense for violating abortion law); TEX. HEALTH AND SAFETY CODE ANN. § 170A.005 (West 2023) (defining civil penalty for violating abortion law); TEX. HEALTH & SAFETY CODE ANN. § 170A.007 (West 2023) (license penalty revocation); TEX. PENAL CODE ANN. § 12.32(a)-(b) (West 2023) (defining punishments for first-degree felony offenses).

61. *See* Abby Schultz, Cambray Smith, Madelyn Johnson & Amy Bryant, *Impact of Post*-Dobbs *Abortion Restrictions on Maternal-Fetal Medicine Physicians in the Southeast: A Qualitative Study*, 6 AM. J. OBSTETRICS & GYNECOLOGY MATERNAL FETAL MED. 1 (2024).

62. Anjali Kaimal & Mary E. Norton, *Society for Maternal-Fetal Medicine Consult Series #55: Counseling Women at Increased Risk of Maternal Morbidity and Mortality*, 224 AM. J. OBSTETRICS & GYNECOLOGY B16 (2021); Justin R. Lappen, Christian M. Pettker & Judette M. Louis, *Society for Maternal-Fetal Medicine Consult Series #54: Assessing the Risk of Maternal Morbidity and Mortality*, 224 AM. J. OBSTETRICS & GYNECOLOGY B2 (2020).

63. Eugene Declercq & Laurie C. Zephyrin, *Maternal Mortality in the United States: A Primer*, COMMONWEALTH FUND (Dec. 16, 2020), https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer [perma.cc/VT5A-VDUY].

64. The exception is Virginia, where abortion is legal until the twenty-seventh week of pregnancy. VA. CODE ANN. § 18.2-71–18.2-76.1 (West 2023).

North Carolina, South Carolina, Tennessee, and Virginia). Participants were recruited through convenience and snowball sampling, using the professional networks of the research team. Interviews took place over videoconferencing or telephone and were audio-recorded. All participants provided informed consent. The study was approved by the Internal Review Board at the University of North Carolina at Chapel Hill.

The final sample included fourteen MFM physicians from North Carolina, ten from Georgia, four from Virginia, four from South Carolina, four from Tennessee, two from Alabama, two from Florida, two from Kentucky, one from Louisiana, and one from Mississippi. Most participants identified as women (n=25) and white (n=30), and their years in practice were evenly split between <5 years in practice (n=11), 5–10 years of practice (n=11), and >10 years of practice (n=13). Most practiced in academic medical centers (n=26).

Interviews with physicians revealed recurring patterns of uncertainty regarding whether statutory exceptions would shield doctors from suit. Subsection A outlines how physicians struggled to apply the statutory language to medical cases. Subsection B describes the conflict that physicians expressed between the mandates of medical exceptions and the ethical practice of medicine. This section also describes physicians' accounts of how the harsh penalties of these statutes drove physicians to comport with abortion restrictions rather than the demands of either ethical medical practice or of avoiding legal malpractices. Subsection C summarizes accounts from physicians who felt chilled in their ability to provide abortion care even when they believed it was lawful, out of fear of being targeted by overeager government actors or medical colleagues seeking to "police" compliance with abortion statutes.

A. Challenges Interpreting and Applying Medical Exceptions

Findings from our study show that state abortion bans prevent patients who are experiencing pregnancy-related medical complications from getting abortions in a timely manner because physicians have difficulty interpreting and applying these exceptions. In the words of one participant in our study: "Nobody knows what the law means until a judge interprets it. So, until you get in front of a judge, it's just words on paper."[65] Despite uncertainty about appropriate legal interpretation, physicians must nonetheless respond to patients' urgent needs, with many of these decisions ultimately made by MFMs. These situations led to substantial uncertainty and distress among the MFMs we interviewed. In what follows, we describe recurring types of challenges that arose in applying medical exceptions.

Importantly, before these laws were implemented, standard medical practice dictated that patients and physicians engage in shared decision making regarding whether or not the physician should intervene, based on a patient's own determination of how much risk she is willing to bear. Comporting with this

65. Interview with Participant 29, Physician.

standard practice, physicians would have discussed with patients the spectrum of risks associated with their medical conditions and laid out the options for treatment, taking into account the patient's tolerance of risk. For example, a patient with colon cancer diagnosed in the second trimester of pregnancy might decide to terminate so that she could pursue surgery and chemotherapy that would not be possible during pregnancy and not delay treatment that could prolong her life. Another patient might opt to delay treatment for several weeks to months, planning to start treatment after a planned early birth. Ultimately, the decision about whether or not to continue the pregnancy would be the patient's to make. The physician would not be required to withhold the option that would reduce the most risk for the patient, which is often termination. Post *Dobbs*, physicians believed they would face liability if they presented these same options to the patient and allowed the patient's views to determine the course of treatment. This left them without their normal, patient-centered standard of deciding how much risk was too much. In its place, they found the statutory standard difficult to apply for several reasons.

1. Level of Risk Relating to the Life Exception

Many statutory exceptions to state abortion bans permit abortion if necessary "to prevent the death" of the pregnant patient,[66] or "to save the pregnant woman's life."[67] Yet MFM physicians we interviewed had difficulty identifying what level of risk must be present to meet these standards. As one physician explained, "The law was written so poorly that we couldn't tell what it meant, like what is dangerous, what counts as lethal. Nothing is 100 percent lethal, so nothing qualified."[68] Another physician noted, "It's obnoxious to think about lawmakers who are not in medicine writing legislation. We don't use those terms . [T]o say that something's lethal without intervention—almost nothing is lethal without intervention."[69]

There are a few conditions associated with pregnancy, particularly cardiac conditions, that rise to a level of risk that approaches certain death. Cardiac conditions, for example, are often risk-stratified by World Health Organization classifications as Class 4, meaning that they pose the highest risk of death in pregnancy.[70] Conditions like these, however, in which the level of risk can be calculated based on standardized risk scores and corresponds with close to a 100 percent chance of death, are quite rare.[71]

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66. *See, e.g.*, KY. REV. STAT. ANN. § 311.772(4) (West 2023); LA. STAT. ANN. § 40:1061 (2023); S.C. CODE ANN. § 44-41-640(B) (2023); GA. CODE ANN. § 16-12-141(a)(3) (West through the 2024 Reg. Sess.); IDAHO CODE § 18-622(2) (2024); N.D. CENT. CODE § 12.1-19.1-03 (through 2023 Special Sess.); TENN. CODE ANN. § 39-15-211(3) (2023).

67. FLA. STAT. ANN. § 390.0111(1) (West 2023). Mississippi law prohibits abortion "[e]xcept in the case where necessary for the preservation of the mother's life." MISS. CODE ANN. § 41-41-45(2) (2023).

68. Interview with Participant 7, Physician.

69. Interview with Participant 2, Physician.

70. *See* The WHO CVD Risk Chart Working Group, *World Health Organization Cardiovascular Disease Risk Charts: Revised Models to Estimate Risk in 21 Global Regions*, 7 LANCET GLOB. HEALTH e1332 (2019).

71. *See* Sara Ornaghi, Nicolo Bellante, Alessandra Abbamondi, Marzia Maini, Francesca Cesana,

Much more commonly, the risk of death associated with medical conditions during pregnancy does not approach 100 percent. Cardiovascular disease, for example, is the leading cause of death for pregnant and postpartum patients, contributing to over a quarter of pregnancy-related deaths in the United States.[72] Yet in most cases, overall risk scores for this condition are significantly lower than 100 percent, even though many patients will wind up dying. In cases like these, MFM physicians were unsure what level of risk was sufficient enough to intervene.

One MFM physician recalled her perpetual uncertainty over "what counts as endangering the mother's life."[73] In one of her cases, the physician had cared for a patient with a cardiac condition associated with a 20–30 percent risk of death. That physician ultimately determined that level of risk was insufficient to meet the statutory maternal life exception:

> One lady, she had heart failure. And her heart failure was controlled through medications that are not safe in pregnancy. And she [got pregnant because she] was using spermicide, [a relatively ineffective type of birth control] because she couldn't use many birth control methods. Because of her heart disease, many of them are contraindicated. And I mean, her risk of going into heart failure, if you look at the data was about 20 percent to 30 percent, which is a really high number, but that's probably not high enough by that law.
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> So for me, [to have to sign off on the patient getting abortion care,] what I would have to do is put my name on this chart saying I condone this. I had a legal team telling me they could not, for sure, say I wasn't going to go to jail. Because if you violate this law, it was two years in prison. And I had some really heartbreaking conversations.
>
> I remember looking this woman in the eyes and saying, "I absolutely support you in this. I know you want to terminate this pregnancy, I know you have other children you want to support and be alive for. And legally, we can't, this is what we're up against." And I was frank with her, I said, "I would go to jail for two years. I would be a felon. I would lose my medical license." She was crying. I was almost crying . She said, "If I have to be the one to die to make this law change, then I'll be the one to die."[74]

Ironically, this patient became pregnant because her heart disease prevented her from using a more effective means of birth control in the first place. Once pregnant, she was unable to take the recommended treatment for her condition because it was unsafe for use during pregnancy. The physician was unwilling to sign off on an abortion, despite believing the patient should be able to have one, because

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Margherita Trabucchi, Davide Corsi, Viola Arosio, Silvana Mariani, Antonietta Scian, Elisabetta Colciago, Maddalena Lettino & Patrizia Vergani, *Cardiac and Obstetric Outcomes in Pregnant Women with Heart Disease: Appraisal of the 2018 mWHO Classification*, 9 OPEN HEART 1 (2022).

72. *See* Am. Coll. Obstetricians & Gynecologists' Presidential Task Force on Pregnancy & Heart Disease Comm. on Prac. Bulletins-Obstetrics, *ACOG Practice Bulletin No. 212: Pregnancy and Heart Disease*, 133 OBSTETRICS & GYNECOLOGY e320 (2019).

73. Interview with Participant 2, Physician.

74. *Id.*

the hospital's legal counsel could not provide adequate reassurance that the physician would not face legal charges, which could potentially lead to a two-year prison sentence. A 20–30 percent risk of death, they had concluded, was insufficient to meet the terms of the statutory exception. Of course, between one in five and one in three of these patients would likely die as a result. Unexplored in this account are the constraints preventing this patient from accessing abortion care out of state, yet the presence of additional children at home highlights a common barrier to such out-of-state travel, one that frequently intersects with, and is exacerbated by, socioeconomic disadvantage.[75]

In another case, an MFM physician described caring for a different patient with a cardiac condition associated with a 5 percent risk of maternal death if the pregnancy were to continue. Absent statutory restrictions on abortion care, the physician would have provided patient-centered counseling on options, including continuing the pregnancy under careful monitoring or terminating the pregnancy. She would then have incorporated the patient's values and preferences in recommending an appropriate course of action.[76] Following *Dobbs*, however, the physician understood the statute to mean that the patient's preferences were irrelevant, on the view that her 5 percent risk of death did not clearly meet the threshold for a maternal life exception. The physician explained:

> Is that 5 percent enough for me to say, "Yeah, we need to offer her termination"? Or will they come back at us and say, "My God, the patient had a 95 percent chance that she'd be fine, what are you doing? We're gonna throw you in jail." Again, it takes it out of the patient's hands. I mean, if you told me that going on a trip to Mexico presented me with a 5 percent risk that I would be killed and not be able to come back, I wouldn't go to Mexico, right? That's a pretty high risk, but again, it is not clear enough with the legislative verbiage that you can use that as a determination.[77]

Physicians encountered difficulties not only in determining how high a risk of death must be to shield them from liability for performing an abortion, but also in calculating exactly how high a risk an individual patient faced. In these cases, physicians struggled to operationalize risk because the disease trajectory was less clear-cut or because the relevant conditions lacked clear risk-stratification guidelines. The outcomes for many maternal health conditions can be highly variable in pregnancy, and the course that a given condition will take in a particular patient can be extremely hard to predict. For example, patients with systemic lupus erythematosus, commonly known as lupus, can have disease ranging from mild to severe. Patients with active disease at the time of conception have a high risk of

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75. *See* Amy N. Addante, Rachel Paul, Megan Dorsey, Colleen McNicholas & Tessa Madden, *Differences in Financial and Social Burdens Experienced by Patients Traveling for Abortion Care*, 31 WOMEN'S HEALTH ISSUES 426 (2021).

76. *See* Am. Coll. Obstetricians & Gynecologists Comm. on Ethics, *ACOG Committee Opinion No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 OBSTETRICS & GYNECOLOGY e34, e34–38 (2021).

77. Interview with Participant 18, Physician.

adverse outcomes, including a twenty-fold increased risk of death, but even patients with mild or well-controlled disease have risks in pregnancy that are far higher than healthy patients.[78] Similarly, patients with a baseline diagnosis of hypertension may have a safe and uneventful pregnancy, but they are at higher risk than healthy patients for a condition called preeclampsia, which can lead to severely high blood pressures, stroke, seizures, and even death.[79] Generally, laboratory values are checked to assess for severity and progression of disease, but still do not definitively predict whether a particular patient's condition will worsen imminently, or at all. As one MFM physician noted, "Preeclampsia can evolve over a longer period of time, and we can start to see some laboratory changes affecting the maternal organs. But are those changes enough? Do we need more? We don't have lab values to define them."[80]

Furthermore, because of the difficulty in calculating risk, physicians in states that applied a "reasonable medical judgment standard" feared that, if they went ahead and performed an abortion, other physicians might disagree with them, leading to legal liability on the grounds that their medical judgment was unreasonable. The same physician quoted above regarding preeclampsia later elaborated: "We don't have any guarantee that if we offer those patients the termination because we deem that it's a threat to their life, that another colleague would[n't] think differently, and that we could not be held liable. And that's terrifying."[81] One physician might be sufficiently alarmed by a change in laboratory values to determine an abortion was warranted, while another might reasonably wait longer to see the trajectory of a patient's course. Under prevailing medical standards, the decision of whether these conditions warranted an abortion would be made in consultation with the patient. But where statutory medical exceptions apply, there are no clear answers to how other physicians will make the decision. Another physician shared:

> How close to death or how close to irreversible organ failure do you have to be to qualify? There's going to be probably some differences in opinions and interpretation of that. And then it comes down to, are you willing to risk your license or being sued or not sued for breaking the law because your interpretation may differ from others?[82]

2. Level of Risk Relating to the Health Exception

Statutory exceptions to state abortion bans often permit abortion to prevent "a serious health risk to the unborn child's mother"[83] or "a serious risk of substantial and irreversible physical impairment of a major bodily function."[84] Other states

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78. *See* Kathryn H. Dao & Bonnie L. Bermas, *Systemic Lupus Erythematosus Management in Pregnancy*, 14 INT. J. WOMEN'S HEALTH 199 (2022).

79. *See* Vesna D. Garovic & Phyllis August, *Preeclampsia and the Future Risk of Hypertension: The Pregnant Evidence*, 15 CURRENT HYPERTENSION REPS. 114 (2013).

80. Interview with Participant 32, Physician.

81. *Id.*

82. Interview with Participant 27, Physician.

83. *See, e.g.,* Ala. CODE § 26-23H-4 (2023).

84. *See, e.g.,* Fla. STAT. ANN. § 390.0111(1) (West 2023).

specify that exceptions are warranted "to prevent the serious, permanent impairment of a life-sustaining organ."[85] In no case does the statutory language give any guidance as to what level of risk constitutes a "serious" or "substantial" risk. Just as our study showed that physicians experienced difficulties in determining which cases rose to the legal threshold for threats to maternal life, applying the term "serious health risk" to medical cases prompted similar difficulties.

How risks inform decision-making for a given patient will often include an array of factors that are subjective to the individual patient, such as how much risk a particular patient is willing to take with her life and health, given how much they desire the pregnancy; whether or not they currently have children; their desire for future children; and potentially other factors such as living situation and partner status. Yet these statutes require that physicians exclude those considerations. Physicians reported that the statutory language thus constrained their normal course of counseling and care.

One physician summed up feeling hampered in their ability to take a patient's full situation into account under the relevant statute. This physician stated:

> Assuming a desired pregnancy I wouldn't bring [the prospect of abortion] up unless I felt like there was a real risk of maternal harm. But [in cases in which I believe such a risk of harm is present], whether this is a reasonable course for reasonable people to agree on and whether the lawyers will take my license away are two very different questions. And it's that gap that I think is so frightening. And it depends. I mean, someone who's got three other kids, you know, and are I mean, there are all sorts of reasons that people would be willing to take different levels of risk with continuing with the pregnancy. And to say it has to be risk of irreversible harm before it's okay for them to make that choice is just infuriating.[86]

Even if the statutory language were clear, physicians would still struggle to determine whether the statutory requirements are met because of the difficulty in ascertaining precisely the level of health-related risk associated with many pregnancy-related complications or medical conditions experienced during pregnancy. Physicians generally use a combination of factors to assess this risk, including the patient's current physical and mental health status, secondary diagnoses, and the risk, based on the medical literature, of a given condition to worsen.[87] MFM physicians repeatedly told us that they felt uncomfortable adjudicating risk because of the great deal of medical uncertainty involved in obstetrics care. Consequently, they depended on patients' values to make determinations about how much potential risk is too much and to advise on appropriate recommendations for care.[88] As one physician put it: "And the patient

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85. *See, e.g.,* KY. REV. STAT. ANN. § 311.772(4) (West 2023).

86. Interview with Participant 23, Physician.

87. *See* HAROLD C. SOX, MICHAEL C. HIGGINS & DOUGLAS K. OWENS, MEDICAL DECISION MAKING (2d ed. Wiley-Blackwell 2013).

88. *See* Michael J. Barry & Susan Edgman-Levitan, *Shared Decision Making—Pinnacle of Patient-centered Care*, 366 NEJM 780 (2012), https://doi.org/10.1056/NEJMp1109283 [perma.cc/4N2M-MBR3].

basically decides, to me, whether they're willing to risk their life to remain pregnant, and every patient is different. But it is so important to me that they make that decision on their own."[89] In the post-*Dobbs* context, such patient-centered decision-making is impossible.

3. Timing of the Abortion

Even when physicians believed that a life or health exception was met with a requisite level of risk, they were often uncertain about when to perform the abortion in order to comply with statutory requirements. How close to death or substantial and irreversible harm did a patient need to be to shield physicians from liability? Language regarding the health exception about the "delay in the termination" creating a "serious risk of substantial and irreversible impairment" would seem to exclude currently stable patients with respect to the health exception. However, stable patients can rapidly destabilize, and then it is too late. As one physician explained:

> I think the hardest is when things are evolving and you have to make decisions in the moment. So people getting septic, people bleeding, you know, how much is too much bleeding? How much is a little sepsis versus [] like overwhelming sepsis? How much is, you know, how low do your platelets have to go before you decide that it's time to go? You know, those kinds of things.[90]

In the case of previable premature rupture of membranes (PPROM), in which the amnion ruptures (i.e., the water "breaks") before the fetus is viable—the condition that occurred in several of the medical cases described in the Introduction—the risk of harm to the mother is high, and the fetus usually does not survive.[91] An individual patient's trajectory, though, can be difficult to predict because a variety of outcomes are possible and research on these issues is limited.[92] Overall, significantly more than half—60 percent—of patients experience complications from one of these conditions, ranging from mild to severe infection, or even uterine rupture, pulmonary embolism, and death.[93] Meanwhile, when PPROM occurs early in pregnancy, the risk of fetal death approaches 100 percent. For gestations closer to viability (just under twenty-three or twenty-four weeks), the possibility of live birth possibly rises to around 40 percent,[94] though this statistic is confounded by the fact that patients often opt for abortion because of

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89. Interview with Participant 20, Physician.

90. Interview with Participant 23, Physician.

91. *See* Am. Coll. Obstetricians & Gynecologists & Soc'y for Maternal-Fetal Med., *Obstetric Care Consensus No. 6: Periviable Birth*, 130 OBSTETRICS & GYNECOLOGY e187 (2017).

92. It would be unethical to require all patients with PPROM to wait and see what happens in a trial, so the data available are for patients who opted to try to continue the pregnancy. Even for these patients, anyone who becomes sick along the trajectory from experiencing PPROM to delivery will likely undergo an abortion, thus removing them from the calculation for survival in studies.

93. *See* Ashley N. Battarbee, Sarah S. Osmundson, Allison M. McCarthy & Judette M. Louis, *Society for Maternal-Fetal Medicine Consult Series #71: Management of Previable and Periviable Preterm Prelabor Rupture of Membranes*, 71 SMFM CONSULT SERIES B2 (2024) [https://doi.org/10.1016/j.ajog.2024.07.016].

94. *Id.*

the high risks involved if they were to continue their pregnancies, so what would happen if all patients were to wait is unknown. Notably, there is no scenario after PPROM occurs in which staying pregnant is safer for the patient than not continuing the pregnancy.[95] As one doctor put it:

> I don't feel like I'm ready to accept a maternal death because of this. Our patients can deteriorate so quickly. Our patients who are young, and otherwise, sometimes healthy, sometimes not so healthy are often stable till they're not. And I'm trying to figure out where that stability is and where that line is when we know that, in the situation of pre-viable PPROM, the best thing for the mom is a termination . But where do we draw the lines as to what is safe enough medical, legally? It's really hard. And I get nervous I'll make the wrong call.[96]

Even with population-level data on maternal outcomes, it is very difficult to know what will happen with an individual patient. Signs of infection or other potentially harmful developments may be subtle or absent, so it can be difficult to know whether a patient needs intervention or not. Yet early intervention is key to minimizing risk to the patient because, although a patient can seem stable for a period of time, once they begin to decompensate, the condition can evolve quickly and be very difficult to treat. While deaths represent only a small portion of PPROM outcomes, avoiding the worst-case scenario is obviously critical to providing safe care.[97] A low percentage risk of dying is meaningless to the patient who actually dies. For them, in the end, the chance of death will be 100 percent. But the physician can know this for certain only after the death occurs.

One physician described changes in how they manage PPROM cases in the face of the new statutes. Prior to *Dobbs*, they would have offered termination due to the substantial risk PPROM posed to the mother's health.[98] Now, however, they believed they could not do so without risking liability:

> In cases of preterm premature rupture of membranes with water breaking, let's say, at twenty weeks, there's a lot of risk to ongoing pregnancy because of risk of hemorrhage, sepsis. And ultimately, a very poor fetal outcome is anticipated even with expectant management [i.e., watching the patient under close surveillance without intervening]. So, a lot of families, because of those risks, will opt for termination. But at this time, most of us have interpreted the law that in an otherwise stable patient with preterm premature rupture of membranes, the kind of imminent risk to the maternal life or to one of the organs, which is how the law is written, is not imminent enough or threatening enough if the patient is otherwise stable without evidence of infection or bleeding . So, at this point, I will tell

95. *Id.* at B2–B15; Alexander M. Saucedo, Chase Calvert, Adrian Chiem, Alan Groves, Kobina Ghartey, Alison Cahill & Lorie Harper, *Periviable Premature Rupture of Membranes-Maternal and Neonatal Risks: A Systematic Review and Meta-analysis*, 41 AM. J. PERINATOLOGY 1604, 1604–15 (2024), https://doi.org/10.1055/a-2302-8657 [perma.cc/W4FH-5M9T].

96. Interview with Participant 32, Physician.

97. *Id.*

98. *See* Battarbee et al., *supra* note 93.

patients that they could travel to another state for that termination.[99]

Another MFM physician reflected on a particular patient put at risk because of timing requirements, saying:

> [Because we are constrained by timing requirements,] I've had a few cases of PPROM where women have gotten floridly sick and they didn't even really have the option to avoid that. And that makes me angry . I watched this woman go from, she broke her water, she was seventeen weeks, she didn't want to go home because she was terrified of delivering at home. So, we just let her sit on our [ward] and I just watched, her temperature went up and then her white count went up, and then she started having periodic discharge. And I was like, how long do I have to sit here and watch this before I'm allowed to do something? And luckily, she delivered on her own, but I was about to be like, "I have to do this now . I feel duty-bound." But again, that's hard. It's a hard thing to take on as a responsibility.[100]

The death of Josseli Barnica in Texas illustrates all too tragically the potential consequences of mistiming intervention in an evolving medical condition. In this case, detailed in a *ProPublica* report,[101] under the threat of violating a statute that imposed up to ninety-nine years in prison and $100,000 in fines, physicians failed to provide an abortion at the time the patient's water broke and her cervix dilated, seventeen weeks into her pregnancy. As a result, Ms. Barnica, a twenty-eight-year-old mother of one, remained in the hospital, exposed to infection through her open cervix, but without being deemed enough of a medical emergency to warrant intervention. Ultimately, the fetus died and was delivered, and Ms. Barnica was discharged home. A few hours later, she developed heavy bleeding and returned to the hospital but was told that such bleeding was normal. When she continued to bleed heavily for two days, she returned to the hospital. It was too late, and she died.[102]

The *ProPublica* report does not detail the cause of Ms. Barnica's death, but it appears that the infection she likely developed while miscarrying led to disseminated intravascular coagulopathy (DIC), a condition of uncontrollable internal bleeding that is very difficult to treat if not caught early. It is highly likely that intervening sooner could have saved her from developing DIC and, ultimately, dying. Although we do not know the exact mindset of the physicians caring for Ms. Barnica at the time, from the physicians interviewed in our study, we can infer that the situation was agonizing for them. Despite the potential for a condition to devolve into a significant threat to the patient's life, the physicians may not have felt comfortable offering intervention while the patient was still stable for fear of risking severe liability. Being forced to decide between committing malpractice or a felony puts

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99. Interview with Participant 23, Physician.

100. *Id.*

101. *See* Cassandra Jaramillo & Kavitha Surana, *A Woman Died After Being Told It Would Be a "Crime" to Intervene in Her Miscarriage at a Texas Hospital*, PROPUBLICA (Oct. 30, 2024, 5:00 AM), https://www.propublica.org/article/josseli-barnica-death-miscarriage-texas-abortion-ban [perma.cc/C27B-V66V].

102. *Id.*

physicians in an impossible quandary.[103]

Physicians fear, quite simply, that even though they know a patient is at substantial risk, the situation may later be determined not to rise to the level of "imminent risk" to maternal life or maternal organs required by statute. Physicians know that medical cases do exist in which patients declined intervention and not only lived, but were also able to continue the pregnancy to a live birth—although these cases are rare. Though this may be the exception, they understand that if they go ahead and perform an abortion, it may later be impossible to prove that the intervention offered was absolutely necessary at that particular moment. The utter uncertainty of an individual patient's medical course makes statutory medical exceptions extremely difficult to apply.

B. Medical Exceptions, the Ethical Practice of Medicine, and Medical Malpractice

Physicians in our study recounted many instances in which they believed that restrictive abortion statutes interfered with the ethical practice of medicine, which requires patient-centered, evidence-based care.[104] Physicians repeatedly described hesitating to initiate care that they believed was medically and ethically required because they feared that it would violate the law. One explained:

> [The medical exception provision] takes a commonly encountered medical situation that the management is no question, you know what to do. And it takes that very simple medical situation and makes one second guess themselves and in turn can put the patient's life in danger because of that hesitation.[105]

Another physician shared two situations in which practicing good medicine required providing immediate care, but attempts to comply with the statutory medical exception led to life-threatening delays in care. The first case involved an ectopic pregnancy (a pregnancy implanted outside the uterus, most often in a fallopian tube), in which the patient was miscarrying. The physician determined that an abortion was warranted, but delayed acting due to the legal risk:

> So we actually had a patient come in with an ectopic pregnancy with a heartbeat. And the way the law was written, we couldn't tell if that met [legal] criteria. And actually, I trained in [an adjacent state with more liberal abortion laws], so I called my colleagues up there and said, "Hey, we're trying to figure out what we can do down here. If we're in a pinch, can I fly her to you? Will you take her?" And they said, "Yes." They were ready

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103. After Ms. Barnica's death, the Texas Supreme Court interpreted the Texas statute's medical exception not to require "imminence." In re State, 682 S.W.3d 890, 894 (Tex. 2023). Had this ruling been announced before Ms. Barnica's death and communicated to physicians, there may have been a better outcome. However, it is also possible that physicians' fear of being sued, combined with the heavy penalties that apply in Texas for violating the statute, would have been sufficient to prevent them from acting, as we discuss in our next subsection. As described in note 35, following the Texas Supreme Court ruling, the Texas legislature explicitly modified the medical exception to delete the requirement of imminence. *Life of the Mother Act*, S.B. 31, 89th Leg. Reg. Sess. (Tex. 2025).

104. *See, e.g.*, Am. Coll. Obstetricians & Gynecologists Comm. on Ethics, *supra* note 72, at e23.

105. Interview with Participant 18, Physician.

> for us to fly her there. And luckily, risk management [eventually] said, "We don't know what to do yet, but go ahead and do it." And by the time she got to the [operating room (OR)], which was a couple of hours later, [the pregnancy] had ruptured. She had liters of blood in her abdomen. If we'd flown her to [the adjacent state], she would have probably died. We [also] had a patient who came in at fifteen weeks with a baby with a heartbeat, who was hemorrhaging, blood everywhere, bleeding through her clothes, hemodynamically unstable. We are activating a massive transfusion protocol, need to take her to the OR for a [dilation and evacuation (D&E)] [but] we [still] had to wait to talk to risk management. It delayed it by about an hour before she could go.[106]

Fear of criminal repercussions often won out over physicians' assessment regarding what ethical medical practice entailed. As one physician stated, "Everyone is scared of being charged with a felony if they provide services that are medically indicated."[107] One physician relayed the consequences of comporting with the law and therefore failing to meet her ethical obligations to patients:

> I was very scared of the risk of jail time and mainly being separated from my family. And that weighed over all my clinical decisions. Knowing ethically what was right to do and not being able to do it was just absolute anguish. It was incredibly stressful and I don't know. I don't know how to describe it more than that. It was daily constant worry about this.[108]

An MFM physician described having to counsel patients who, despite having life-threatening conditions, were denied abortions because of her state's statute:

> [T]here have been times where we have seen a patient in that 20 to 22-week range, you know, where they're not viable, but we can't offer termination [because of the abortion law]. [These patients] have had conditions such as fetal hydrops that [were] a threat to maternal life because of the risk for mirror syndrome [a life-threatening condition in which swelling in the fetus also occurs in the pregnant person]. And that was difficult to counsel patients. You can't legally terminate in this state. We can certainly send you out of state but the particular patient I'm thinking about didn't have financial means to do that. And oh, by the way, you are at risk for developing preeclampsia, or mirror syndrome, [both of] which will be a threat to your life so we're gonna ask you to come in, you know, on a fairly regular basis for blood pressure checks and weight checks. And that particular patient was like, "Well, if you're telling me this is a threat to my life, why can't I terminate?" And she was right. What do you tell somebody?[109]

Another physician recounted that she sees a lot of "patients in the periviable period [for whom] maybe it's not clear that they're quite medically sick enough to justify termination, but they're kind of riding that border. Those are patients that

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106. *Id.*
107. Interview with Participant 5, Physician.
108. Interview with Participant 7, Physician.
109. Interview with Participant 16, Physician.

previously I would offer termination to when I was practicing in a different state."[110] In her current state, though, she explained, "There's a lot of resistance to that from the provider side, and I would say that a lot of these periviable patients end up with poor outcomes that could have been prevented with termination. And that goes for both poor maternal and poor neonatal outcomes."[111]

One physician recalled a patient "with cancer, with metastatic cancer that really needed not only chemo[therapy], which can be safe for the pregnancy, but also needed radiation therapy, which you can't do in pregnancy."[112] That patient was ultimately sent to another state for pregnancy termination because, in the physician's words, "our legal counsel said because it can't be proven that pregnancy termination is going to enhance the patient's outcome or that pregnancy will worsen her outcome, it's not proof that the patient's life is in danger, so you can't terminate the pregnancy."

Fears of the steep consequences of violating abortion statutes frequently won out over physicians' desire to avoid committing medical malpractice. Medical malpractice standards require that physicians comport with customary practices among reasonable and prudent physicians.[113] But those customary practices require the very patient-centered and evidence-based care that physicians see as conflicting with restrictive medical exceptions. In one doctor's words:

> [W]e had to meet with risk management [during one medical emergency] , [who] said if you practice this standard of care, then we can defend it. And we said, do you understand the standard of care is illegal in this state right now? You keep saying that, but you also can't guarantee I won't go to jail. Those were real conversations we were having. Just awful, awful [114]

One physician described the ethical and legal dilemma that the criminal penalties for misinterpreting the statute created for them:

> I'm really worried about patients dying . You drive to work and you wonder, "Am I going to be strong enough or brave enough or ethical enough to do the right thing if faced with a patient who truly needs a lifesaving abortion, and I don't have time to do all of the song and dance of getting approval, which doesn't matter anyway, when it comes to people deciding if they want to make an example of you?" But, you know, you drive and you wonder "Am I gonna be brave enough if this comes up to actually just do what needs to be done to legitimately prevent someone from dying?"
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> And I think until you're faced with that, you question and if I were brave enough, does that make me good or stupid? Does that make me a good

110. Interview with Participant 14, Physician.

111. *Id.*

112. Participant 18, *supra* at note 106.

113. *See, e.g.*, Hemsley v. Langdon, 909 N.W.2d 59, 67 (Neb. 2018) ("[I]n a medical malpractice case, the standard of care is found in the customary practices prevailing among reasonable and prudent physicians."); Palandjian v. Foster, 842 N.E.2d 916, 921 (Mass. 2006) ("The standard of care is determined by the care customarily provided by other physicians, it need not be scientifically tested or proven effective: what the average qualified physician would do in a particular situation is the standard of care.").

114. Participant 7, *supra* at note 108.

> doctor or does that make me a stupid mom and wife? Or all three of those things? And if you're not brave enough, does that make you a good citizen? And, you know, what is more permissible, medical malpractice or a criminal felony? What is permissible? Because, you know, committing a felony is going to be appropriate care, you know, and not committing the felony is going to be negligence in a lot of these situations. So, it's like, which is the lesser of two evils?
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> And I'll tell you that it's really sad because obviously, medical malpractice to me as a physician is less dangerous than criminal repercussions. It just is. And then that puts the patient at the crosshairs. It's just hurting patients. That's, at the end of the day, the only thing that is happening as a result of this, because none of us wanna let people die.[115]

C. The Chilling Effect on Medical Practice

Our interviews show that physicians' uncertainty in interpreting medical exceptions created fears that legitimate clinical actions might be construed as illegal. These fears produced a chilling effect on clinical practice that interfered with even the provision of abortions that providers believed were likely statutorily protected.[116] Physicians mentioned two factors that increased this chilling effect: (1) fears of being publicly targeted by anti-abortion government officials in restrictive states; and (2) other medical personnel raising objections to providing care based on unduly-broad interpretations of abortion laws, sometimes combined with MFM physicians perceiving threats that these personnel could report them for violating the vague language of the statutes.

1. Fears of Being Targeted by Anti-Abortion Government Actors

In our interviews, physicians were acutely aware of anti-abortion sentiments voiced by government officials, and the role of such sentiments in passing abortion regulations. Physicians generally understood the motivation of the statutes to be to prevent any abortions that might not be absolutely indicated. They worried that their judgment would be questioned, given this presumed intent. As one participant put it:

> I mean, if I try to wrap my head around their stance, if they believe that every fertilized egg is a unique soul that has a destiny for the universe, and if a single fertilized egg, you know, every sperm is sacred from "Monty Python." If a single embryo is terminated when they should have been allowed to live, that that is unforgivable and they'd sooner kill the mother than have the embryo, you know, be terminated inappropriately. I mean, if that's truly their core belief, then I suppose it makes sense to say it doesn't matter if we kill some mothers along the way because at least we haven't

115. Interview with Participant 10, Physician.

116. Yvonne Lindgren and Michelle Oberman refer to this phenomenon as cases that involve "yellow-light" rather than "red-light" situations, in which clinicians know that patients need abortion care but hesitate or refuse to provide it because it seems legally risky. Lindgren & Oberman, *supra* note 39. Because of this, the care physicians provide to pregnant patients "no longer turns exclusively on the largely national professional standard of care. Instead, it also depends on a doctor's risk tolerance." *Id.*

killed any embryos without taking them on at the same time.[117]

Some physicians believed that the statutes were deliberately written vaguely in order to chill abortions. In the words of one physician:

> I think the point of these restrictive laws has been historically to be vague and kind of to cast a shadow of uncertainty so that people feel less comfortable. You know, if you draw the lines really clearly, people are like, "Okay, that's the line, I know where I can go to." But you know, the legislation definitely left us in a place where we're like, "Ah, we're not really sure how to interpret this and how would we go about this?"[118]

Physicians' concerns about the ambiguity of the scope of the medical exceptions were heightened in states in which legislators and prosecutors had politicized abortion. Physicians were very aware of politicians' public statements on the issue. To take one example, an interviewee noted that she lived "in a state that has a very aggressive and politically ambitious attorney general that has made it known both publicly, but also through back channels, that he has every intention of aggressively prosecuting anyone who is performing elective terminations."[119] Physicians repeatedly expressed their fear that such politicians would make examples of them. One physician shared, "Even though it met the criteria, it's just this angst that hangs over you. Like, 'Am I going to end up on the wrong side of the attorney general?' I mean, I think the sentencing is ten years in prison or something like that. It just feels super, super intense."[120] Another physician who performed an abortion that she deemed medically necessary still told the patient:

> [P]lease don't spread my name in the community as the one that signed off on this. I really want to protect my family, and I really don't want to go to jail. I don't want any attention from any politicians, if they found out they would have no qualms about making me a political spectacle, talking up the young MFM physician who violated their law.[121]

In this context, waiting to ensure that abortion is medically necessary makes sense for physicians hoping to avoid being made a public example. Yet swift action is often necessary to prevent the "serious risk of substantial and irreversible harm" that is supposed to be exempted from abortion bans by medical exceptions.

2. Objections to Providing Care by Other Medical Personnel Based on Overly Broad Readings of Abortion Statutes

In some cases, other actors in the medical system assumed the role of "enforcing" what physicians perceived to be overly broad readings of abortion statutes, objecting to providing care for pregnant patients even when that care was not statutorily prohibited (including cases in which it was unrelated to an abortion procedure). Resistance to care was especially likely to arise from nursing, anesthesiology, and other non-obstetric

117. Interview with Participant 19, Physician.
118. Interview with Participant 4, Physician.
119. *Id.*
120. *Id.*
121. *Id.*

specialties. One physician described a patient with a high-risk pregnancy complicated by Wolff-Parkinson-White Syndrome, a congenital heart abnormality that can lead to an abnormal rhythm, enlarged heart, and, in some cases, sudden death.[122] This pregnancy occurred shortly after the patient's prior delivery, an event also associated with complications given the strains of pregnancy on the heart and body.[123] The patient was admitted for a cardiology evaluation. Based on the severity of the damage already sustained by her heart, the physician planned to discuss the patient's care options with her. These options included an ablation procedure to improve her heart rhythm, which would be performed by the hospital's electrophysiologist (a cardiology subspecialist), and an abortion, should the patient's risk level prove high enough. When the physician discussed this plan with the electrophysiologist, though, he stated that he did not want to perform the ablation procedure on the patient while she was pregnant, despite the fact that the abortion ban did not speak to such a procedure. Further, when the MFM physician told the electrophysiologist she would offer the patient an abortion if the patient's risk proved sufficiently high, the electrophysiologist balked. The MFM physician shared:

> I said, "Well I want to wait and see what her echo[cardiogram] is because if her echo shows significantly reduced ejection fraction, I would actually offer her termination." And that physician actually is like, "Can you do that in this state? I mean, I could report that and you could ." I was like, "I'm sorry, excuse me?" He basically threatened to turn me into the state even though that is not his job. And that is the only electrophysiologist I have in the hospital. So now if I feel like I want to talk to him or somebody, like the appropriate specialist about care of a pregnant person, I have no option because I do not want to be reported to the state by him for discussing termination, which I think most people would assume is totally appropriate, depending on what the circumstances may be. So that made me very uncomfortable.[124]

Here, the state's abortion restrictions potentially chilled both an ablation and abortion care of a grievously ill patient whose pregnancy posed a life-threatening risk to her weakened heart—despite the fact that the former was certainly legal because it did not involve abortion care—and the latter was likely legal under the state's medical exception. In addition, the cardiologist noted that he could report the MFM physician. This statement stoked fear and mistrust in the MFM physician, who, interpreting it as a threat, no longer felt comfortable discussing termination for a cardiac patient with the only electrophysiologist in the hospital. This case suggests that the statutory valuing of the fetus over the mother emboldens some hospital personnel to devalue the mother's health beyond what is demanded by the statute.

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122. *See* Amit Sapra, Janet Albers, Priyanka Bhandari, Dean Davis & Eukesh Ranjit, *Wolff-Parkinson-White Syndrome: A Master of Disguise*, 12 CUREUS e8672 (2020), https://doi.org/10.7759/cureus.8672 [perma.cc/45RE-AV8Q].

123. Laura Schummers, Jennifer A. Hutcheon, Sonia Hernandez-Diaz, Paige L. Williams, Michele R. Hacker, Tyler J. VanderWeele & Wendy V. Norman, *Association of Short Interpregnancy Interval with Pregnancy Outcomes According to Maternal Age*, 178 JAMA INTERNAL MED. 1661 (2018).

124. Interview with Participant 23, Physician.

Other MFM physicians reported similar experiences. One described how an anesthesiologist challenged the MFM physician's medical judgment in advising that a pregnant woman with a pelvic fracture undergo orthopedic surgery without continuous fetal monitoring. Despite the fact that the procedure was not an abortion—the only procedure regulated by state law—the anesthesiologist expressed concern that if the fetus died during surgery, they could be found in violation of state law. Such monitoring, the anesthesiologist asserted, would enable the medical team to shift to an emergency cesarean section in case of fetal distress. However, continuous fetal monitoring was not possible with the orthopedic surgeon stabilizing her hip. More importantly, the patient did not want an emergency cesarean section in the middle of her hip surgery, and the MFM physician maintained that she was within her legal right to refuse it. The MFM physician recounted:

> They basically accused me of not offering the standard of care, and this was from an anesthesiologist telling me I wasn't doing the OB-appropriate standard of care . We talked about it. She was twenty-three weeks [pregnant], she did not want a crash [cesarean] section in the middle of her hip reduction. She felt like her pelvic fracture was more important at this point. We've had a risk-benefit discussion with the patient, which is what I've always done. But if they opt not . And then these other specialists are telling them, "Actually you don't have a choice, I am going to say that we have to, otherwise I'm going to refuse to provide care." That was different. And not every anesthesiologist has been like that, but I have run into two or three since the abortion laws.[125]

The patient did not want fetal monitoring or to undergo an emergency cesarean section at the threshold of viability—a time when the infant would have a very low chance of survival. Nevertheless, the anesthesiologist pushed for both. His intervention demonstrates the chilling effects of abortion laws even on medical procedures besides abortion.

Several MFM physicians reported that *Dobbs* heightened resistance from nurses and anesthesiologists even for medically necessary abortions. In one interviewee's words:

> We have to fight harder to do the right things. There's always been, you know, other healthcare providers, including nurses that have always been uncomfortable with what I would consider an augmentation of an ongoing process, especially, periviable PPROM . [W]e've had to really fight a little bit harder to get the right lifesaving care to the patient because we're getting a lot more backlash, I think, from nurses and other healthcare, you know, and anesthesiologists. So, whereas we've always kind of had to say, "Okay, well, we gotta make sure we have the right team assembled in order to care for that patient"—that scrutiny, I think, is much higher , even though we're doing the right thing . And so pushing against this kind of backlash because I think people say, "Okay, well, now [after

125. Interview with Participant 23, Physician.

> the] *Dobbs* decision, I can let my underlying biases free and push back in these situations," when perhaps before they didn't feel empowered to do so.[126]

This pushback led several physicians to voice concerns that their colleagues would report them for perceived violations of state abortion bans. One physician stated: "I think the *Dobbs* decision has just made the scrutiny so much higher rather than changing really anything we do . I'm trying to make sure that I'm really following my moral compass. And if that means that somebody with alternative motives will report me when I'm saving her life, then I don't care."[127] Another physician noted that sometimes she would not perform an abortion, partly out of worry that "a nurse says this is against her beliefs and then she reports it to the prosecutor."[128]

In a number of other cases, the resistance or outright refusal of hospital legal counsel to confirm the legality of abortions delayed or deterred abortion care, despite MFM physicians' judgment that a patient met the statutory criteria for abortion.[129] In this way, hospital attorneys promoted chilling of care. In one case reported to us, a patient presented with placenta accreta, a condition in which the placenta grows into the wall of the uterus.[130] In such cases, the placenta does not peel off of the uterus easily, which may result in excessive bleeding. Placenta accreta usually worsens over the course of pregnancy, as the placenta grows deeper into the wall of the uterus, or even all the way across it into the bowel or bladder, a condition known as placenta percreta. Removal can then necessitate hysterectomy, damage the bladder or bowel, and, in rare cases, result in the death of the fetus or mother. The MFM physician recalled:

> We had [a] patient who had a placenta accreta and it was found really early, at thirteen weeks when she was still eligible for termination for whatever reason in our state. And it was gross on the MRI, you could absolutely see placental tissue extruded through the uterine serosa. And we got pushback from the hospital about [performing an abortion], "Well, how do you know? Are you sure?" Yes, we're sure. Since when have you questioned our diagnoses? And we had to fight to get it approved and the clock was marching toward fifteen weeks [the state's gestational limit for abortion

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126. Interview with Participant 8, Physician.

127. *Id.*

128. Interview with Participant 20, Physician.

129. *See* STAFF OF S. COMM. ON FIN., 118TH CONG., REP. ON EMERGENCY REPROD. CARE POST-DOBBS, PRACTICING AMID "A MINEFIELD": EMERGENCY REPRODUCTIVE HEALTH CARE POST-DOBBS (Dec. 2024), https://legacy.www.documentcloud.org/documents/25463495-senate-committee-report-on-emergency-reproductive-health-care-post-dobbs [perma.cc/T7H9-YE7K]; Kavitha Surana, *Report: Hospitals Rarely Advise Doctors on How to Treat Patients Under Abortion Bans*, PROPUBLICA (Dec. 19, 2024), https://www.propublica.org/article/abortion-ban-deaths-report-ron-wyden [perma.cc/FQY8-6TEJ] ("Doctors described hospital lawyers who 'refused to meet' with them for months, were hard to reach during 'life or death' situations and offered little help beyond 'regurgitating' the law, according to a Senate Finance Committee report.").

130. *See* American Coll. Obstetricians & Gynecologists & Soc'y for Maternal-Fetal Med., *Obstetric Care Consensus No. 7: Placenta Accreta Spectrum*, 132 OBSTETRICS & GYNECOLOGY e259 (2018).

> absent the medical exception], and we were all starting to panic . So thankfully, [hospital approval] finally happened, but they had to convene the ethics committee and then the ethics people weren't available, so they had to meet the next day and there were all these like little roadblocks and I'm like, "This feels like TRAP laws [Targeted Regulation of Abortion Provider Laws, meaning laws designed to impose unnecessary restrictions to accessing legal abortions that were put in place by anti-choice legislatures during the *Roe* era]. What the heck is happening?" But yeah, it finally got done, and she certainly had a raging accreta and had to have a hysterectomy and actually had bowel resected because it was just bad.[131]

The delays associated with convening the ethics committee and navigating other administrative hurdles in this case may have led to unnecessary medical complications since it gave the placenta more time to grow through the uterine wall. When the patient finally obtained her abortion, she lost her uterus and had to undergo a bowel resection, both of which might have been avoided had she obtained the procedure earlier.

III. VOID-FOR-VAGUENESS DOCTRINE AND THE PROBLEM OF ABORTION EXCEPTIONS BEFORE *DOBBS*

Physicians' confusion in attempting to apply the language of abortion exceptions raises questions regarding whether these exceptions provide certain enough direction for the physicians charged with following them. These issues implicate the constitutional void-for-vagueness doctrine. This part considers law relating to that doctrine. Section A outlines the basic tenets of void-for-vagueness law. Section B turns to court decisions that applied that doctrine to abortion statutes before and during the *Roe* era.

A. The Void-for-Vagueness Doctrine Generally

The Supreme Court has long held that laws that are overly vague cannot be enforced. This void-for-vagueness doctrine "rests on the twin constitutional pillars of due process and separation of powers."[132] Each of these two constitutional guarantees provides a route through which a statute can be struck down for providing insufficient direction.

The constitutional guarantee of due process derives from guarantees that government may not deprive persons of life, liberty, or property without due process of law.[133] A state therefore violates a person's due process interests if it fails to provide them "fair warning" as to what conduct will subject them to liability.[134] This guarantee requires that a statute be clear to those charged with following it regarding exactly what conduct is proscribed. In the Supreme Court's words, "[B]ecause we assume that man is free to steer between lawful and unlawful

131. Interview with Participant 2, Physician.
132. United States v. Davis, 588 U.S. 445, 451 (2019).
133. U.S. CONST. amend. XIV.
134. *See* Kolender v. Lawson, 461 U.S. 352, 357 (1983).

conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning."[135] A state law that fails to provide fair notice must therefore be deemed unenforceable.

Meanwhile, the constitutional guarantee of separation of powers provides that a statute should be deemed void if it does not contain "an explicit and ascertainable standard to prevent those charged with enforcing the statute's provisions from engaging in 'arbitrary and discriminatory' enforcement."[136] Only the people's elected representatives in the legislature" are authorized to make conduct unlawful.[137] This means that officials charged with enforcement must not be able to exercise their own independent judgment regarding what constitutes a breach of the statute.[138] Statutes that leave officials in doubt about what conduct to charge must be struck down as violating the separation of powers guarantee.[139]

The seminal decision in the 1926 case of *Connally v. General Construction Company* provides a useful illustration of the void-for-vagueness doctrine.[140] In it, the Supreme Court struck down an Oklahoma statute mandating that the state pay its workers "not less than the current rate of per diem wages in the locality where the work is performed."[141] The Court counseled that "the terms of a penal statute creating a new offense must be sufficiently explicit to inform those who are subject to it what conduct on their part will render them liable to its penalties," and cannot "reasonably admit of different constructions."[142] Two phrases in the statute, according to the Court, were insufficiently specific: First, the term "current rate of wages" failed to "denote a specific or definite sum," but was instead potentially "dependent upon the class and kind of work done, the efficiency of the workmen, etc."; it also did not specify whether the measure required was "either the lowest rate or the highest rate, or any intermediate rate, or, if it were possible to determine the various factors to be considered, an average of all rates."[143] Second, the use of the qualifying word "locality" also inserted unconstitutional ambiguity.[144] In the Court's words:

Who can say, with any degree of accuracy, what areas constitute the locality

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135. Grayned v. City of Rockford, 408 U.S. 104, 108 (1972); *see also Kolender*, 461 U.S. at 357 ("[T]he void-for-vagueness doctrine requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited."); *Davis*, 588 U.S. at 451 ("Vague laws contravene the first essential of due process of law that statutes must give people of common intelligence fair notice of what the law demands of them.") (internal citations removed); Johnson v. United States, 576 U.S. 591, 595 (2014) (holding that a statute violates due process when it is "so vague that it fails to give ordinary people fair notice of the conduct it punishes").

136. Karlin v. Foust, 188 F.3d 446, 458-59 (7th Cir. 1999).

137. *Davis*, 566 U.S. at 451 (quoting U.S. v. Hudson, 11 U.S. 32, 34 (1812)).

138. *See Grayned*, 408 U.S. at 108–09; *see* Karlin v. Foust, 188 F.3d 446, 458–59 (7th Cir. 1999).

139. *Davis*, 556 U.S. at 451.

140. Connally v. General Construction Co., 269 U.S. 385 (1926).

141. *Id.* at 388.

142. *Id.* at 391, 393.

143. *Id.* at 393–94.

144 *Id.*

> where a given piece of work is being done? Two men, moving in any direction from the place of operations, would not be at all likely to agree upon the point where they had passed the boundary which separated the locality of that work from the next locality.[145]

The presence of both terms in the statute created a "double uncertainty" that was "fatal to [the law's] validity as a criminal statute."[146]

Of course, all language is, to some extent, indeterminate. More recent cases analyzing voidness challenges make clear that "[t]he degree of vagueness that the Constitution tolerates—as well as the relative importance of fair notice and fair enforcement—depends in part on the nature of the enactment."[147] Courts have articulated three factors that heighten the level of clarity required.[148] First, and "[p]erhaps the most important" such factor, "is whether [the law] threatens to inhibit the exercise of constitutionally protected rights."[149] Second, the Constitution requires more clarity where violation of the statute causes significant penalties. Historically, more specificity was required to impose criminal penalties "because the consequences of imprecision" are more severe.[150] More recently, the Supreme Court has applied a heightened standard to "quasi-criminal penalties," meaning those civil penalties that carry harsh consequences, as well.[151] Third, greater clarity is required when the statute does not include a heightened mens rea requirement—imposing liability only where the actor subjectively understands that they are violating the law. As the Supreme Court has stated, the requirement that an act "be willful or purposeful may not render certain, for all purposes, a statutory definition of the crime which is in some respects uncertain. But it does relieve the statute of the objection that it punishes without warning an offense of which the accused was unaware."[152]

Federal courts developed the void-for-vagueness doctrine long before they applied it to medical exceptions to abortion statutes. Nevertheless, they deepened that doctrine in a range of challenges to abortion bans prior to *Dobbs*. We turn to those cases now.

*B. Vagueness Doctrine in Abortion Cases Pre-*Dobbs

Judicial opinions parsed the language of medical exceptions and other provisions of abortion statutes for vagueness during the *Roe* era. The guidelines they crafted in those opinions are critical to evaluating today's medical exceptions. What follows is a very partial history directed at cases that illuminate assessment of

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145. *Id.*

146. *Id.*

147. Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc., 455 U.S. 489, 498 (1982).

148. *Id.*

149. *Id.* at 499; *see also* Colautti v. Franklin, 439 U.S. 379, 394 (1979) (holding a statute was impermissibly vague because liability was conditioned "on confusing and ambiguous criteria" which "present[ed] serious problems of notice, discriminatory application, and [a] chilling effect on the exercise of constitutional rights").

150. *Village of Hoffman Estates*, 455 U.S. at 498–99.

151. Sessions v. Dimaya, 584 U.S. 148, 157 (2018).

152. Screws v. United States, 325 U.S. 91, 102 (1945) (plurality opinion).

contemporary medical exceptions.

In *Doe v. Bolton*, released on the same day as *Roe* was issued, the Supreme Court considered a vagueness challenge to a Georgia abortion ban centered on the statute's medical exception.[153] That exception, following the removal of several clauses struck down by the district court as unconstitutional, exempted a physician from criminal liability when, "based upon his best clinical judgment [he determined that] an abortion is necessary."[154] The challengers asserted that "the word 'necessary' does not warn the physician of what conduct is proscribed; that the statute is wholly without objective standards and is subject to diverse interpretation; and that doctors will choose to err on the side of caution and will be arbitrary."[155]

Interestingly, the Court held that the statute cleared the constitutional bar for vagueness precisely based on the wide breadth granted physicians by the revised exception's language:

> The net result is that the abortion determination, so far as the physician is concerned, is made in the exercise of his professional, that is, his "best clinical" judgment in the light of *all* the attendant circumstances. He is not now restricted to the three situations originally specified [in the clauses struck down by the district court]. Instead, he may range farther afield wherever his medical judgment, properly and professionally exercised, so dictates and directs him.[156]

Also integral to the Court's upholding the statute was the exception's inclusion of a subjective standard for liability, exempting the procedure when, "based upon [the physician's] best clinical judgment," an abortion was necessary.[157] Inclusion of this standard, in conjunction with the broad language of the rest of the exception, "allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman."[158] *Doe*'s reliance on the broad language of Georgia's exception, in combination with the exception's inclusion of a subjective standard for liability, challenges contemporary medical exceptions, which have sought to narrow physicians' discretion considerably, at the same time as most have failed to include a subjective standard for liability.

Six years later, in the case of *Colautti v. Franklin*, the Court struck down an abortion statute for vagueness, although its determination related to the statutory

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153. Doe v. Bolton, 410 U.S. 179, 191–92 (1973).

154. GA. CRIM. CODE § 26-1202(a) (1966) (repealed 1973). The medical exception as passed by the Georgia legislature originally exempted abortions performed by a physician if:

> [B]ased upon his best clinical judgment, an abortion is necessary because: "'(1) A continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health; or (2) The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect .'"

Doe, 410 U.S. at 191. The district court, however, struck down the statutorily specified reasons, leaving the other language intact.

155. *Doe*, 410 U.S. at 191.

156. *Id.*

157. *Id.* at 183.

158. *Id.* at 192.

requirements for physicians to determine viability rather than on the medical exception.[159] The Pennsylvania statute at issue required a physician contemplating an abortion to "ma[ke] a determination based on his experience, judgment or professional competence that the fetus is not viable"; further, "if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable," the provision required that a statutorily-mandated procedure be followed.[160] The *Colautti* Court noted as a preliminary matter that prohibitions against vagueness are heightened where a criminal statute is at issue, and that "[t]his appears to be especially true where the uncertainty induced by the statute threatens to inhibit the exercise of constitutionally protected rights."[161]

Ultimately, the Court found the statute unconstitutionally vague for three reasons that bear on today's medical exceptions.[162] Two of these related to ambiguities in the language of the statute. First, the Court found the statute unclear on whether the determination that "the fetus may be viable" should be judged according to the attending physician's own "experience, judgment, or professional competence" or based on an objective standard.[163]

Second, the Court found the statutory language ambiguous with respect to the relationship and meaning of the terms "viable" and "may be viable" in the exception:

> On the one hand, it may be that "may be viable" carves out a new time period during pregnancy when there is a remote possibility of fetal survival outside the womb, but the fetus has not yet attained the reasonable likelihood of survival that physicians associate with viability. On the other hand, it may be that "may be viable" refers to viability as physicians understand it, and "viable" refers to some undetermined stage later in pregnancy.[164]

The absence of clarity on this issue, the Court observed, put physicians in an untenable position in making abortion determinations.[165] The Court contrasted this language with the language evaluated in *Doe v. Bolton*, as well as the pre-*Roe* case of *United States v. Vuitch*, in which the medical exception had been upheld by the Court:[166]

> The contested provisions in those cases had been interpreted to allow the physician to make his determination in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient. The present statute does not afford broad discretion to the physician. Instead, it conditions potential criminal liability on confusing and ambiguous criteria. It therefore presents serious problems of notice, discriminatory application, and chilling effect on the exercise of constitutional rights.[167]

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159. Colautti v. Franklin, 439 U.S. 379 (1979).
160. *Id.* at 380 n.1; 35 PA. STAT. AND CONS. STAT. § 6605 (West 1974) (repealed 1982).
161. *Colautti*, 439 U.S. at 391.
162. *Id.* at 390–96.
163. *Id.* at 391.
164. *Id.* at 393.
165. *Id.*
166. United States v. Vuitch, 402 U.S. 62, 69–72 (1971); Doe v. Bolton, 410 U.S. 179, 191–92 (1973).
167. *Colautti*, 439 U.S. at 393–94.

In addition to these ambiguities, the *Colautti* Court held the vagueness of the statutory language was "compounded by the fact that the Act subjects the physician to potential criminal liability without regard to fault."[168] Specifically, the Pennsylvania statute, by failing to "make the physician's good faith determination of viability conclusive," did not require the type of blameworthy mental state usually attached to violations of criminal law.[169] This was important because "[t]his Court has long recognized that the constitutionality of a vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea."[170] Without such a subjective standard, "the statute is little more than 'a trap for those who act in good faith.'"[171] The Court also noted the uncertainty inherent in the medical determination of viability, which involved a complex calculation with a number of variables, including some that could not be known precisely, and which physicians often differed over, and noted that this uncertainty, "in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment."[172]

In sum, these *Roe* era cases show that abortion statutes that, rather than giving physicians broad discretion to exercise their medical judgment, instead seek to slice and dice the condition under which physicians can perform abortions, must be especially clear since they are prone to creating unconstitutional liability traps. Further, any vagueness is compounded by statutes that omit a subjective test exempting physicians' good-faith determinations that medical requirements have been met. Of course, as the next part discusses, both statutory features deemed problematic by the Court—statutes that slice and dice the conditions in which abortion can be performed without setting clear limits, and which omit a good-faith test—appear in medical exceptions in almost every restrictive state.

IV. RESTRICTIVE MEDICAL EXCEPTIONS POST *DOBBS* & VOID-FOR-VAGUENESS CHALLENGES

In the post-*Dobbs* world, it might at first blush seem as if medical exceptions to abortion statutes should no longer be subject to heightened protections against vagueness. After all, as the Supreme Court stated, "perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights."[173] And in our post-*Roe* legal regime, abortion is no longer constitutionally protected. Yet this contention would be in dire error.

As we explain in Section A, medical exceptions in states with previability

168. *Id.* at 394.
169. *Id.* at 389, 395, n.12.
170. *Id.* at 395.
171. *Id.* (quoting United States v. Ragen, 314 U.S. 513, 524 (1942)).
172. *Id.* at 396.
173. Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc., 455 U.S. 489, 499 (1982).

abortion bans warrant heightened scrutiny for vagueness for three reasons. These bans implicate fundamental rights aside from the right to abortion; their violation brings harsh penalties; and all but one state's exception lacks a subjective mens rea test. In Section B, we lay out the specific features of existing medical exceptions that provide inadequate direction to the physicians and prosecutors who must apply them. In Section C, we show that ambiguities in the medical exceptions of all restrictive states are significant enough to violate constitutional proscriptions on vagueness under the applicable heightened standards. Finally, Section D contends that challengers to such medical exceptions based on vagueness should be able to make—and win—even facial challenges to such statutes.

A. Even After Dobbs*, Medical Exceptions Should be Subjected to a Heightened Test for Vagueness*

Medical exceptions in states with restrictive abortion laws, even after *Dobbs*, must be subjected to rigorous scrutiny for vagueness because all have at least two, and most have all three, of the factors laid out by the Supreme Court that heighten strictures against statutory vagueness. First, while the choice to undergo an abortion is no longer protected by the right to privacy, all states' medical exceptions directly implicate the most basic of constitutional protections—for life and health—embodied in the U.S. Constitution and in state constitutions. Accordingly, all possess "the most important factor affecting the clarity that the Constitution demands of a law."[174]

State supreme courts have recognized that medical exceptions to abortion bans implicate such fundamental constitutional rights in the aftermath of *Dobbs*. In the Supreme Court of North Dakota's words, "[I]t is clear the citizens of North Dakota have a right to enjoy and defend life and a right to pursue and obtain safety, which necessarily includes a pregnant woman['s] fundamental right to obtain an abortion to preserve her life or her health."[175] Likewise, the Oklahoma Supreme Court applied strict scrutiny in a due process challenge and struck down a restrictive abortion statute on the ground that it violated pregnant women's fundamental right to life.[176]

Texas Supreme Court Justice Debra Lehrmann asserted this same principle in

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174. *Id.*

175. Wrigley v. Romanick, 988 N.W.2d 231, 242 (N.D. 2023); *see also id.* at 245, 246 (Tufte, J., concurring) ("The North Dakota Constitution guarantees the 'inalienable right[ ] of enjoying and defending life and liberty.' N.D. CONST. art. I, § 1. Commonly, an individual exercises this right of self-defense by responding to a threat of imminent serious bodily injury or death with physical force. Where a pregnancy raises a similar threat of serious bodily injury or death, the pregnant woman has a fundamental right to preserve her life and health with the aid of a physician."). Similarly, albeit somewhat more narrowly, the Oklahoma Supreme Court held that the Oklahoma Constitution "creates an 'inherent right to life' as well as 'liberty' and stands as the basis for protecting a pregnant woman's right to terminate a pregnancy in order to preserve her life." Okla. Call for Reprod. Just. v. Drummond, 526 P.3d 1123, 1130 (Okla. 2023). This right exists for medical conditions "that the woman is either currently suffering from or likely to suffer from during the pregnancy. Absolute certainty is not required ." *Id.*

176. *Drummond*, 526 P.3d at 1123.

a concurrence in *Texas v. Zurawksi*.[177] In her words: "[I]t should go without saying that, although the U.S. Supreme Court has concluded that abortion is not a constitutional right, a pregnant patient retains a liberty interest in access to medical care, including abortion, to protect her life and health."[178] In recognizing the continued constitutional implications of pregnant persons' right to life and health, Justice Lehrmann affirmed the principle that the Supreme Court recognized in *Roe* and reaffirmed in *Casey*, that even when the State may permissibly promote "its interest in the potentiality of human life," "the preservation of the life or health of the mother" retains fundamental constitutional status.[179] As such, in the U.S. Supreme Court's words, "precision must be the touchstone of legislation affecting basic freedoms."[180]

Second, the harsh penalties imposed on physicians deemed to violate medical exceptions in every state also require strict protection against vagueness.[181] As the U.S. Supreme Court has stated, the requirement of "fair notice" is heightened where violation of a statute leads to criminal penalties.[182] And even being subjected to loss of a medical license, a penalty characterized by a "prohibitory and stigmatizing effect," means that medical exceptions warrant heightened protections against vagueness.[183] The Fifth Circuit recognized this doctrine when it subjected an

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177. State v. Zurawski, 690 S.W.3d 644, 671 (Tex. 2024) (Lehrmann, J., concurring). Justice Lehrmann concurred to an opinion evaluating the Texas equivalent of a due-process challenge under the Texas Constitution. The Justice noted that the plaintiffs in the case had failed to raise a void-for-vagueness challenge; accordingly, such a challenge remained unresolved. A strong dissent from Idaho Justice Colleen Zahn to the denial of challengers' due process claims to the abortion statute's medical exception made a similar point. Zahn asserted that the Idaho Constitution protects women's right to abortion in order to preserve their life and health. Accordingly, strict scrutiny should have been applied to the consideration of the due process challenge to Idaho's medical exceptions. Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1215 (Idaho 2023) (Zahn, J., dissenting).

178. *Zurawski*, 690 S.W.3d at 673 (Lehrmann, J., concurring) (citation omitted). In contrast, the majority opinion in that case announced that the Texas Constitution "does not include general health among the rights it protects ." *Id.* at 666. To the extent that a state refuses to recognize a general right to health, we believe that it should find that a right to be free of substantial and permanent bodily impairment is constitutionally protected, either independently or as an integral part of the constitutionally protected right to life. If a court disagrees, the highest standard of scrutiny should still apply to the life exception.

179. Roe v. Wade, 410 U.S. 113, 164–65 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022); *see also* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992) (striking down statute excepting abortion only where there is "significantly greater medical risk" for the life or health of the woman facially invalid), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

180. Aptheker v. Sec'y of State, 378 U.S. 500, 514 (1964) (citing NAACP v. Button, 371 U.S. 415, 438 (1963)).

181. *See* Access Indep. Health Servs., Inc. v. Wrigley, 16 N.W.3d 902, 912 (N.D. 2025) ("The harsh punishment the plaintiffs face if they fail to conform their medical practice to the requirements of the law makes the degree of specificity required here very high.").

182. *See* Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc., 455 U.S. 489, 498 (1982) ("The degree of vagueness that the Constitution tolerates—as well as the relative importance of fair notice and fair enforcement—depends in part on the nature of the enactment.").

183. *See id.* at 499 ("[T]he village concedes that the ordinance is 'quasi-criminal,' and its prohibitory and stigmatizing effect may warrant a relatively strict test.") (citing Transcript of Oral Argument at 4–5, Flipside, Hoffman Ests., Inc. v. Vill. of Hoffman Ests., 639 F.2d 373 (7th Cir. 1981)); *see also* Sessions v. Dimaya, 584 U.S. 148, 156 (2018) (applying "the most exacting vagueness standard"

abortion regulation to heightened scrutiny for imposing "potentially significant civil and administrative penalties, including fines and license revocation, which can be characterized as quasi-criminal."[184]

The sanctions imposed by such statutory schemes mean that medical exceptions require high scrutiny not only because they threaten physicians' liberty but also because these penalties significantly increase the risks of depriving patients' constitutional rights to life and health through chilling abortions that are arguably legal, as the medical and legal cases in the Introduction demonstrated. As Idaho Supreme Court Justice Colleen Zahn recently noted, medical exceptions that are compounded by harsh penalties will cause physicians to consult a lawyer when women's lives are at risk, putting women in jeopardy from the delay, and infringing on physicians' sound judgments since lawyers will ultimately make the decisions.[185] The empirical data from our study show quite clearly that this is exactly what physicians placed in this predicament do.[186]

Third, requirements of specificity are greater when statutes that impose significant liability do not include heightened standard for mens rea.[187] Put another way, if a statute fails to "require[] that a defendant have some degree of guilty knowledge or culpability in order to be found liable for [their] conduct," strictures against vagueness are increased.[188] In the context of medical determinations regarding abortion restrictions, courts frame this inquiry as whether the statute exempts good-faith determinations by the physician, and therefore conditions liability on the finding of a "guilty mind."[189] Of the twenty states imposing strict limits on abortion, only one state, Idaho, includes such a "good faith medical judgment" standard in its medical exception.[190] Of the remaining nineteen states, fifteen evaluate whether the terms of the exception apply under a "reasonable medical judgment" standard,[191] and would therefore impose liability on physicians

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to immigration removal cases, despite their being civil penalties, because the consequence is so severe); *id.* at 184 (Gorsuch, J., concurring) ("[T]he happenstance that a law is found in the civil or criminal part of the statute books cannot be dispositive."); Manning v. Caldwell for City of Roanoke, 930 F.3d 264, 273 (4th Cir. 2019) ("[E]ven laws that nominally impose only civil consequences warrant a 'relatively strict test' for vagueness if the law is 'quasi-criminal' and has a stigmatizing effect.").

184. Women's Med. Ctr. of Nw. Houston v. Bell, 248 F.3d 411, 422 (5th Cir. 2001); *see also Manning*, 930 F.3d at 273 (holding that laws that impose stigmatizing civil penalties demand a heightened vagueness analysis); United States v. Clinical Leasing Serv., Inc., 925 F.2d 120, 122 n.2 (5th Cir. 1991) (finding civil penalty provision of the Controlled Substances "warrants a relatively strict test," because "the Government does not dispute that [21 U.S.C. § 842(a)(2) (1988)] authorizes fines which, although civil in description, are penal in character.").

185. Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1215 (Idaho 2023) (Zahn, J., dissenting).

186. *See supra* Part II.

187. *See* Women's Med. Pro. Corp. v. Voinovich, 130 F.3d 187, 203–04 (6th Cir. 1997), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

188. *See id.* at 203–04; *see* Morissette v. United States, 342 U.S. 246, 252 (1952). *See generally* Mary Claire Bartlett, *Physician Mens Rea: Applying* United States v. Ruan *to State Abortion Statutes*, 123 COLUM. L. REV. 1699, 1722 (2023).

189. *See Voinovich*, 130 F.3d at 204; *see* Colautti v. Franklin, 439 U.S. 379, 391 (1979), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

190. *See supra* note 48.

191. *See supra* note 49.

who lack knowledge that their conduct is wrongful.[192] Another four simply state that an abortion must be "necessary" to prevent specific health outcomes for the pregnant person, therefore also lacking a subjective standard to assess liability.[193]

This means that all three factors heightening the test for vagueness are present in the nineteen states that do not include a subjective standard in their medical exceptions. Two of the three factors—including the most significant factor of implicating fundamental constitutional rights—are present in the remaining state. We now turn to consider states' medical exceptions under these heightened standards.

B. Medical Exceptions in Restrictive States Fail to Give Doctors and Law Enforcement Officials Adequate Direction of When Abortion Care Is Lawful

As Part II made clear, several features of existing statutes make it difficult for physicians to determine whether medical exceptions are met in particular cases. In this section, we explain why these features contribute to these statutes' failing to clear the vagueness bar.

1. Issues Relating to the Level of Risk Required (All Restrictive States)

As our empirical study shows, medical exceptions raise questions regarding the level of risk to both life and health that a patient must face in order to authorize abortion. Consider the language of Idaho's medical exception that abortion be "necessary to prevent the death of the pregnant woman."[194] Does this language mean that a physician can lawfully perform an abortion only if the patient's chances of death are a hundred percent? To the extent that seems like an unreasonably strict reading of the statute, recognize that this is the interpretation that the state of Idaho initially argued for, and which the district court initially adopted, early in the litigation in *Moyle v. United States*.[195] In that case, the U.S. Department of Justice sued the state of Idaho, contending that the narrow scope of its medical exceptions conflicted with hospitals' duty to stabilize patients obtaining emergency care under federal law. The state argued early in that litigation that abortion was not permitted under state law in a range of medical conditions "because a physician could not know, 'with certainty,' that an abortion is necessary to save the mother's life in those

192. *See Voinovich*, 130 F.3d at 204.

193. *See supra* note 51. The fact that some states that omit subjective requirements in their medical exceptions elsewhere condition liability for performing the abortion on the physician's intent to end the fetus's survival does not satisfy the requirement that mens rea be necessary to meet the medical exception. *See Colautti*, 439 U.S. at 394–95 (applying heightened vagueness standard to provision requiring a physician to make a viability determination that did not include a mens rea requirement, despite recognizing that another provision in the statute specified that the physician must "intentionally, knowingly, recklessly or negligently caus[e] the death of another human being" to be subjected to liability).

194. IDAHO CODE ANN. §18-622(2)(a)(i) (West 2020).

195. United States v. Idaho, 342 F.R.D. 144 (D. Idaho 2022), *motion denied, writ of cert. granted sub nom.*, Moyle v. United States, 144 S. Ct. 540 (2024), *motion denied, petition dismissed as cert. improvidently granted*, 603 U.S. 324 (2024).

circumstances."[196] Based on this testimony, the district court determined that the exception required that the "pregnant woman's death be objectively 'imminent' before a physician can perform an abortion."[197] Subsequently, the Idaho Supreme Court, in construing the exception, denied that the exception "require[d] *objective* certainty."[198] After this, Idaho announced during U.S. Supreme Court review that the statute allowed physicians to treat a range of conditions for which the chances of death could be substantially less than certain.[199] The U.S. Supreme Court ultimately dismissed its review as improvidently granted, in part based on the state's changing position.[200]

If judges and lawyers—who are trained experts in reading statutes—cannot provide clear answers regarding when abortions are legal, how can a physician be expected to know what level of risk the life exception requires in the many states that authorize abortion when it is "necessary" to prevent the patient's death? What if the risk of death is only 95 percent? What if it is 50 percent? Would a 10 percent chance of death suffice? Except in the situation where there is 100 percent risk of death, the physician must consider themselves at risk of prosecution—and properly so.

Similar issues arise with respect to the health exception. What level of risk is required to constitute "serious risk of substantial and irreversible physical impairment of a major bodily function"?[201] As judges and tort scholars commonly assess risk in negligence, when serious bodily harm is at issue, even a very small risk that such harm will occur—just a few percentage points or even less—will often be too much risk to impose on others.[202] Likewise, in standard medical practice, physicians will raise the possibility of abortion to a patient when the level of risk involved is quite low if the potential impairment is serious and irreversible. But "serious risk" under the statute might equally be deemed to require more than 60 percent or even 75 percent; the physician simply has no way to know. And, threatened with prison or the loss of their profession if they are second-guessed by a prosecutor or jury, the likely result is that they will hesitate—sometimes with dire consequences to their patient, as the stories in our Introduction demonstrate. To the extent that the legislature intended this result, the statute should be struck down as violating the pregnant patients' right to preserve their health. To the extent that the legislature intended a broader exception, it is deeply unclear how much broader it should be read—leaving the physician who must make the determination at threat of severe penalties with no guardrails.

Another set of issues induces still more difficulty for physicians tasked with

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196. *Moyle*, 603 U.S. at 333 (Barrett, J., concurring) (citing 1 App. 30–38).
197. *Id.* at 324 (Barrett, J., concurring).
198. Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1203 (Idaho 2023).
199. *Moyle*, 603 U.S. at 333 (Barrett, J., concurring) (citing 1 App. 30–38).
200. *Id.*
201. N.C.G.S. § 90-21.81(5) (defining "medical emergency").
202. *See, e.g.,* Williams v. Hous. Auth. of the City of Bridgeport, 327 Conn. 338, 383, 174 A.3d 137, 163 (2017) ("[W]e have recognized that the failure to protect against a low probability of grave harm may constitute negligence, as long as the burden of prevention is not substantial in relation to that risk.").

applying these exceptions: Physicians acting in the moment will often lack sufficient information to know whether the statutory requirements (even if they were clear) are met on the facts of the medical case before them because they cannot precisely determine the level of risk the patient faces. When a patient has multiple health conditions that make determining their level of risk difficult on the spot, but the patient's condition is rapidly deteriorating, or when accurately determining a patient's level of risk requires laboratory or other testing whose results are not immediately available, or even when medical knowledge about the level of risks resulting from a condition or set of conditions is not yet well developed, these statutes requires a level of clarity about the amount of risk that physicians often will not be able to ascertain in the moment.

The fact that fifteen states use the term "reasonable medical judgment," or an equivalent term, in their medical exception might at first blush seem to give some latitude to the determination that the physician must make on the spot, suggesting that a physician who is reasonable in being wrong would not ultimately face liability.[203] Yet, as North Carolina's and other emergency exceptions are framed, that reasonableness requirement does not apply to a general determination that an abortion is appropriate, which would absolve the physician from liability. Instead that reasonableness requirement applies specifically to the determination that an immediate abortion is necessary to avert death or serious risk of physical impairment.[204] There are many situations in which no reasonable physician would be in a position to make that determination. As the Supreme Court noted in *Colautti*, medical determinations that require complex calculations with multiple variables, particularly when some variables cannot be known precisely, and over which physicians may differ, in combination with statutes that impose strict penalties for erroneous determinations, can "have a profound chilling effect on the willingness of physicians to perform abortions in the manner indicated by their best medical judgment."[205]

Justice Evelyn Wilson of the Kansas Supreme Court raised similar issues in a concurring opinion in a case striking down a Kansas abortion statute on the ground that it violated the state constitution's right to privacy.[206] The medical exception at issue used language common to post-*Dobbs* abortion exceptions, permitting abortions "necessary to preserve the mother's life;" as well as in cases in which "a continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[207] Justice Wilson asserted that the statute's medical exception violated constitutional guarantees against vagueness because it did not define the terms "necessary" or "substantial," and because "whether a major bodily function is 'irreversibly' impaired is a fact,

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203. *See supra* note 49.

204. In North Carolina, medical emergency is defined as "[a] condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death ." N.C. GEN. STAT. § 90-21.81(5) (2024).

205. Colautti v. Franklin, 439 U.S. 379, 396 (1979).

206. Hodes & Nauser, MDs, P.A. v. Kobach, 551 P.3d 37, 56 (Kan. 2024) (Wilson, J., concurring).

207. KAN. STAT. ANN. § 65-6743 (2015).

rather than subjective or objective opinion, but that fact may not be obvious at the time of the procedure."[208] The language, she observed, left many questions unanswered for the physician, including: "What if something goes wrong during an abortion operation—such as unforeseen bleeding, a drop in blood pressure, unexpected pain, sudden unconsciousness—and the doctor determines a surgical procedure that may involve separation of fetal 'members' of a living fetus is necessary to save the life of the mother?"[209] Under the "plain language" of the medical exception, she said, "it is unclear if the physician's medical opinion on the matter is sufficient to allow her to perform the procedure she deems necessary without risk of civil liability or criminal culpability. The statute provides no standard for the physician to ascertain legal versus illegal action before she takes that action."[210]

2. Issues Relating to the Timing of an Abortion (19 of 20 Restrictive States)

Issues of timing relating to when an abortion could legally be performed arise in all states with restrictive statutes except Texas.[211] These issues are most obvious in the eight restrictive states whose statutory exceptions permit abortion for medical reasons only in the case of a "medical emergency."[212] Two states go still further, defining "medical emergency" to require some immediacy of the medical threat, for example, stating that "immediate abortion" must be necessary to avert the patient's death.[213] Scrutiny of the language of exceptions framed in terms of medical emergencies leaves little doubt that they do not rise to the exacting standards of notice required by the void-for-vagueness doctrine.[214]

Consider once again North Carolina's abortion statute, the violation of which can result in license revocation, civil damages, and six months of imprisonment, and which bars routine abortions beyond twelve weeks after conception.[215] The statute makes an exception for "[w]hen a qualified physician determines there exists a medical emergency."[216] "Medical emergency," in turn, is defined as "a condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible physical impairment of a major bodily function."[217] The statutory language raises a

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208. Hodes & Nauser, 551 P.3d at 58 (Wilson, J., concurring) (citing State v. Norris, 595 P.2d 1110, 1113 (Kan. 1979)).

209. *Id.* at 60.

210. *Id.*

211. *See supra* note 35 for a discussion of Texas's recent clarification on the issue of the timing of an abortion under the state's medical exception.

212. These include Alabama, Arkansas, Georgia, Iowa, Nebraska, North Carolina, South Carolina, and West Virginia. *See infra* Appendix.

213. N.C. GEN. STAT. § 90-21.81(5) (2024); *see also* NEB. REV. STAT. § 71-6914(3)(a)-(b) (2024) (requiring that "a delay in terminating [the] pregnancy will create a serious risk ").

214. *See* Morrison, *supra* note 38.

215. N.C. GEN. STAT. § 90-21.81A(a) (2024); N.C. GEN. STAT. § 14-44 (2023); N.C. GEN. STAT. § 90-21.88(a) (2024); N.C. GEN. STAT. § 90-21.88A (2024); N.C. GEN. STAT. § 15A-1340.17 (2025).

216. N.C. GEN. STAT. § 90-21.81B (2024).

217. *Id.* § 90-21.81(5). The definition excludes psychological and emotional conditions. *Id.*

number of issues relating to timing for physicians seeking to determine if they may legally deliver abortion care. For one, what does the statute's requirement mean that a medical emergency must necessitate "immediate" abortion to avert the patient's death? If a patient is getting septic, or is experiencing internal hemorrhaging, but the risk of death is hours away, meanwhile the patient's chances of death are rising, is an abortion lawful under the "immediate" language? If a patient's condition is stable, but her condition is associated with a significant risk of death, and her condition may become unstable at any time in the future and therefore raise her risk of death still further, is an abortion lawful? A physician faced with loss of medical license has no way to avoid liability with certainty without denying abortions in both these cases. In fact, under this language, the only time that a physician would be absolutely certain of being protected from liability is at the last moment that an abortion could be performed to save the patient's life—and the physician will almost never know exactly when this point will be until after the fact. To the extent that the legislature intended to impose such a harsh requirement, it should certainly be deemed a violation of women's due process interest in life. Yet reading any more leeway into this requirement inevitably introduces ambiguity, which subjects not only the patient, but also the physician, to significant risk. Because the exception fails to give physicians "a reasonable opportunity to know what is prohibited, so that [they] may act accordingly," it is unconstitutionally vague.[218]

Similar issues arise with respect to timing in interpreting North Carolina's health exception's requirement that a "delay" in abortion would "create serious risk of substantial and irreversible physical impairment of a major bodily function."[219] If a physician is monitoring a patient who is stable but faces a serious risk of substantial impairment, must they wait to perform the abortion because it is not clear that a delay would "create" heightened risk for the patient? And would this be the case even if it is predictable but not certain that, if and when the patient starts to go into crisis, it would be too late to stop that impairment? Reading the requirement to necessitate that a doctor be certain that any delay whatsoever would result in an increased risk that would trigger the exception would lead to draconian consequences. But it is deeply unclear how much more leeway can be read into the statute, introducing ambiguity and threat, not only to the pregnant patient, but to the physician making the determination.

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218. Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc., 455 U.S. 489, 498 (1982) (quoting Grayned v. City of Rockford, 408 U.S. 104, 108–09 (1972)); *see also, e.g.*, Kolender v. Lawson, 461 U.S. 352, 357 (1983) ("[T]he void-for-vagueness doctrine requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited . ."); United States v. Davis, 588 U.S. 445, 451 (2019) ("[I]n our constitutional order, a vague law is no law at all. Only the people's elected representatives in Congress have the power to write new federal criminal laws. And when Congress exercises that power, it has to write statutes that give ordinary people fair warning about what the law demands of them. Vague laws transgress both of those constitutional requirements."); Johnson v. United States, 576 U.S. 591, 595 (2015) (holding that a statute violates due process when it is "so vague that it fails to give ordinary people fair notice of the conduct it punishes . .").

219. N.C. GEN. STAT. § 90-21.81(5) (2024).

Issues regarding timing emerge with exceptions framed in terms of "a medical emergency" even when they do not use the immediacy language used in North Carolina. Consider Iowa's medical exception, which permits an abortion only when "in the physician's reasonable medical judgment, a medical emergency exists."[220] If Amanda Zurawski had lived in Iowa, when, after her water broke, would a physician have been authorized to perform an abortion? Although she was at high risk for sepsis when she was sent home from the hospital, she had no infection at that time. Would her condition still constitute a "medical emergency"? Or would physicians have to have waited until she returned with sepsis, when it would be difficult to control? And if they had managed to stabilize her condition but she still faced a significant risk of death, would that have constituted a medical emergency that authorized abortion?

And although statutes that do not use "medical emergency" language avoid issues regarding what, exactly, constitutes a medical emergency, they still raise questions regarding timing. Take South Carolina's exception for cases in which abortion is necessary "to prevent the death of the pregnant woman."[221] If a pregnant woman is at risk of death, but her death is not imminent, may a physician perform an abortion lawfully?

The divergent readings of timing possible with these medical exceptions are demonstrated by the very different interpretations of these laws that different courts have reached. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court, in assessing the challengers' due process claim during the *Roe* era, considered the medical exception to Pennsylvania's abortion restriction.[222] That statute restricted abortions to a "medical emergency,"[223] defining the term as a "condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function."[224] The Supreme Court upheld the statute only after accepting the Third Circuit's construction of the statute, which adopted the clarification of the statute proposed by the state during the litigation. This construction read the medical exception to allow abortions for all conditions that, "if left untreated *could progress to such a point* that death or substantial and irreversible impairment of a major bodily function will occur."[225]

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220. IOWA CODE ANN. § 146E.2(2)(a)(2) (West 2024).

221. S.C. CODE ANN. § 44-41-640(B)(1) (2023).

222. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

223. *See infra* Part IV.B.3 for a discussion of the significance of moving from a good-faith standard to a "reasonable medical judgment test."

224. Planned Parenthood of Se. Pa. v. Casey, 947 F.2d 682, 699 (3d Cir. 1991), *aff'd in part*, *rev'd in part*, 505 U.S. 833 (1992); 18 PA. STAT. AND CONS. STAT. ANN. §§ 3201–3220 (West 1983 & Supp. 1991).

225. *Casey*, 947 F.2d at 700 (emphasis added). In the words of the *Casey* Court:

> The Commonwealth does not challenge the assertion that its regulations would be unconstitutional if women having preeclampsia, inevitable abortion, or prematurely ruptured membrane were required to satisfy all of the requirements of the Act before having an abortion. Rather, the Commonwealth responds that preeclampsia, inevitable abortion, and

Casey's broad reading of Pennsylvania's medical exception contrasts sharply with the Oklahoma Supreme Court's narrow interpretation of a medical exception's similar language in *Oklahoma Call for Reproductive Justice v. Drummond*.[226] That case considered a substantive due process challenge to an abortion statute based on the narrowness of its medical exception, which barred abortion "except to save the life of a pregnant woman in a medical emergency."[227] Despite the fact that the language of Oklahoma's exception did *not* contain the same terminology about immediacy present in the Pennsylvania statute considered in *Casey*, (the terms "immediate" and "delay" were not included in the Oklahoma statute), the Court struck the statute down based on determining that the exception narrowly required that the threat to life and health of the woman be immediate, thereby endangering her life. In the Court's words:

> We read this section of law to require a woman to be in actual and present danger in order for her to obtain a medically necessary abortion. We know of no other law that requires one to wait until there is an actual medical emergency in order to receive treatment when the harmful condition is known or probable to occur in the future. [This requirement] would further endanger the life of the pregnant woman and does not serve a compelling state interest.[228]

Two concurrences to the opinion also spoke to problems with timing raised by the exception's language. Justice Yvonne Kauger asked, "Must an Oklahoma physician wait until their patient has a seizure, a stroke, experiences multiple organ failure, goes septic, or goes into a coma because of the fear of criminal prosecution?"[229] Justice Doug Combs added:

> We must define the right to preserve the life of the mother to mean something more than waiting until she actually has a life-threatening medical emergency before she is allowed to receive treatment to terminate a pregnancy. If not, the healthcare practitioner will continue to face the impossible dilemma of deciding how close to death the woman must be to provide medical care while fearing such actions are outside the confines of the law. How imminent must death be?[230]

The language in both the Pennsylvania and Oklahoma statutes is very different

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> prematurely ruptured membrane are "medical emergencies" as defined in the Act because "all of these conditions, if left untreated, could progress to such a point that death or substantial and irreversible impairment of a major bodily function will occur."

Id. (citing Reply Br. Appellants at 4 n.2).

226. Okla. Call for Reprod. Just. v. Drummond, 526 P.3d 1123 (Okla. 2023) (striking down OKLA. STAT. tit. 21, § 861 (2021) and OKLA. STAT. tit. 63, § 1-731.4 (Supp. 2022)).

227. *Id.*

228. *Id.* at 1131.

229. *Id.* at 1144 (Kauger, J., concurring).

230. *Id.* at 1147 (Combs, J., concurring); *see also* Wrigley v. Romanick, 988 N.W.2d 231, 240 (N.D. 2023) (recognizing a "fundamental right for a woman to obtain an abortion in instances where it is necessary to preserve her life or health," and finding the state's abortion exceptions likely violated this test because they were framed as an affirmative defense and failed to include an exception for the health of the pregnant patient).

from that of Idaho's statute, which does not use the language of "medical emergency;" instead, framing the exception in terms of permitting abortions "necessary to prevent the death of the pregnant woman."[231] Yet despite the omission of the term "medical emergency," even this framing raises difficult issues regarding timing, as shown by the Supreme Court's recent dismissal of certiorari as improvidently granted in the *Moyle v. United States* case.[232] The district court below relied on testimony from government witnesses to determine that, under the exception, the "pregnant woman's death must be objectively 'imminent' before a physician can perform an abortion."[233] Subsequently, the Idaho Supreme Court construed the Act differently, stating that the statute "does not require a particular level of immediacy before the abortion can be 'necessary' to save the woman's life."[234] After this, while the case was under review by the Supreme Court, the state announced that several conditions it had earlier contended did not fall within the medical exception, in fact were subject to treatment "even if the threat to the woman's life is not imminent."[235]

The question all this raises for courts considering vagueness challenges is this: if the language of these statutes is sufficiently unclear so that even courts reach different results in interpreting them, and even the state's attorneys charged with defending the laws are so insufficiently guided by these words that they radically change their own positions about what it means, how can physicians who do not read statutes for a living and must make decisions on the spot, apply them to reach determinate results?[236] The answer, of course, is that they cannot and will not, causing patients to die.

3. Absence of a Good-Faith Medical Judgment Standard (19 of 20 Restrictive States)

Statutory language dictating the medical conditions that warrant exceptions cannot be considered in a vacuum. Instead, as the Supreme Court has repeatedly stated, this language must be judged according to the standard of mens rea under which the presence of these conditions will be assessed.[237] When the presence of the medical conditions is determined based on the attending physician's own good-

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231. IDAHO CODE ANN. §18-622(2)(a)(i) (West 2020).

232. Moyle v. United States, 603 U.S. 324 (2024) (Barrett, J., concurring).

233. *Id.* at 332.

234. *Id.* at 333 (quoting Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1203 (Idaho 2023)).

235. Brief for the Respondent at 8–9, Moyle v. United States, 603 U.S. 324 (2024), No. 23–726.

236. As this Article went to press, the U.S. District Court for the Northern District of Idaho made just this point with respect to Idaho's abortion ban:

> Although the Idaho Supreme Court has said that a pregnant woman's death need not be "imminent" to qualify under the life-saving exception, the Defense of Life Act plainly requires that an abortion is "necessary to prevent the death." If "imminent" is not the standard, how close must the woman be to death for the abortion to be "necessary"? There is no way for physicians to know this, and the price of falling on the wrong side of the line is a felony conviction.

St. Luke's Health Sys., Ltd. v. Labrador, 782 F. Supp. 3d 953, 975-76 (D. Idaho 2025).

237. *See* Doe v. Bolton, 410 U.S. 179, 192 (1973), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022); Colautti v. Franklin, 439 U.S. 379, 395 (1979), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

faith medical judgment, this "subjective test" of mens rea helps cure ambiguities regarding the required medical conditions because it frees the physician from liability so long as the assessment is made in good faith. As the Supreme Court has stated, inclusion of a subjective standard serves to "mitigate a law's vagueness, especially with respect to the adequacy of notice to the complainant that his conduct is proscribed."[238] Such a subjective standard, however, is applied in only two restrictive states.[239]

As mentioned above, the Supreme Court's decision in *Doe v. Bolton* explains why the presence of a subjective medical standard is so critical for physicians seeking to determine whether a medical exception applies to a patient's case.[240] In *Doe*, the challengers to the Georgia statute contended that the exception's language allowing an abortion when it is "necessary" because continued pregnancy would endanger a pregnant woman's life or injure her health was unconstitutionally vague.[241] The Court responded that inclusion of the good-faith medical judgment standard in that exception remedied problems with the language's ambiguity by "allow[ing] the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman."[242] In fact, the *Doe* Court recognized, the vagueness of statutory language actually increased the range of discretion of the attending physician when it was combined with a subjective standard. The good-faith belief standard, for example, would allow the physician to construe whether an abortion was "necessary" in whatever way he thought was appropriate, so long as he did so exercising good faith.[243] Likewise, the Idaho Supreme Court in *Planned Parenthood Great Northwest v. State*, held that although the phrase "necessary to prevent the death of the pregnant woman" might otherwise be deemed unconstitutionally vague, that provision was saved by the inclusion of a "good-faith medical judgment" standard, which "allows the attending physician the room he needs to make his best medical judgment.'"[244]

Does the "reasonable medical judgment" standard, used in fifteen restrictive states,[245] similarly protect physicians from incurring unsuspecting liability as they struggle to determine whether a medical exception applies? The Texas Supreme Court, assessing the equivalent of a due process challenge under the state's constitution, found this standard both to give more guidance to, and be even more protective of, physicians than a subjective good-faith test.[246] According to the Court:

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238. Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc., 455 U.S. 489, 499 (1982); *see Colautti*, 439 U.S. at 395.

239. *See supra* note 48.

240. *See supra* Part III.B.

241. *Doe*, 410 U.S. at 190.

242. *Id.* at 192.

243. *Id.* (noting that the indeterminacy of statutory language allows the "attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.").

244. Planned Parenthood Great Nw. v. Idaho, 522 P.3d 1132, 1203–04 (Idaho 2023) (quoting Spears v. State, 278 So.2d 443, 445 (Miss. 1973)).

245. For a list of those states, see *supra* note 49.

246. *See* State v. Zurawski, 690 S.W.3d 644 (Tex. 2024). No void-for-vagueness challenge was

> [A] subjective standard is less insulating of a physician's decision-making than the [reasonable-medical judgment standard] that the Legislature has adopted . [Under this test,] physicians can turn to peer-reviewed best practices associated with a patient's particular diagnosis and treatment. A subjective standard, in contrast, examines a doctor's intent instead of medical facts. This intent would be subject to scrutiny based on a physician's views about abortion and its availability. Regardless of those views, the law permits an abortion when reasonable medical judgment would find one indicated to avert death or substantial bodily impairment of a pregnant woman diagnosed with a life-threatening physical condition arising from or aggravated by her pregnancy. With confirmation of those facts through the exercise of reasonable medical judgment, the law permits an abortion without inquiring into a physician's state of mind.[247]

In a similar vein, other judges have opined that the inclusion of a reasonable medical judgment standard remedies statutory ambiguities in medical exceptions by simply requiring physicians to conform to the customary standards in medical practice. Imposing such a standard, they say, is no different from imposing the standard of care that generally applies in medical malpractice actions.[248]

Unfortunately, as our empirical study shows, these contentions are starkly untrue when it comes to giving physicians the guidance needed to avoid violating abortion statutes. Medical malpractice actions determine whether physicians have comported with customary practices in the medical profession.[249] However, established practices among physicians regarding abortions consider the patient's own preferences regarding their tolerance for risk; yet statutory medical exceptions apply standards for risk external to the patient. This means that the "reasonable medical judgment" language does not and cannot have any firm meaning in the context of assessing medical exceptions to abortion statutes. Indeed, the American College of Obstetricians and Gynecologists has stated that it is contrary to good medical practice for physicians to make abortion decisions without according the patient autonomy.[250] No medical standards of conduct exist regarding how to assess

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brought in that suit. *See supra* note 177.

247. *Zurawski*, 690 S.W.3d at 663.

248. *See, e.g.*, Karlin v. Foust, 188 F.3d 446, 464 (7th Cir. 1999) ("[T]his is the same standard by which all of their medical decisions are judged under traditional theories of tort law."); *Zurawski*, 690 S.W.3d at 678 (Busby, J., concurring) (citations omitted) (noting that the reasonable medical judgment standard "is neither novel nor unique to the abortion context. Rather, it echoes the familiar standard of care that applies to all common-law negligence claims alleging medical malpractice."); Hodes & Nauser, MDs, P.A. v. Kobach, 551 P.3d 37, 58–59 (Kan. 2024) (Wilson, J., concurring) (criticizing medical exception for omitting "reasonably prudent physician" standard).

249. *See, e.g.*, Hemsley v. Langdon, 909 N.W.2d 59, 67 (Neb. 2018) ("[I]n a medical malpractice case, the standard of care is found in the customary practices prevailing among reasonable and prudent physicians."); Palandjian v. Foster, 842 N.E.2d 916, 921 (Mass. 2006) ("The standard of care is determined by the care customarily provided by other physicians, it need not be scientifically tested or proven effective: what the average qualified physician would do in a particular situation *is* the standard of care.").

250. *See Abortion Policy: Statement of Policy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (July 2025), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy [perma.cc/DA3G-Z6S6].

how much risk is too much to a particular patient's life or health, considered apart from the patient's own views. Neither are there well-developed and established medical practices regarding when and which situations would warrant abortions in compliance with abortion statutes. By imposing a reasonable medical judgment standard while removing the patient's assessment of how much risk constitutes too much risk or amounts to a "serious" risk, these statutes impose a standard with no clear content for physicians to follow.

Further, established medical standards have developed over time, in discussion among physicians and medical boards, in collaboration with medical schools, and in consultation with medical literature. There is no similar body of medical experience from which to determine what constitutes the reasonable medical judgment required to be relieved of liability in these statutes. Of course, testimony on the issue of what constitutes reasonable medical judgment may still be presented by a medical witness after the fact, if and when a physician is charged with violating an abortion statute. But that testimony will not and cannot draw on those well-established practices in the profession from which physicians will draw on when they testify as experts in medical malpractice cases. More importantly for void-for-vagueness purposes, physicians who must make abortion determinations in the moment have no such body of reasonable medical judgment that they can call on to determine whether they will face significant liability. Neither will enthusiastic prosecutors have such standards to constrain their discretion in later determining whether to file charges against the physicians who had to make these determinations without such guidelines.

The absence of either a good-faith subjective standard or a reasonable medical judgment test in the remaining four states provides physicians neither further clarity nor insulation from liability.[251] These are states that hold physicians to the standard that abortion must be "necessary" to prevent specific health outcomes for the pregnant person. This objective standard does not introduce added indeterminacy by imposing a medical judgment standard that has no concrete content. Yet by combining vague language with an objective test of necessity, statutes containing this standard also fail the vagueness test—indeed, they impose yet more risk on attending physicians by making a jury the ultimate arbiter of whether the indeterminate terms of the statute are deemed to apply on the particular set of facts. The Pennsylvania statutory provision that the Supreme Court analyzed in *Colautti* was similar in imposing a standard that contained no mens rea requirement: that provision required doctors to perform abortions in a manner that "would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother."[252] The Court determined that, on this language, there was "nothing to suggest a *mens rea* requirement with respect to a decision whether a particular abortion method is

251. For a list of those states, see *supra* note 51.
252. Colautti v. Franklin, 439 U.S. 379, 397 (1979).

necessary in order to preserve the life or health of the woman."[253] It also stated that, when statutes impose uncertain requirements on physicians in a context in which they must make complex medical calculations with respect to a number of variables, including some that may not be known precisely, and over which physicians differ, "the statute is little more than 'a trap for those who act in good faith.'"[254] In conjunction with a statute "imposing strict civil and criminal liability for an erroneous determination," the statute could result in having "a profound chilling effect on the willingness of physicians to perform abortions in the manner indicated by their best medical judgment."[255]

Kansas Supreme Court Justice Evelyn Wilson's concurrence in *Hodes & Nauser, MDS, P.A. v. Hobach*, addressed the problems with imposing an objective test in a medical exception.[256] The medical exception related to a Kansas statute banning the dilation and evacuation abortion procedure,[257] which exempted abortions "necessary to preserve the mother's life," as well as those in which "a continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[258] The problems with the failure to define terms such as "necessary" and "substantial," she stated, raised problems with due process notice for physicians because they could not be certain whether abortions were warranted in a specific medical case. Yet, she observed, by failing to state whose perspective the requisite conditions would be assessed from, the exception also "runs afoul of the second, and 'more important,' concern [—]arbitrary enforcement."[259] In her words:

> [T]he physician will be vulnerable to the retroactive analysis of prosecutors and juries who may conclude the procedure was not necessary based on a standard other than reasonable medical judgment and the physician's good faith assessment . Put simply, the physician has no idea how her actions will be judged. Despite the possibility that ill-advised inaction or insufficient action may lead to negative consequences for her woman patient, the physician may be hesitant to act as she believes she should if, by doing so, she risks civil or criminal liability for herself under the restrictions of S.B. 95 .
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> In my view, the Legislature's omission of any discernable standard means the physician's expert decision will inevitably be second-guessed by prosecutors, judges, and juries applying a personal and ultimately mysterious standard to the physician's conduct. But in our structure of government the Legislature

253. *Id.* at 401.
254. *Id.* at 395.
255. *Id.* at 396.
256. Hodes & Nauser, MDs, P.A. v. Kobach, 551 P.3d 37 (Kan. 2024).
257. *See* KANS. STAT. ANN. § 65-6743 (West 2024). The statute refers to the procedure as a "dismemberment abortion," a term that, according to the American College of Obstetricians and Gynecologists, is a deliberately inflammatory, non-medical term. *ACOG Guide to Language and Abortion,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/contact/media-center/abortion-language-guide (last visited Apr. 29, 2026).
258. S. 95, 2015 Leg. (Kan. 2015); KAN. STAT. ANN. § 65-6741 (2015).
259. *Hodes & Nauser*, 551 P.3d at 58 (Wilson, J., concurring).

makes the law, not those charged with enforcing it.[260]

C. Medical Exceptions in All States Violate Constitutional Proscriptions on Vagueness

As we noted in the last section, the medical exceptions of the twenty restrictive states raise significant issues of ambiguity when physicians seek to apply them: all raise questions regarding how much risk is necessary before an abortion can be performed without liability, and, with the exception of Texas, which has now amended its exception to declare that an abortion may be performed before the mother suffers any effects from the life-threatening risk,[261] all raise questions regarding timing over when an abortion may permissibly be employed.[262] As our empirical study shows, both types of ambiguity are so significant that physicians have profound difficulties determining how to apply these exceptions.[263] Further, nineteen states lack a subjective good-faith standard that helps remedy these ambiguities.[264]

Could a court adopt a limiting construction that would remedy this vagueness in the states whose medical exceptions lack a good-faith standard?[265] It is very difficult to see how. The usual way of construing a statute to avoid vagueness is to narrow the term to "some practically identifiable core."[266] Yet narrowing the statutory meanings of the terms "necessary" to "preserve" a patient's life to those that require some high chance of death or the term "medical emergency" to require some immediate risk of grievous harm would not only amount to guessing about the legislature's intentions with few contextual clues, it would also construe the statute in a manner likely to violate the pregnant patient's fundamental constitutional right to life and health. Because no limiting construction is possible, the abortion restrictions in these nineteen states should be declared unconstitutionally vague.

The North Dakota Supreme Court, in considering its state's newly passed abortion statute on a motion to stay a lower court's injunction of the statute on appeal, reached just this conclusion. In its words:

> On preliminary review, it appears this law does not meet the high level of specificity our Constitution demands. The law uses terms that are by nature general and ambiguous, such as "reasonable," "prudent," and "knowledgeable." We acknowledge generalized language itself does not make a law unconstitutionally vague. However, the difference in complexity between a law prohibiting conduct like "unreasonable noise" and one requiring a physician to use "reasonable medical judgment" cannot be denied. Nor can we ignore the fact that doctors may be required to make their medical judgments quickly, without the benefit of hindsight, and in the face of potentially grave if not deadly consequences for their patients.

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260. *Id.* at 60–61 (citations omitted).
261. S. 31, 89th Leg., Reg. Sess. (Tex. 2025); *see supra* note 35.
262. *See supra* Part IV.B.1; Part IV.B.2.
263. *See supra* Part II.
264. *See supra* note 48.
265. *See* Joel S. Johnson, *Vagueness Avoidance*, 110 VA. L. REV. 71 (2024).
266. *Id.* at 75.

> The law itself contemplates an abortion may be necessary care in difficult situations. Along with its general language, the law uses complex terms like "serious health risk" and "substantial physical impairment," yet the law provides no definition or guidance as to what these terms are supposed to mean. All of this is to say nothing about the main rationale for the district court's decision, which was that the law used "both subjective and objective elements" and "simply does not allow a physician to know against which standard his conduct will be tested and his liability determined." As a result, on our preliminary review we are not convinced the State is likely to succeed on this issue.[267]

The same conclusion should be reached on vagueness challenges in the eighteen other states that lack a subjective medical standard.

What about Idaho, which includes a good-faith medical judgment standard in its emergency exception? Does inclusion of this subjective test allow it to clear the vagueness bar? The Idaho Supreme Court's decision in *Planned Parenthood Great Northwest v. Idaho* denied a voidness challenge to a medical exception authorizing abortion if "[t]he physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman."[268] According to the court, inclusion of the "good faith medical judgment" standard relieved any potential problem with notice relating to level of risk or timing required, since it meant that "the statute does not require *objective* certainty, or a particular level of immediacy, before the abortion can be 'necessary' to save the woman's life."[269]

We think that the Idaho court erred in this determination. While the Idaho exception is only somewhat more complicated than the exception approved by the Supreme Court in *Doe v. Bolton*, which excluded medical cases when "an abortion is necessary,"[270] we think the Idaho court failed to recognize two crucial differences. First, the Idaho statute, in adding the words "to prevent the death of the pregnant woman," introduces critical ambiguity in failing to explain what this phrase means in relation to the word "necessary."[271] Indeed, the Idaho Supreme Court, itself, put its finger on the exact problem with the language of the exception. In its words:

> [T]here is no "certain percent chance" requirement that death will occur under the term "necessary"—and to impute one would only add an

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267. Access Indep. Health Servs., Inc. v. Wrigley, 16 N.W.3d 902, 912 (N.D. 2025) (internal citations omitted). As this Article was in the production process, this case returned to the North Dakota Supreme Court following final judgment by the trial court declaring that North Dakota's medical exception violated the North Dakota Constitution on grounds of vagueness. Although a majority of the Supreme Court's five justices agreed with this determination, because the majority consisted of only three justices, it failed to clear the bar set by the North Dakota Constitution, which requires four members of the court to declare a legislative enactment unconstitutional. N.D. CONST. art. VI, § 4. North Dakota's vague medical exception is therefore now in effect. *See* Access Indep. Health Servs., Inc. v. Wrigley, 28 N.W.3d 850 (2025).

268. Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1204 (Idaho 2023).

269. *Id.* at 1203 (emphasis in original).

270. *See supra* notes 153–158 (discussing *Doe*).

271. IDAHO CODE § 18-622(a) (2022).

> objective component to a wholly subjective defense. Of course, a prosecutor may attempt to prove that the physician's subjective judgment that an abortion was "necessary to prevent the death of the pregnant woman" was not made in "good faith" by pointing to other medical experts on whether the abortion was, in their expert opinion, medically necessary. However, this does not make the affirmative defense requirement under Idaho Code section 18-622(3)(a)(ii) so vague that no person of ordinary intelligence could understand whether the physician exercised his medical judgment in "good faith."[272]

But, of course, what the court describes here is a statute that fails to provide "an ascertainable standard to prevent those charged with enforcing the statute's provisions from engaging in 'arbitrary and discriminatory' enforcement."[273] And the court's statement that the exception's language is clear enough that persons of ordinary intelligence would understand that it contained no particular "percent chance" requirement that death would occur insults the intelligence of the state's own lawyers: In the *Moyle* litigation in which the Biden Department of Justice sued the state of Idaho, lawyers for the state initially took the position that the medical exception would not permit abortion in cases where the threat of death was not certain.[274] If the state's own lawyers believed to the contrary, the language cannot and will not give sufficient direction to the physicians required to apply it on threat of felony conviction.

Second, in determining that the exception's language sufficiently eased physicians' minds in making medical determinations, the Idaho Supreme Court ruling unrealistically abstracted the language of the exception from the heated political environment surrounding abortion in that state. In 2020, Idaho passed its "trigger ban," the "Defense of Life Act," banning almost all abortions once the Supreme Court overturned *Roe v. Wade* on penalty of a felony conviction.[275] That statute was passed by legislators so averse to abortion in any circumstances that, rather than substantively exempt abortions performed for medical reasons from the abortion ban, they made the medical exception (which covers only life and not health) a narrow affirmative defense.[276] Doing so requires physicians to be charged before they can invoke the exception. In this politicized climate, Idaho prosecutors won office by promising to be more aggressive on issues like abortion.[277] Physicians who handle high-risk pregnancies began to leave the state as, in the words of the *New York Times*, "part of a wave of obstetricians fleeing restrictive abortion laws

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272. *Planned Parenthood Great Nw.*, 522 P.3d at 1204.

273. Karlin v. Foust, 188 F.3d 446, 459 (7th Cir. 1999).

274. Moyle v. United States, 603 U.S. 324, 334–35 (2024) (Barrett, J., concurring).

275. IDAHO CODE § 18-622(1)(a) (2022).

276. IDAHO CODE § 18-622(3)(a) (2022). Idaho later removed the requirement from an affirmative defense. IDAHO CODE § 18-622(2) (2024).

277. *See* Ryan Suppe, *The People's Lawyer? Raúl Labrador Term Marked by Conflict with Officials, Employees*, E. IDAHO NEWS (May 31, 2023, 10:02 AM), https://www.eastidahonews.com/2023/05/the-peoples-lawyer-raul-labrador-term-marked-by-conflict-with-officials-employees [perma.cc/LN8L-6PW4].

and a hostile state legislature."[278] These physicians, like the MFM physicians interviewed in our study, understood that today's political climate is not the same political climate that existed when abortion was outlawed pre-*Roe*, in which physicians felt free to exploit ambiguity in life and health exceptions with little fear of prosecution.[279] In this political climate, physicians hesitate to act in the face of ambiguity, causing pregnant patients to die.

The Idaho court also erred in asserting that a final factor that redeemed the ambiguity of the medical exception's language from vagueness was that it allowed for the "clinical judgment that physicians are routinely called upon to make for proper treatment of their patients."[280] As Part II showed, the standards of clinical practice require consulting patients with respect to how much risk is too much. Accordingly, these standards do not and cannot clarify the language of medical exceptions like Idaho's, in which patient's voices are excluded from the calculus.[281] Idaho's abortion ban, too, should be deemed to fail the void-for-vagueness test.

D. Facial Challenges Based on Vagueness Should Be Allowed Regardless of Whether a Medical Exception Clearly Permits Abortions in Some Set of Circumstances

In recent years, courts have disagreed over when a plaintiff can bring a "facial" challenge to a statute based on vagueness against when the plaintiff must make such a challenge "as-applied."[282] A facial challenge is "an attack on a statute itself as opposed to a particular application."[283] An "as-applied" challenge, meanwhile, contests only the particular application of the statute the challenger brings relating to their own proposed or actual conduct. The controversy between courts concerns whether a facial challenge may be brought only when the statute fails to provide notice that *any* particular set of circumstances falls within its scope.[284]

The U.S. Supreme Court explicitly rejected such a narrow standard for bringing a facial challenge in federal courts in a trio of related Supreme Court cases

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278. Sheryl Gay Stolberg, *As Abortion Laws Drive Obstetricians from Red States, Maternity Care Suffers*, N.Y. TIMES (Sept. 7, 2023), https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html [perma.cc/5UGD-GWZE].

279. *See* Alicia Gutierrez-Romine, *Her "Health and Thus Her Life": Abortion Exceptions in Legal History*, PERSPS. ON HIST. (Jan. 29, 2025), https://www.historians.org/perspectives-article/her-health-and-thus-her-life [perma.cc/8QFR-UBN9].

280. Planned Parenthood Great Nw. v. State, 522 P.3d 1132, 1203–04 (Idaho 2023).

281. *See supra* Part II.

282. *Compare* SisterSong Women of Color Reprod. Just. Collective v. Governor of Ga., 40 F.4th 1320, 1327 (11th Cir. 2022) ("We have explained that '[f]acial vagueness occurs when a statute is utterly devoid of a standard of conduct so that it simply has no core and cannot be validly applied to any conduct.'"), *and Planned Parenthood Great Nw.*, 522 P.3d at 1201 ("[W]e have explained that '[f]or a facial constitutional challenge to succeed, the party must demonstrate that the law is unconstitutional in all of its applications.'"), *with* Guerrero v. Whitaker, 908 F.3d 541, 544 (9th Cir. 2018) (retracting the "no set of circumstances" standard).

283. City of Los Angeles v. Patel, 576 U.S. 409, 415 (2015).

284. *See supra* note 235.

over the last decade,[285] albeit over disagreement by Justices Thomas and Alito.[286] In the Court's words in *Johnson v. United States*:

> [O]ur holdings squarely contradict the theory that a vague provision is constitutional merely because there is some conduct that clearly falls within the provision's grasp. For instance, we have deemed a law prohibiting grocers from charging an "unjust or unreasonable rate" void for vagueness—even though charging someone a thousand dollars for a pound of sugar would surely be unjust and unreasonable.[287]

Some lower federal courts that had used that narrow standard have now rejected it in the wake of the Supreme Court's speaking to the issue in these three cases;[288] however, the Second Circuit has held that the narrow standard still holds except when the statute challenged meets a small range of exceptions.[289] Still other federal courts, unaccountably, have continued to hew to the narrow standard for facial challenges without discussion and to subject abortion bans to that standard.[290] Meanwhile, several state courts in the post-*Dobbs* era have rejected such a narrow standard and considered pre-enforcement challenges on the merits.[291] Yet other state courts analyzing claims under their state constitution, who of course are not required to use the federal test, also apply such a narrow test,[292] and have upheld

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285. *See* Johnson v. United States, 576 U.S. 591, 597 (2015); Sessions v. Dimaya, 584 U.S. 148, 174 (2018); United States v. Davis, 588 U.S. 445, 470 (2019).

286. *See Johnson*, 576 U.S. at 607 (Thomas, J., concurring in the judgment) (arguing that, to warrant a facial challenge, the statute must fail to provide notice to any defendant); *id.* at 636 (Alito, J., dissenting) ("[A] law is facially invalid 'only if the enactment is impermissibly vague in all of its applications.'"); *see also Dimaya*, 584 U.S. at 220 (Thomas, J., dissenting) (arguing that the Court's precedents "recognize that, outside the First Amendment context, a challenger must prove that the statute is vague as applied to him while *Johnson* weakened the principle that a facial challenge requires a statute to be vague 'in all applications' it did not address whether a statute must be vague as applied to the person challenging it.").

287. *Johnson*, 576 U.S. at 602–03 (quoting United States v. L. Cohen Grocery Co., 255 U.S. 81, 89 (1921); Coates v. Cincinnati, 402 U.S. 611, 612 (1971)).

288. *See, e.g.*, Guerrero v. Whitaker, 908 F.3d 541, 544 (9th Cir. 2018) (retracting the "no set of circumstances" standard); Loc. 8027, AFT-N.H., AFL-CIO v. Edelblut, 651 F. Supp. 3d 444, 457 (D.N.H. 2023) ("[T]he Johnson trio heralded a more meaningful shift in the void for vagueness doctrine than the Second Circuit recognized.").

289. United States v. Requena, 980 F.3d 30, 39–40 (2d Cir. 2020) (finding the "no set of circumstances" standard applies to facial vagueness challenges except in cases that implicate First Amendment rights, challenge statutes with criminal penalties that lack a mens rea requirement and burden a constitutional right, or to challenges of statutes similar to those contested in *Johnson*, 576 U.S. 591).

290. *See, e.g.*, SisterSong Women of Color Reprod. Just. Collective v. Governor of Ga., 40 F.4th 1320, 1327 (11th Cir. 2022) (continuing to use the "no set of circumstances" standard).

291. *See* Access Indep. Health Servs., Inc. v. Wrigley, 16 N.W.3d 902, 914 (N.D. 2025) ("We have addressed pre-enforcement facial vagueness claims to other laws . The law currently before us criminalizes aspects of reproductive healthcare—conduct much weightier than dancing in bars or selling products and services on Sunday. In the context of state regulation of abortion since *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022), other states have addressed due process void-for-vagueness challenges on the merits. *See, e.g.*, *Planned Parenthood Great Northwest v. State*, 171 Idaho 374, 522 P.3d 1132, 1200–09 (2023); *Oklahoma Call for Reproductive Justice v. Drummond*, 526 P.3d 1123, 1131–32 (Okla. 2023). Under the guidance of our precedent, consistent with our sister states, we believe the plaintiffs' due process void for vagueness claim is subject to consideration on appeal.").

292. *See, e.g.*, Am. Falls Reservoir Dist. No. 2 v. Idaho Dept. of Water Res., 154 P.3d 433, 441

medical exceptions against facial challenges as a result.[293]

Our empirical study makes a powerful case for why application of the broader test to medical exceptions is critical. As with First Amendment challenges, fundamental constitutional rights are at stake—the rights of pregnant persons to life and health. And as in such free speech challenges, these rights are subject to being chilled by statute: physicians stymied over how to apply the medical exceptions' language are failing to perform abortions and therefore imposing great risk to women's lives. These physicians are not in a position to challenge application of these exceptions prospectively in individual cases because these cases arise quickly and must be decided in the moment. And physicians are not well positioned to challenge these cases after the fact because so much abortion care is being chilled by threat of liability. Even if a particular challenge were made retrospectively, any judgment would then enjoin the statute's application only in the specific medical circumstance at issue, continuing to allow the statute's application to the infinite array of other circumstances with which physicians must then struggle.

The reasons to apply a broad test for facial challenges in the medical exception context therefore greatly resemble the reasons that the Supreme Court has stated underlie application of the broad rule in the First Amendment context:

> A criminal prosecution under a statute regulating expression usually involves imponderables and contingencies that themselves may inhibit the full exercise of First Amendment freedoms. When the statutes also have an overbroad sweep, the hazard of loss or substantial impairment of those precious rights may be critical. For in such cases, the statutes lend themselves too readily to denial of those rights. The assumption that defense of a criminal prosecution will generally assure ample vindication of constitutional rights is unfounded in such cases. For "[t]he threat of sanctions may deter almost as potently as the actual application of sanctions ." Because of the sensitive nature of constitutionally protected expression, we have not required that all of those subject to overbroad regulations risk prosecution to test their rights. For free expression—of transcendent value to all society, and not merely to those exercising their rights—might be the loser . If the rule were otherwise, the contours of regulation would have to be hammered out case by case—and tested only by those hardy enough to risk criminal prosecution to determine the proper scope of regulation . Moreover, we have not thought that the improbability of successful prosecution makes the case different. The chilling effect upon the exercise of First Amendment rights may derive from the fact of the prosecution, unaffected by the prospects of its success or failure.[294]

(Idaho 2007); *see also* State v. Leferink, 992 P.2d 775, 779 (Idaho 1999) ("It must be shown that the enactment is invalid *in toto*.").

293. *See, e.g.,* Planned Parenthood Great Nw. v. Idaho, 522 P.3d 1132, 1201 (Idaho 2023) (upholding medical exception based on applying test that "[f]or a facial constitutional challenge to succeed, the party must demonstrate that the law is unconstitutional in all of its applications").

294. Dombrowski v. Pfister, 380 U.S. 479, 485–87 (1965).

As with free speech, the threat of criminal punishment or loss of a medical license, in combination with ambiguous phrasing, means that abortions that are necessary to save patients' lives and preserve their health will not be performed. In fact, the reasons to allow facial challenges in the context of medical exceptions go beyond those for offering such protections in the First Amendment context. It is not just free speech rights that are at stake, important as those are in our nation's tradition: it is women's lives. As our empirical study and the news stories recounted in our Introduction amply show, physicians are delaying or denying abortions they believe are medically indicated—at great cost to women's lives and health. Prohibiting striking down a law that is causing women repeatedly to die on the ground that the statute is clear with respect to at least one set of circumstances would be an egregious standard to hold women's lives to.

With that said, we believe that even if the stricter standard were applied, medical exceptions in every restrictive state should still be deemed to fail. As Part II makes clear, medical science has not progressed to the point where a physician can be certain that a patient has a 100 percent chance of death in the very next moment that an abortion would allay. Yet absent clarification from a statute about both timing and level of risk, which no statute currently provides, those are the only medical cases clearly excused by the statutory exceptions. Kansas Supreme Court Justice Evelyn Wilson reached the same conclusion about her state's medical exception, stating her view that the challenged exception "cannot withstand scrutiny under *either* type [i.e., facial or as-applied] of challenge. I do not believe any set of factual circumstances would render S.B. 95 constitutional."[295] While Justice Wilson based her conclusion on the Kansas statute's failure to include a good-faith medical judgment standard, we have shown that no state medical exception is framed in sufficiently determinate language.[296]

V. "LEAST-VAGUE" ABORTION EXCEPTIONS

In our view, pregnancy is too complicated to be regulated without risking the lives and health of pregnant persons, for the reasons laid out in Part II.[297] We also think that, when medical risks are presented in pregnancy, what constitutes unacceptable risk should be determined jointly by the physician and the patient,

295. Hodes & Nauser, MDs, P.A. v. Kobach, 551 P.3d 37, 58 (Kan. 2024).

296. *See supra* Part IV.B.2. Our analysis shows how the Supreme Court of Idaho erred in its 2023 decision of *Planned Parenthood Great Northwest v. State* in resolving the vagueness challenge on the more-demanding "core of circumstances" test for facial challenges. 522 P.3d 1132 (Idaho 2023). According to the court, physicians would, in fact, "unquestionably understand" that a core of cases satisfied the terms of the statute: "That 'core of circumstances' includes every situation where, in the physician's good faith medical judgment, an abortion was 'necessary' to prevent the death of the pregnant woman." *Id.* at 1203–04. Yet our explanation shows that there will be no "core of cases" that physicians will understand are unquestionably covered by the exception since they will never be certain that a patient has a one hundred percent chance of dying in the next moment. *Id.* at 1201–02. In our empirical study, Tennessee physicians, who were also subject to a good-faith standard, reported no core of medical cases they saw as clearly covered by the medical exception. *See supra* Part II.

297. *See supra* Part II.

rather than by a legislature. With those large caveats, we nevertheless believe that states determined to restrict abortion could construct medical exceptions that are far clearer about when abortions are permitted and when they are not. Put another way, we believe that it is possible for states to restrict abortion significantly while still imposing medical exceptions that are clear enough to pass the void-for-vagueness test, significantly reduce chilling, and save some pregnant persons' lives. (Whether these medical exceptions would sufficiently safeguard pregnant persons' life and health to avoid violating due process guarantees is a different issue—we discuss here only challenges based on vagueness, which can be remedied by more clarity.).

Such medical exceptions would clarify issues relating to risk and timing and include a good-faith standard. They would also provide a non-exclusive list of conditions that would satisfy the standard in order to ensure physicians have no worries about protecting pregnant patients' lives and health in this range of cases.[298] Further, to avoid unduly chilling abortions resulting from the inevitable ambiguity associated with regulating as variable a condition as pregnancy, we believe that criminal penalties cannot attach to violation of the medical exception. We believe that the following medical-exception language would meet this test, provided that the penalty for its violation was not criminal:

(A) Abortions that would otherwise violate state law are permitted if the treating physician determines in her good-faith medical judgment that the patient has a medical condition that:
  (i) increases the risk to the pregnant patient's life; or
  (ii) that increases the risk of substantial impairment to the pregnant patient's physical health or future fertility.

(B) As used in subsection (A):
  (i) the term "substantial" means impairment that is more than trivial, in the sense that it would be experienced by the patient as more than an insignificant loss. For example, minor cosmetic impairments would likely not count as substantial.
  (ii) Otherwise, the meanings of the terms in subsection (A) are subject to interpretation by the physician based on their own good-faith judgment.

(C) There is no requirement that the risks laid out in subsection (A) must be imminent to authorize an abortion under this section. Once the treating physician forms a good-faith medical judgment that the patient's condition meets the requirements of subsection (A), an abortion may be performed immediately.

(D) The treating physician's clinical judgment that the conditions laid out in subsection (A) are met cannot be second-guessed after the fact, nor can violation of the statute be prosecuted, unless there is proof that the

298. This list of conditions would therefore provide the certainty of medical conditions that would meet the standard that South Carolina's and Tennessee's list of conditions fail to provide. *See supra* notes 54-55 and accompanying text; *see supra* note 35.

physician acted without good faith.[299]

(E) Some conditions that would warrant performing an abortion because of risk to life include but are not limited to severe preeclampsia and eclampsia, placental abruption, previable and periviable premature rupture of membranes, sepsis, and uterine rupture. This list is not intended to exclude or abrogate other conditions that meet the terms of subsection (A)(i), nor is it an assessment of the level of harm necessary to meet the terms of subsection (A)(i); it is merely an enumeration of some of the many conditions that would meet the terms of subsection (A)(i).

(F) In performing an abortion authorized under this section, the treating physician may exercise her own clinical judgment in determining the appropriate medical procedure in light of the pregnant patient's condition and medical needs.

CONCLUSION

The lives and health of pregnant persons are continually being put at risk, and sometimes lost, by physicians' difficulty with applying the terms of medical exceptions to abortion statutes in individual medical cases. Some legislators deny that these harms result from the statutory language itself, claiming instead that the fault lies with physicians. Our study shows that the problem lies, not with these physicians, but with the wide disjuncture between the current practice of medicine and the language of these medical exceptions. Because these exceptions fail to give adequate guidance to the physicians they subject to criminal and quasi-criminal liability, they violate constitutional proscriptions on vagueness. Accordingly, the restrictions on abortion they apply to should be deemed void. Otherwise, these medical exceptions will continue to pose great danger to the very patients they are supposed to save.

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299. This language comes from Arizona Attorney General Kris Mayes's Attorney General Opinions, *Re: The Meaning of "Medical Emergency" Under A.R.S. § 36-2321(7)*, Ariz. Op. Att'y Gen. No. 124-009 (R24-011) (2024).

APPENDIX

***AUTHORS' NOTE**: Where two statutes are in effect in a state, the medical exception of the stricter statute is described. The authors have not included any procedural requirements associated with medical exceptions in this chart, only substantive standards. Additionally, the authors have not included provisions excluding psychological conditions or self-harm from inclusion in medical exceptions, nor any requirements that abortions be performed in a particular manner. This chart is current as of April 29, 2026.

State	**Stage in Pregnancy at which abortion is banned**	**Medical exceptions under which an abortion is permitted by statute**	**Relevant definitions provided in the statute and provisions involving "medical emergencies"**	**Penalties for violation of statute**
Alabama	All stages ALA. CODE § 26-23H-4 (2023)	"This chapter shall not apply to a physician licensed in Alabama performing a termination of a pregnancy or assisting in performing a termination of a pregnancy due to a medical emergency." ALA. CODE § 26-23H-7 (2023). "An abortion shall be permitted if an attending physician licensed in Alabama determines that an abortion is necessary in order to prevent a serious health risk to the unborn child's mother." ALA. CODE § 26-23H-4(b) (2023).	Medical Emergency: "A condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that her pregnancy must be terminated to avoid a serious health risk as defined in this chapter." ALA. CODE § 26-23H-3(4) (2025). Serious Health Risk to the Unborn Child's Mother: "In reasonable medical judgment, the child's mother has a condition that so complicates her medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function." ALA. CODE § 26-23H-3(6) (2025).	Criminal: Performing an unlawful abortion is a "Class A felony," which can carry prison sentences that range from ten years to life, as well as fines of up to $60,000. ALA. CODE. § 26-23H-6(a) (2025) (defining unlawful abortion as a felony); ALA. CODE. § 13A-5-6 (2023) (defining sentencing range for felonies); ALA. CODE. § 13A-5-11(a) (2025) (defining potential fines for felonies). Civil: A civil action for damages can be brought by "[a]ny person who can demonstrate personal injury, including physical injury, emotional distress, or mental anguish, where such injury has resulted from the failure of an abortion or reproductive health center to conform to the requirements of this chapter." ALA. CODE. § 26-23E-13 (2025).

				License revocation: "The failure of any physician, nurse practitioner, physician assistant, registered professional nurse, or licensed practical nurse to conform to the requirements of this chapter or any rule or regulation adopted under provision of this chapter may be grounds for adverse licensure action, up to and including license revocation." ALA. CODE. § 26-23E-14(a) (2025).
Arkansas	All stages ARK. CODE ANN. § 5-61-304(a) (West 2025)	"A person shall not purposely perform or attempt to perform an abortion except to save the life of a pregnant woman in a medical emergency." ARK. CODE ANN. § 5-61-304(a) (West 2025).	Medical emergency: "[A] condition which, in reasonable medical judgment, complicates the medical condition of a pregnant woman to such an extent that termination of a pregnancy is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." ARK. CODE ANN. § 5-61-303(3) (West 2025). Reasonable Medical Judgment: "[A] medical judgment that would be made or medical action that would be undertaken by a reasonably prudent, qualified physician, knowledgeable about the	Criminal: "Performing or attempting to perform an abortion is an unclassified felony with a fine not to exceed one hundred thousand dollars ($100,000) or imprisonment not to exceed ten (10) years, or both." ARK. CODE ANN. § 5-61-304(b) (West 2024). License revocation: A physician might also have their license revoked by the Arkansas State Medical Board by procuring a criminal abortion and the conviction of a felony as described in ARK. CODE ANN. § 5-61-304(b). ARK. CODE ANN. § 17-95-409(a)(2)(A)(i), (D) (West 2024).

			case and the treatment possibilities with respect to the medical conditions involved." 2025 Ark. Acts 387.	
Florida	6 weeks FLA. STAT. ANN. § 390.0111(1) (West 2023).	Permits abortions if "termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman." FLA. STAT. ANN. § 390.0111(1)(a)-(b) (West 2025).		Criminal: "Any person who willfully performs, or actively participates in, a termination of pregnancy in violation of the requirements of this section commits a felony of the third degree," which can carry a prison sentence of up to five years and a fine of up to $5,000. FLA. STAT. ANN. § 390.0111(10)(a) (West 2023); FLA. STAT. § 775.082(3)(e) (2023) (defining sentencing range for felony classes); FLA. STAT. § 775.083(1)(c) (2023) (defining fines for felony classes). License revocation: Physicians who violate the abortion law can face license revocation or suspension. FLA. STAT. ANN. § 390.0111(13) (West 2023) (listing disciplinary action as a consequence for violating the state abortion statute); FLA. STAT. § 456.072(2) (2023) (listing potential consequences for physicians).
Georgia	"[D]etectable human heartbeat" GA. CODE ANN. § 16-12-141(b) (2024)	Permits abortions if "[a] physician determines, in reasonable medical judgment, that a medical emergency exists." GA. CODE ANN. § 16-12-141(b)(1)(Westlaw	Medical emergency: "[A] condition in which an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major	Criminal: "A person convicted of the offense of criminal abortion shall be punished by imprisonment for not less than one nor more than ten years." GA. CODE ANN. § 16-12-140(b)

		through the 2024 Reg. Sess.).	bodily function of the pregnant woman." GA. CODE ANN. § 16-12-141(a)(3) (Westlaw through the 2024 Reg. Sess.).	(2023). License revocation: For violating the abortion statute, physicians can face discipline and medical licensing sanctions. GA. CODE ANN. § 31-9B-2(b) (2023); GA. CODE ANN. § 43-34-8 (Westlaw through the 2024 Reg. Sess.).
Idaho	All stages IDAHO CODE § 18-622(1) (2024)	Permits abortions if "[t]he physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman." IDAHO CODE § 18-622(2)(a)(i) (2024).		Criminal: "[E]very person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion," which is a felony "punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison." IDAHO CODE § 18-622(1) (2024). Civil: "[T]he father of the preborn child, a grandparent of the preborn child, a sibling of the preborn child, or an aunt or uncle of the preborn child may maintain an action for [a]ll damages from the medical professionals who knowingly or recklessly attempted, performed, or induced the abortion in violation of this chapter," and "statutory damages in an amount not less than twenty thousand dollars ($20,000) from the medical professionals who knowingly or recklessly attempted, performed, or induced an

				abortion in violation of this chapter." IDAHO CODE § 18-8807(1)(a)-(b) (2024). License revocation: "The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense." IDAHO CODE § 18-622(1) (2024).
Indiana	All stages IND. CODE § 16-34-2-1(a) (2024)	Permits abortions if "the abortion is necessary when reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life." IND. CODE § 16-34-2-1(a)(1)(A)(i) (2024).		Criminal: "[A] person who knowingly or intentionally performs an abortion prohibited by this chapter commits a Level 5 felony," which is punishable by one to six years in prison and a fine of up to $10,000. IND. CODE § 16-34-2-7(a) (2024); IND. CODE § 35-50-2-6(b) (2024) (defining sentences for felonies). License revocation: A physician's license may be revoked if "the attorney general proves by a preponderance of the evidence that the physician performed an abortion in violation of IC 16-34-2-7(a) through IC 16-34-2-7(c) with the intent to avoid the requirements of IC 16-34-

				2-1." IND. CODE ANN. § **25-22.5-8-6(b)(2)** (West 2024).
Iowa	Abortion is prohibited after a heartbeat becomes detectable. IOWA CODE ANN. § 146E.2(1)(b)(2) (West 2024).	"A physician shall not perform an abortion upon a pregnant woman when it has been determined that the unborn child has a detectable fetal heartbeat, unless, in the physician's reasonable medical judgment, a medical emergency exists." IOWA CODE ANN. § 146E.2(2)(a) (West 2024).	Medical emergency: "[A] situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy." IOWA CODE ANN. § 146A.1(6)(a) (West 2024). Reasonable medical judgment: "[M]eans a medical judgment made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." IOWA CODE ANN. § 146E.1(6) (West 2024).	Criminal Penalty: A person who violates Iowa's abortion restrictions may be found guilty of a class D felony, which is punishable by up to five years of confinement and a fine of between $1,025 and $10,245 (so long as the individual in question is not a habitual offender). IOWA CODE ANN. § 148.6(3) (West 2024); IOWA CODE ANN. § 902.9(1)(e) (West 2024). License revocation: Failure to comply with the state's abortion restrictions "is grounds for licensee discipline." IOWA CODE § 146B.3(1) (2024); IOWA CODE § 148H.7 (2024).
Kentucky	All stages KY. REV. STAT. ANN. § 311.772 (West 2023)	Permits "a medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman." KY. REV. STAT. ANN. § 311.772(4)(a) (West 2023).		Criminal: Violation of the statute can result in a Class D felony, which can carry a sentence of between one and five years of imprisonment and a fine of up to $10,000. KY. REV. STAT. ANN. § 311.772(3)(b) (West 2023) (classifying the offense of abortion); KY. REV. STAT. ANN. § 532.060 (West 2023) (defining prison sentencing for felonies); KY. REV. STAT. ANN. § 534.030(1) (West 2023)

				(defining fines for felonies).
Louisiana	All stages LA. STAT. ANN. § 14:87.7 (West 2023)	"It shall not be a violation of this Section for a licensed physician to perform a medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman." LA. STAT. ANN. § 40:1061(F) (West 2025).		Criminal: Committing "the crime of abortion" shall result in being "imprisoned at hard labor for not less than one year nor more than ten years and shall be fined not less than ten thousand dollars nor more than one hundred thousand dollars." LA. STAT. ANN. § 14:87.7(C) (West 2025). License revocation: "[I]t shall be grounds for the nonissuance, suspension, revocation, or restriction of a license, or the denial of reinstatement or renewal of a license, issued by the Louisiana State Board of Medical Examiners, that the applicant or licensee has performed an abortion in violation of this Section." LA. STAT. ANN. § 40:1061.1.5(D) (West 2025).
Mississippi	All stages MISS. CODE ANN. § 41-41-45(2) (2024)	Prohibits abortions "[e]xcept in the case where necessary for the preservation of the mother's life." MISS. CODE ANN. § 41-41-45(2) (2024).		Criminal: "Any person, except the pregnant woman, who purposefully, knowingly or recklessly performs or attempts to perform or induce an abortion in the State of Mississippi, except in the case where necessary for the preservation of the mother's life or where the pregnancy was caused by rape, upon conviction, shall be punished by imprisonment in the custody of the

				Department of Corrections for not less than one (1) year nor more than ten (10) years." MISS. CODE ANN. § 41-41-45(4) (2024).
Nebraska	12 weeks NEB. REV. STAT. § 71-6915(2)(b) (2024)	"It shall not be a violation of this section for a physician to perform or induce an abortion in the case of [m]edical emergency." NEB. REV. STAT. § 71-6915(3)(a) (2024).	Medical emergency: "[A]ny condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the termination of her pregnancy to avert her death or for which a delay in terminating her pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function." NEB. REV. STAT. § 71-6914(3)(a) (2024). Reasonable medical judgment: "[A] medical judgment that could be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." NEB. REV. STAT. § 71-6914(6) (2024).	Criminal: "Any person who intentionally or recklessly performs an abortion in violation of section 28-3,106 is guilty of a Class IV felony." NEB. REV. STAT. ANN. § 28-3,108 (West 2025). A Class IV felony carries a maximum of two years imprisonment and twelve months of post-release supervision or a fine of ten thousand dollars. NEB. REV. STAT. ANN. § 28-105(1) (West 2025). License revocation: "If the petition is brought with respect to subdivision (5) of section 38-2021, the director shall make findings as to whether the licensee performed or induced an unlawful abortion in violation of section 71-6915. If the director finds such a violation, the director shall enter an order revoking the licensee's credential to practice pursuant to the Uniform Credentialing Act in the State of Nebraska in accordance with subsection (2) of section 38-196 and section 38-1,100." NEB. REV. STAT. § 38-193(2) (2023); NEB. REV. STAT. § 38-2021(5) (2023).

North Carolina	12 weeks N.C. GEN. STAT. § 90-21.81A(a) (LEXIS through the 2024 Reg. Sess. of the Gen. Assemb.).	Permits abortions "[w]hen a qualified physician determines there exists a medical emergency." N.C. GEN. STAT. § 90-21.81B(1) (LEXIS through the 2024 Reg. Sess. of the Gen. Assemb.).	Medical emergency: "A condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including any psychological or emotional conditions." N.C. GEN. STAT. § 90-21.81(5) (LEXIS through the 2024 Reg. Sess. of the Gen. Assemb.).	Criminal: "If any person shall willfully administer to any woman, either pregnant or quick with child, or prescribe for any such woman, or advise or procure any such woman to take any medicine, drug or other substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, he shall be punished as a Class H felon." N.C. GEN. STAT. § 14-44 (2023). The punishment could include five to six months of imprisonment and a fine. N.C. GEN. STAT. § 15A-1340.17 (2025). Civil: "Any person upon whom an abortion has been performed and any father of an unborn child that was the subject of an abortion may maintain an action for damages against the person who performed the abortion in knowing or reckless violation of this Article." N.C. GEN. STAT. § 90-21.88(a) (LEXIS through the 2024 Reg. Sess. of the Gen. Assemb.). License revocation: "A physician who violates any provision of this Article shall be subject to discipline by the North Carolina Medical Board under G.S. 90-14(a)(2) and any other applicable law or rule," which includes license revocation. N.C. GEN. STAT. § 90-21.88A

				(LEXIS through the 2024 Reg. Sess. of the Gen. Assemb.); N.C. GEN. STAT. § 90-14(a)(2) (2023).
North Dakota	All stages N.D. CENT. CODE § 12.1-19.1-02 (LEXIS through 2024 Singular Sess.)	Permits "[a]n abortion deemed necessary based on reasonable medical judgment which was intended to prevent the death or a serious health risk to the pregnant female." N.D. CENT. CODE § 12.1-19.1-03(1) (LEXIS through 2024 Special Sess.).	Reasonable medical judgment: "[A] medical judgment that would be made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." N.D. CENT. CODE § 12.1-19.1-01(4) (LEXIS through 2023 Special Sess.). Serious health risk: "[A] condition that, in reasonable medical judgment, complicates the medical condition of the pregnant woman so that it necessitates an abortion to prevent substantial physical impairment of a major bodily function, not including any psychological or emotional condition." N.D. CENT. CODE § 12.1-19.1-01(5) (LEXIS through 2023 Special Sess.).	Criminal: Performing an unlawful abortion is a class C felony, N.D. CENT. CODE § 12.1-19.1-02 (LEXIS through 2023 Special Sess.), which can carry a "maximum penalty of five years' imprisonment, a fine of ten thousand dollars, or both, may be imposed." N.D. CENT. CODE § 12.1-32-01(4) (2023).
Oklahoma	All stages OKLA. STAT. tit. 21, § 861 (2023).	"Every person who administers to any woman, or who prescribes for any woman, or advises or procures any woman to take any medicine, drug or substance, or uses or employs any instrument, or other means whatever, with intent thereby to	N/A	Criminal: Any individual who violates this statute "shall be guilty of a Class D1 felony offense." 2025 Okla. Sess. Law Serv. Ch.486 (H.B. 2104) (West). This is punishable by up to ten years imprisonment, depending upon the individual's record. OKLA. STAT. tit.

		procure the miscarriage of such woman, unless the same is necessary to preserve her life, shall be guilty of a felony." OKLA. STAT. tit. 21, § 861 (2023).		21, § 20N (2025). Civil: A cause of action for injunctive relief is available against any abortion provider (by various parties) to "prevent the abortion provider from performing further abortions." Any person who violates an injunction issued for the above purposes may be held in civil contempt and will be fined $10,000 for the first violation, $50,000 for the second violation, and $100,000 for each violation after. The fines are for civil contempt alone and "[e]ach performance or attempted performance of an abortion in violation of the terms of an injunction is a separate violation." OKLA. STAT. ANN. tit. 63, § 1-729.3(E) (West 2025). License Revocation: "A physician who performed or induced an abortion or attempted to perform or induce an abortion in violation of this act shall be considered to have engaged in unprofessional conduct for which his or her license to practice medicine in the State of Oklahoma may be suspended or revoked by the State Medical Board of Licensure and Supervision or the State Board of Osteophathic [sic] Examiners." OKLA. STAT. ANN. tit. 63, § 1-729.3(F) (West 2025).

South Carolina	Detectable heartbeat S.C. CODE ANN. § 44-41-630(B) (2023).	Abortions are permitted "if the physician determines according to standard medical practice that a medical emergency exists" or "to prevent the death of the pregnant woman or to prevent the serious risk of a substantial or irreversible impairment of a major bodily function." S.C. CODE ANN. § 44-41-640(B)(1) (2023). "It is presumed that the following medical conditions constitute a risk of death or serious risk of a substantial and irreversible physical impairment of a major bodily function of a pregnant woman, not including psychological or emotional conditions: molar pregnancy, partial molar pregnancy, blighted ovum, ectopic pregnancy, severe preeclampsia, HELLP syndrome, abruptio placentae, severe physical maternal trauma, uterine rupture, intrauterine fetal demise, and miscarriage." S.C. CODE ANN. § 44-41-640(C)(2) (2023).	Medical emergency: "[A] condition exists that has complicated the pregnant woman's medical condition and necessitates an abortion to prevent death or serious risk of a substantial and irreversible physical impairment of a major bodily function." S.C. CODE ANN. § 44-41-610(9) (2023).	Criminal: "A person who violates this subsection is guilty of a felony and, upon conviction, must be fined ten thousand dollars, imprisoned for not more than two years, or both." S.C. CODE ANN. § 44-41-630(B) (2023). License revocation: "[A] physician or any other professionally licensed person who intentionally, knowingly, or recklessly violates the prohibition on abortion contained in this article commits an act of unprofessional conduct. A physician's license to practice in this State immediately shall be revoked by the State Board of Medical Examiners, after due process according to the board's rules and procedures." S.C. CODE ANN. § 44-41-690 (2023).
South Dakota	All stages S.D. CODIFIED LAWS § 22-17-5.1 (2023).	Permits abortions if "there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant female." S.D.		Criminal: "Any person who administers to any pregnant female or who prescribes or procures for any pregnant female any medicine, drug, or substance or uses or employs any instrument

		CODIFIED LAWS § 22-17-5.1 (2023).		or other means with intent thereby to procure an abortion, unless there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant female, is guilty of a Class 6 felony." S.D. CODIFIED LAWS § 22-17-5.1 (2023). Class 6 felonies are punishable by up to "two years imprisonment in a state correctional facility or a fine of four thousand dollars, or both." S.D. CODIFIED LAWS § 22-6-1(9) (2023).
Tennessee	All stages TENN. CODE ANN. § 39-15-213(4)(b) (LEXIS through Ch. 1069 of the 2024 Reg. Sess.).	Permits abortion if "[t]he physician determined, using reasonable medical judgment, based upon the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." TENN. CODE ANN. § § 39-15-213 (c)(1)(A)(2024).	Serious risk of substantial and irreversible impairment of a major bodily function: (A) Means any medically diagnosed condition that so complicates the pregnancy of a woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function; (B) May include previable preterm premature rupture of membranes; inevitable abortion; severe preeclampsia; mirror syndrome associated with fetal hydrops; and an infection that can result in uterine rupture or loss of fertility ." Tenn. Code Ann. §§ 39-15-213(a) (6). (effective April 17, 2025).	Criminal: "A person who performs or attempts to perform an abortion commits the offense of criminal abortion. Criminal abortion is a Class C felony." TENN. CODE ANN. § 39-15-213(b) (LEXIS through Ch. 1069 of the 2024 Reg. Sess.) (criminal abortion statute). Class C felonies are punishable by up to ten to fifteen years of imprisonment. TENN. CODE ANN. § 40-35-112(c)(3) (2025) (defining felony classes). A fine of up to $10,000 might also be levied. TENN. CODE ANN. § 40-35-111(b)(3) (West 2025).

Texas	All stages TEX. HEALTH & SAFETY CODE ANN. § 170A.002(a) (West 2023)	Permits abortion if "in the exercise of reasonable medical judgment, the pregnant female has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced." TEX. HEALTH & SAFETY CODE ANN. § 170A.002(b)(2) (West 2023). "[I]f a pregnant woman has a life-threatening physical condition [as is described in (b)(2)], a physician may address [that risk] before the female suffers any effects of the risk. Subsection (b)(2) does not require that, before the physician may act: (1) a risk described by (b)(2) be imminent; (2) the pregnant female first suffer physical impairment; or (3) the physical condition has caused damage to the pregnant female." S. 31, 89th Leg., Reg. Sess. (Tex. 2025).	Reasonable medical judgment: "[A] medical judgment made by a reasonably prudent physician, knowledgeable about a case and the treatment possibilities for the medical conditions involved." TEX. HEALTH & SAFETY CODE ANN. § 170A.001(4) (West 2023). This "includes removing: (1) an ectopic pregnancy as defined by Section 245.002(4-a)." S. 31, 89th Leg., Reg. Sess. (Tex. 2025). Life-threatening: A physical condition "capable of causing death or potentially fatal." It is "not necessarily one actively injuring the patient." S. 31, 89th Leg., Reg. Sess. (Tex. 2025).	Criminal: "An offense under this section is a felony of the second degree, except that the offense is a felony of the first degree if an unborn child dies as a result of the offense." TEX. HEALTH & SAFETY CODE ANN. § 170A.004(b) (West 2023). A felony of the first degree is punishable by five years to life in prison, as well as a fine of up to $10,000. TEX. PENAL CODE ANN. § 12.32(a)-(b) (West 2023) (defining punishments for first-degree felony offenses). Civil: "A person who violates Section 170A.002 is subject to a civil penalty of not less than $100,000 for each violation." TEX. HEALTH & SAFETY CODE ANN. § 170A.005 (West 2023). License revocation: "In addition to any other penalty that may be imposed under this chapter, the appropriate licensing authority shall revoke the license, permit, registration, certificate, or other authority of a physician or other health care professional who performs, induces, or attempts an abortion in violation of Section 170A.002." TEX. HEALTH & SAFETY CODE ANN. § 170A.007 (West 2023).

Utah	18 weeks UTAH CODE ANN. § 76-7-302(2) (LEXIS through May 1, 2024 of the 2024 Gen. Sess.) Note that abortion is legal to 18 weeks because of a preliminary injunction barring enforcement of a Utah law that would ban abortions from the time of conception. Planned Parenthood Ass'n of Utah v. State, 2024 UT 28, ¶ 230, 554 P.3d 998, 1046.	Permits abortion if "[t]he abortion is necessary to avert the death of the woman on whom the abortion is performed" or "a serious physical risk of substantial impairment of a major bodily function of the woman on whom the abortion is performed." UTAH CODE ANN. § 76-7-302(2)(b)(i)(A)-(B) (LEXIS through May 1, 2024 of the 2024 Gen. Sess.).		Criminal: "A person who performs an abortion in violation of this section is guilty of a second degree felony," which is punishable by between one and fifteen years of imprisonment. UTAH CODE ANN. § 76-7a-201(4) (LEXIS through May 1, 2024 of the 2024 Gen. Sess.) (classifying the offense as a felony); UTAH CODE ANN. § 76-3-203(2) (LexisNexis 2023) (defining sentencing for felony offenses). They might also face a maximum fine of $10,000. UTAH CODE ANN. § 76-3-301(1)(a) (West 2025). License revocation: "[T]he department may take appropriate corrective action against a health care facility, including revoking the health care facility's license, if a violation of this chapter occurs at the health care facility." UTAH CODE ANN. § 76-7a-201(5) (LEXIS through May 1, 2024 of the 2024 Gen. Sess.).
West Virginia	All stages W. VA. CODE § 16-2R-3 (2023)	Allows abortions if "in the reasonable medical judgment of a licensed medical professional a medical emergency exists." W. VA. CODE § 16-2R-3(a)(3) (2023).	Medical emergency: "[A] condition or circumstance that so complicates the medical condition of a patient as to necessitate an abortion to avert serious risk of the patient's death or serious risk of substantial life-threatening physical impairment of a major bodily function, not	Criminal: "A person who was formerly a licensed medical professional and whose license has been revoked pursuant to the provisions of § 16-2R-7 of this code, and who knowingly and willfully performs, induces, or attempts to perform or induce a subsequent abortion, is guilty of a felony and, upon

			including psychological or emotional conditions. This term includes a circumstance in which it is necessary to terminate a pregnancy of one or more fetuses to preserve the life of another fetus or fetuses." W. VA. CODE § 16-2R-2 (2023). Reasonable medical judgment: "[A] medical judgment that would be made by a licensed medical professional who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." W. VA. CODE § 16-2R-2 (2023).	conviction thereof," will be imprisoned for three to ten years. W. VA. CODE § 61-2-8(b) (2025). License revocation: "A licensed medical professional who knowingly and willfully performs, induces, or attempts to perform or induce an abortion, with the intent to violate the provisions of § 16-2R-3 of this code, is subject to disciplinary action by his or her applicable licensing board. If the licensing board finds that the licensed medical professional has knowingly and willfully performed, induced, or attempted to perform or induce an abortion, with the intent to violate the provisions of § 16-2R-3 of this code, the licensing board shall revoke medical professional's license." W. VA. CODE § 16-2R-7 (2023).