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AIR FORCE WOMEN'S ACCESS TO ABORTION SERVICES AND THE EROSION OF 10 U.S.C. § 1093

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I. INTRODUCTION

Military women in general, and Air Force women in particular, face significantly more restrictions on their access to abortion services than their peers without military affiliation.¹ Regulatory restrictions, funding issues, local laws, and the potential unavailability of services in the local community all present obstacles to an airman or family member seeking an abortion. Federal law prohibits funding for abortion services for both active duty and military family members except in cases where the woman's life is at risk or the pregnancy results from rape or incest.² Despite a regulatory requirement mandating referrals, military treatment facilities do not have referral guidelines.³ Air Force commanders have tremendous discretion in determining when to allow leave, even medical leave, giving them an effective veto over abortion in some locations. Finally, the woman must find a facility willing to perform the abortion, a significant problem given the geographic remoteness of many Air Force facilities and the potential hostility of host nation laws.⁴ As a consequence, Air Force women suffer wide disparities in their access to abortion when compared with their civilian counterparts.

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1. As used in this paper, "Air Force women" encompasses both women in the Air Force and women who are military family members. While this article focuses on the Air Force, the federal laws discussed apply equally to all the services. The Civilian Health and Medical Program Uniformed Service (CHAMPUS) regulations cited apply equally to all military family members. The Air Force Instructions (AFI) cited apply only to the Air Force, but the other services have similar regulations.

2. See e.g. Continuing Appropriations, Pub. L. No. 99-591, 100 Stat. 3341 (1987); Department of Defense Authorization Act, Pub. L. No. 98-525, 98 Stat. 2492 (1985); Continuing Appropriations, Pub. L. No. 98-107, 97 Stat. 733 (1984); District of Columbia Appropriation Act, Pub. L. No. 96-530, 94 Stat. 3121, 3127-28 (1980); Departments of Labor and Health, Education, and Welfare, Appropriation Act, Pub. L. No. 94-439, 90 Stat. 1418 (1977); Foreign Assistance Act of 1973, Pub. L. No. 93-189, § 114, 87 Stat. 714 (1973).

3. In the Air Force, for example, the requirement is in the AFI regulations. AFI 44-102, § 2.10.7, (Nov. 17, 1999) *Community Health Management*, at <http://www.publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>.

4. A "host nation" is a foreign country where the United States stations troops.

A significant aspect of the problem is that many, if not all, Air Force medical facilities lack referral procedures for abortion services, despite a regulatory requirement that they have such procedures.⁵ Should an active duty military woman choose to have an abortion, she must request leave, which her commander has no obligation to grant. She must then find a facility willing to perform the abortion, although the Air Force may have stationed her in a county or state that has no abortion services or prohibits abortions entirely. A similarly situated civilian woman in the United States has the option of requesting either a medical or surgical abortion directly from her provider or obtaining a referral to a provider or facility that will provide such services. Even a clinic that provides family planning advice to the poor under *Title X*,⁶ a woman will be informed that the clinic can only provide pre-conception services and should receive a referral to a physician who will be obligated to provide a complete range of options to the woman.⁷

Recent federal district court decisions have eroded the prohibition on the use of federal funds for abortions for military family members, but will probably not extend abortion funding beyond payments for therapeutic abortions in cases of anencephalic fetuses.⁸ The recent cases of *Britell v. United States*⁹ and *Doe v. United States*¹⁰ expanded coverage of abortion services to military women carrying anencephalic fetuses by invalidating the Civilian Health and Medical Program Uniformed Service (CHAMPUS) regulations that prohibited such funding as lacking a rational basis.¹¹ Those courts held that protection of potential life could only

5. The requirement is in AFI 44-102, § 2.10.7, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>. The lack of any written guidelines is per my review of AFPUBS conducted December 2, 2002, available at Air Force Publishing, <http://www.e-publishing.af.mil>. It is further supported by acknowledgements by the physicians interviewed for this paper that no such referral procedures exist.

6. 42 U.S.C. § 300-300a-6 (2003).

7. This is required by common law principles of informed consent and the Am. College of Obstetricians and Gynecologists. See Code of Prof. Ethics of the Am. C. of Obstetricians and Gynecologists, at http://www.acog.org/from_home/acogcode.pdf (last visited Apr. 4, 2003) (providing the general requirement that obstetricians and gynecologists present their patients with options and consequences of treatment).

8. An anencephalic fetus suffers from a developmental flaw that causes it to fail to form large portions of the brain. For more information see National Institute of Neurological Disorders and Stroke Anencephaly Information Page, http://www.ninds.nih.gov/health_and_medical/disorders/anencephaly_doc.htm (last visited Apr. 4, 2003).

9. *Britell v. United States*, 204 F. Supp. 2d 182 (D. Mass. 2002).

10. *Doe v. United States*, C02-1657Z, (W.D. Wash. 2002) (unpublished) (order granting Plaintiff's Motion for a Temporary Restraining Order).

11. 32 C.F.R. § 199(e) (2003). CHAMPUS is administered through the managed care program TRICARE.

serve as a rational basis for a denial of funding when some potential for life outside the womb exists.¹² The courts will probably not require funding for abortions except for cases of anencephaly or other fetal conditions that cause immediate postnatal death, despite support in the medical community for broadening the policy to include therapeutic abortions.

This paper argues that the Air Force should take affirmative steps to ensure access to abortion services. The conservative nature of Air Force commanders and physicians, as well as unfriendly host nation laws, impair the exercise of a woman's constitutional right to abortion services. By enacting regulatory protections, such as requiring commanders to grant leave to pregnant women seeking to terminate a pregnancy and extending the emergency leave program definitions to include termination of pregnancy, the Air Force can protect the reproductive rights of women.¹³

II. ABORTION RIGHTS AND FUNDING IN THE CIVILIAN CONTEXT

Abortion rights and abortion funding law developed through two separate lines of cases. The Supreme Court distinguished the right to terminate a pregnancy from the government's decision not to provide funding for the exercise of those rights. The Court has consistently upheld a woman's right to choose to have an abortion with few restrictions early in the pregnancy. The Court also has given great deference to legislative decisions to not provide funding for abortions.¹⁴ These two lines are worth examining separately.

A. *Privacy Background Cases—Roe through Casey*

Although we often think of *Roe v. Wade*¹⁵ as the seminal abortion law case, the legal underpinnings of *Roe* were developed a decade earlier in *Griswold v. Connecticut*.¹⁶ In *Griswold*, the Supreme Court held that married women had the constitutional right to obtain birth control, despite a Connecticut law prohibiting

12. *Britell*, 204 F. Supp. 2d at 198.

13. See generally AFI 36-3003, *Military Leave Program* (Apr. 14, 2000) (detailing procedures and requirements for granting leave), available at <http://www.publishing.af.mil/pubfiles/af/36/afi36-3003/afi36-3003.pdf>.

14. See *Rust v. Sullivan*, 500 U.S. 173 (1991); *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).

15. 410 U.S. 113 (1973).

16. 381 U.S. 479 (1965).

it.¹⁷ Justice Douglas enunciated a "privacy right" arising from the "penumbras" of other constitutional guarantees.¹⁸

A later case, *Eisenstadt v. Baird*, expanded the right to contraception to single people.¹⁹ The Court found the guarantees of the Constitution were not strictly limited, but rather applied to diverse situations to "give them life and substance."²⁰ At the time, the states generally outlawed abortion, although it was still generally accessible for wealthy women.²¹

Roe v. Wade involved three sets of plaintiffs.²² Jane Roe, a pregnant single woman, lived in Dallas County, Texas, where abortion was illegal.²³ She sued the District Attorney, challenging the constitutionality of the abortion prohibition.²⁴ The Court permitted Dr. James Hallford, a Texas physician with two pending abortion cases, to intervene.²⁵ A married, childless couple, the Does, also sued, alleging injury based on the future possibilities of contraceptive failure leading to pregnancy, lack of preparedness for parenthood, and impairment of the wife's health.²⁶ The Does, however, eventually were dismissed from the case because their injury was too speculative.²⁷

In crafting the majority opinion that overturned the prohibitions, Justice Blackmun examined the history of abortion and legal limitations on the practice.²⁸ Justice Blackmun noted the recently recognized liberty interests surrounding the right to privacy, and concluded that the right to privacy necessarily included abortion.²⁹ He also found that the state had a compelling interest in preserving fetal life that could override such a decision.³⁰ After the first trimester, however, the state could only impose such restrictions as were necessary to preserve and protect maternal health.³¹ Embracing the idea of "quickenings" at the start of the

17. *Id.* at 485-86.

18. *Id.* at 483-84.

19. 405 U.S. 438, 460 (1972).

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

21. David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 ALB. L. REV. 833, 834 (1999).

22. *Roe*, 410 U.S. at 120-121.

23. *Id.* at 120.

24. *Id.*

25. *Id.*

26. *Id.* at 121.

27. *Id.* at 129.

28. *Id.* at 136-1129-50.

29. *Id.* at 154.

30. *Id.*

31. *Id.* at 163.

third trimester, Justice Blackmun found that the state could then prohibit abortion.³² The decision left first trimester abortion decisions to the woman and her physician, allowed some interference by the state to preserve the woman's health in the second trimester, and recognized a compelling state interest in the preservation of potential life in the third trimester, except when the abortion was necessary to preserve the health of the mother.³³ The Court concluded that the Texas statute prohibiting all abortions was therefore unconstitutional.³⁴

That same year, the Supreme Court decided *Doe v. Bolton*,³⁵ invalidating a Georgia statute prohibiting abortion³⁶ except in the cases of a threat to the life of the mother,³⁷ a fetus with grave, permanent and immutable birth defects,³⁸ or when the pregnancy was the result of rape.³⁹ Mrs. Doe, a pregnant indigent woman, had requested an abortion on the grounds that she was economically unable to care for her current children.⁴⁰ In fact, two of her children had been removed from the home, and it was likely that she would be unable to care for a new child.⁴¹ The Court struck down the statute's prohibition on elective abortion, as well as other restrictions that: limited abortions to accredited hospitals; required consultation with a hospital abortion committee; and required two additional physicians to confirm the attending physician's opinion regarding the clinical necessity of the abortion.⁴² The Court did uphold the statute's requirement that the physician find that the abortion was "necessary" in his or her best clinical judgment, holding that this requirement actually benefited the woman without unduly burdening her right to abortion.⁴³ While not expanding the privacy doctrine, the opinion did provide more guidance on its application.

Many state legislatures opposed the decisions in *Roe* and *Doe*, and moved quickly to restrict access to abortion. In particular, Missouri passed a statute defining viability, requiring the written consent of the woman and the woman's spouse during the first

32. *Id.* at 163-64.

33. *Id.* at 164-65.

34. *Id.* at 163-64.

35. 410 U.S. 179 (1973).

36. *Id.* at 201.

37. *Id.* at 183.

38. *Id.*

39. *Id.* at 183.

40. *Id.* at 185.

41. *Id.*

42. *Id.* at 192-99.

43. *Id.* at 191-92.

twelve weeks of pregnancy, requiring a physician performing an abortion to exercise professional due care to preserve the life and health of the fetus regardless of its viability, holding the physician liable for failing in that duty, requiring the written consent of one parent for unmarried minors, prohibiting saline amniocentesis as a method of abortion, and imposing recordkeeping requirements for facilities and physicians performing abortions.⁴⁴ A case contesting the constitutionality of the statute inevitably made its way to the Supreme Court, which had anticipated the arrival of these "secondary issues" involving abortion rights.⁴⁵

In *Planned Parenthood v. Danforth*, the Court issued a mixed decision on the Missouri statute. It upheld the statute's definition of viability, finding that it only confirmed that viability was a medical decision based upon the facts available to the physician at the time.⁴⁶ As *Roe* contemplated the same determination of viability, the Court found no conflict between *Roe* and the statute.⁴⁷ To the extent written informed consent procedures are common for medical procedures, the Court found the consent requirement was not unduly burdensome to a woman seeking an abortion.⁴⁸ The majority also upheld the recordkeeping requirements as reasonably directed toward the preservation of maternal health, in that they were confidential and used to ensure the facility's compliance with medical safety regulations.⁴⁹

The Court, however, struck down the spousal consent provision, the parental consent provision, the prohibition on saline amniocentesis, and the requirement that a physician use due care to preserve the life of the fetus.⁵⁰ Justice Blackmun, again writing the majority opinion, wrote that the state could no more grant a woman's husband veto power over abortion than it could exercise such power itself.⁵¹ Under the same reasoning, the state also could not require parental consent for unwed minors.⁵² While saline amniocentesis was the method used in seventy percent of all United States abortions and was safer than many (but not all) other techniques, the majority felt that Missouri's attempt to outlaw the

44. See *Planned Parenthood v. Danforth*, 428 U.S. 52, 84-89 (1976) (providing the complete text of the Act).

45. *Id.* at 55.

46. *Id.* at 64.

47. *Id.* at 65.

48. *Id.* at 67.

49. *Id.* at 80.

50. *Id.* at 70, 74, 79, 83-84.

51. *Id.* at 69-70.

52. *Id.* at 74.

practice was no more than an arbitrary restriction on the right to abortion.⁵³ The Court held that the state could not require a physician to provide care to a non-viable fetus, as it was not a child and essentially has no life or health to preserve.⁵⁴ After *Danforth*, the Court did not substantially address abortion for several years, preferring to rule only on funding issues and to make minor interpretations of the *Roe* framework.

In 1991, the Supreme Court put forth its current view on abortion in *Planned Parenthood v. Casey*.⁵⁵ *Casey*, another mixed decision, addressed a Pennsylvania law with five relevant provisions.⁵⁶ First, the law required "a woman seeking an abortion give her informed consent prior to the abortion procedure, and specifies that she be provided with certain information at least 24 hours before the abortion is performed."⁵⁷ Second, a minor seeking an abortion had to obtain the informed consent of one of her parents or guardians, but could use a judicial bypass procedure if the minor did not want to or could not obtain such consent.⁵⁸ Third, the law required a married woman to certify that she had notified her husband of an intended abortion.⁵⁹ Fourth, a "medical emergency", as determined by a physician to require an immediate abortion to avert the woman's death or a serious risk of impairment of a major bodily function, eliminated these requirements.⁶⁰ Finally, the law required facilities providing abortion services to keep records that did not disclose the identities of the women who had undergone abortions, but did require reporting of a married woman's decision not to provide notice to her husband.⁶¹

Casey fractured the Court into several different opinions. A majority of the justices agreed that the emergency provision, the minor parental consent provision with a judicial bypass, the 24 hour waiting period, the informed consent provision, and the general reporting requirements met constitutional standards.⁶² Yet, the majority also struck down the spousal notification requirement and the reporting of failures of spousal notification.⁶³ The *Casey*

53. *Id.* at 78-79.

54. *Id.* at 83.

55. 505 U.S. 833 (1992).

56. *Id.* at 844 (explaining the Pennsylvania Abortion Control Act of 1982, 18 PA. CONS. STAT. §§ 3203-3220 (1990) (as amended in 1988 and 1989)).

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.* at 901.

63. *Id.*

opinions upheld the continuing validity of the rights enunciated in *Roe* and supported the protection of those rights from the imposition of "undue burdens" by the states.⁶⁴

Of particular interest was the Court's definition of such an "undue burden". In *Casey*, the Court wrote that "a law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability" is unconstitutional.⁶⁵ Further, an "undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."⁶⁶ In other words, a regulation need not have the *purpose* of placing a substantial obstacle in the path of a woman seeking to terminate her pre-viable pregnancy in order to run afoul of her rights; it need only have that *effect*. As applied to a given situation, a facially neutral regulation might unduly interfere with an individual woman's access to an abortion.

Casey also upheld the principle that the state's interest in fetal life did not outweigh the mother's interest in her own health even after viability.⁶⁷ Although *Casey* did not involve regulations pertaining to a woman's right to terminate her pregnancy for health reasons, except in situations which involved relieving pregnant women from waiting, informed consent, parental consent, and spousal notification provisions in a medical emergency. The Court later addressed the right to terminate a pregnancy in *Stenberg v. Carhart*.⁶⁸ In this case, the Court specifically ruled that a Nebraska statute prohibiting partial birth abortion when only the health, but not the life, of the woman was at risk was unconstitutional.⁶⁹ The Court found that because partial birth abortion better protects the woman's health in some circumstances because a complete ban represented an undue burden on a woman's right to have an abortion to protect her health.⁷⁰

In sum, the decisions from *Roe* to *Stenberg* support a woman's right to choose to have an abortion free from unreasonable burdens imposed by the States. However, these cases only address State attempts to limit *legal* access, not *economic* barriers such as lack of government funding. The Court addressed these issues in a

64. *Id.* at 876.

65. *Id.* at 877.

66. *Id.*

67. *Id.* at 879.

68. 530 U.S. 914 (2000).

69. *Id.* at 921-22.

70. *Id.* at 945-46.

separate line of opinions that do not support the existence of an affirmative government duty to fund abortion.

B. Funding Background Cases—Maher, Harris, Webster and Rust

The federal courts draw a clear line between a woman's right to have an abortion and the government's decision not to fund abortion services. The line of cases *Roe v. Wade*⁷¹ to *Stenberg v. Carhart*⁷² guarantee the right to abortion and freedom from excessive state interference with that right, but a separate line of cases supports government funding denials. These cases, described below, generally hold that the government need not fund abortion services, even when medically necessary.

*Maher v. Roe*⁷³ was the first case to address the issue of state funding for abortions after *Roe v. Wade*.⁷⁴ In *Maher*, two indigent Medicaid-eligible women sought funding for their abortions without a physician's opinion, stating that the abortions were "medically necessary", as was required by the Connecticut Welfare Department regulation providing coverage.⁷⁵ The District Court for the District of Connecticut initially held that the Social Security Act (SSA) required the funding of non-therapeutic abortions upon request from a Medicaid-eligible recipient.⁷⁶ On appeal, the United States Court of Appeals for the Second Circuit held that the SSA did not require such funding.⁷⁷ On remand, the District Court convened a three judge panel and held that the Equal Protection Clause of the Fourteenth Amendment forbade the exclusion of non-therapeutic abortions from state funding when the funding program otherwise provided coverage for pregnancy.⁷⁸ The Court cited both *Roe v. Wade* and *Doe v. Bolton* as establishing the equality of abortion and childbirth as medical means of addressing pregnancy.⁷⁹ The court wrote,

71. 410 U.S. 113 (1973).

72. 530 U.S. 914 (2000).

73. *Maher v. Roe*, 432 U.S. 464 (1977).

74. *Roe*, 410 U.S. at 113. (1973).

75. *Maher*, 432 U.S. at 46.

76. *Roe v. Norton*, 380 F. Supp. 726, 730-31 (D. Conn. 1974), *reversed by Roe*, *infra* note 77.

77. *Roe v. Norton*, 522 F.2d 928 (2d Cir. 1975).

78. *Roe v. Norton*, 408 F. Supp. 660, 665 (D. Conn. 1975), *reversed by Maher v. Roe*, 432 U.S. 464 (1977).

79.

The state may not justify its refusal to pay for one type of expense arising from pregnancy on the basis that it morally opposes such an expenditure of money. To sanction such a justification would be to permit discrimination against those seeking to exercise a constitutional right on the basis that the state simply does not approve of the exercise of that right.⁸⁰

The Supreme Court, in *Maher*, overturned the Court of Appeals for the Second Circuit.⁸¹ The Court noted that the state had no obligation to provide abortion services to the poor, but in choosing to do so, must provide the service in a constitutional manner.⁸² Having framed the question in Fourteenth Amendment Equal Protection terms, the court applied the following standard analysis: does the State act to the detriment of a suspect classification or infringe on a fundamental constitutional right?⁸³ If so, does the State meet the compelling interest requirements of strict scrutiny?⁸⁴ If not, is the State acting rationally to protect some legitimate, articulated state interest?⁸⁵

The Court quickly dismissed the suspect class argument, holding that poverty was insufficient to define a suspect class.⁸⁶ Moving on to the issue of whether a fundamental constitutional right was implicated by the Connecticut regulation, the Court found that no such interest was affected.⁸⁷ Justice Powell, who authored the majority opinion, contrasted the criminal abortion prohibition in *Roe v. Wade* with the denial of funding for abortions under the Connecticut regulation.⁸⁸ While a blanket prohibition on abortion impermissibly interfered with a fundamental right, the mere decision not to subsidize abortion only required a rational basis.⁸⁹

The Court found that the regulation was rationally related to promoting a legitimate, articulated State interest, citing *Roe v. Wade* itself as conceding a State interest in fetal protection.⁹⁰ The court declined to inquire too deeply into the State's reasoning that "when an issue involves policy choices as sensitive as those implicated by public funding of non-therapeutic abortions, the

80. *Id.* at 664.

81. *Maher*, 432 U.S. at 465.

82. *Id.* at 469-70.

83. *Id.*

84. *Id.*

85. *Id.* at 470 (citing *San Antonio School Dist. v. Rodriguez*, 411 U.S. 1, 17 (1973)).

86. *Id.* at 470-71.

87. *Id.* at 474.

88. *Id.* at 471-74.

89. *See id.*

90. *Id.* at 478.

appropriate forum for their resolution in a democracy is the legislature."⁹¹

In dissent, Justice Brennan wryly quoted Justice Frankfurter and Anatole France:

To sanction such a ruthless consequence, inevitably resulting from a money hurdle erected by the State, would justify a latter-day Anatole France to add one more item to his ironic comments on the 'majestic equality' of the law. 'The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread'⁹²

He went on to write that the Connecticut regulation clearly infringes on the privacy rights of poor women "by bringing financial pressure on indigent women that force them to bear children."⁹³ *Maher* set the first precedent in the development of this line of cases. While limited on its facts to elective, non-therapeutic abortions, the case clarified abortion's status as a right, but not a right that the government must facilitate. The Court essentially held that the government had no affirmative duty to subsidize abortion rights for the poor.

In 1976, the Hyde Amendments began to severely limit the types of abortions funded under Title XIX of the Social Security Act.⁹⁴ The "Hyde Amendment", named for its sponsor, United States Representative Henry Hyde, is actually a series of amendments to various bills. The first amendment was to the Foreign Assistance Act of 1973, which restricted Medicaid abortions.⁹⁵ Over the next 25 years, Congress added additional restrictions in other acts. These included amendments to the 1977 Departments of Labor and Health, Education, and Welfare,

91. *Id.* at 479.

92. *Id.* at 483 (Brennan, J., dissenting) (citing *Griffin v. Illinois*, 351 U.S. 12, 23 (1956) (concurring opinion)).

93. *Id.* at 484.

94. Foreign Assistance Act of 1973, Pub. L. No. 93-189, 87 Stat. 714 (1973). Other legislation containing abortion restrictions includes (1) the Legal Services Corporation Act of 1974, Pub. L. No. 93-355, 88 Stat. 378 (1974) (restricting Legal Aid agencies receiving federal funds from engaging in litigation to procure non-therapeutic abortions); (2) the Civil Rights Act of 1964, Pregnancy Discrimination, Pub. L. No. 95-555, 92 Stat. 2076 (1978) (permitting employers not to cover abortion services in healthcare plans); and Title IX of the Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 535, 592 (1981) (permitting the allocation of federal funds only to health programs that do not advocate or provide abortions, except in the case of a pregnant minor who had the permission of both her parents or guardians).

95. Foreign Assistance Act of 1973, Pub. L. No. 93-189 § 114, 87 Stat. 714.

Appropriation Act,⁹⁶ the 1984 Department of Defense Appropriation Act,⁹⁷ the 1979 District of Columbia Appropriation Act,⁹⁸ and the 1984 Department of the Treasury and Postal Service Appropriations Act.⁹⁹ These Acts eliminated federal funding for abortions in various programs except when the life of the mother would be endangered if the child were carried to term. In 1987, a Continuing Resolution (a legislative budgetary stopgap measure) allowed federal abortion funding in cases of rape.¹⁰⁰

Several groups challenged the regulations as violating the First and Fifth Amendments. They requested a ruling that the States were required to fund abortions when medically necessary despite the Hyde Amendment. The District Court for the Eastern District of New York initially issued a preliminary injunction enjoining enforcement of the Hyde Amendments.¹⁰¹ The Supreme Court vacated the injunction and remanded the case for reconsideration¹⁰² in light of *Maher* and *Beal v. Doe*, another case that held that Medicaid rules did not require funding for abortion.¹⁰³

Upon reconsideration, the district court again ruled that the Amendments violated the Free Exercise Clause of the First Amendment and the Equal Protection component of the Fifth Amendment by impinging on the privacy rights of indigent women to terminate a pregnancy rather than suffer a health risk.¹⁰⁴ On the Equal Protection component, the district court found no rational basis for choosing not to fund medically necessary abortions while choosing in general to fund necessary medical services.¹⁰⁵ Similarly, the court found that the Free Exercise of Religion rights of Jewish and Protestant women were violated, as the law reflected traditional Catholic view of abortion and the beginning of life.¹⁰⁶ The Court, however, did not find that states were compelled to fund

96. Departments of Labor and Health, Education, and Welfare, Appropriation Act, Pub. L. No. 94-439, 90 Stat. 1418 (1977).

97. Department of Defense Authorization Act, Pub. L. No. 98-525, 98 Stat. 2492 (1985).

98. District of Columbia Appropriation Act, Pub. L. No. 96-530, 94 Stat. 3121, 3127-28 (1980).

99. Continuing Appropriations, Pub. L. No. 98-107, 97 Stat. 733 (1984).

100. Continuing Appropriations, Fiscal Year 1987, Pub. L. No. 99-591, 100 Stat. 3341 (1987).

101. *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976) *judgment vacated by Califano v. McRae*, 433 U.S. 916 (1977).

102. *Califano v. McRae*, 433 U.S. 916 (1977).

103. *Beal v. Doe*, 432 U.S. 438 (1977).

104. *McRae v. Califano*, 491 F. Supp. 630, 739-42 (E.D.N.Y. 1980) *judgment reversed by Harris v. McRae*, 448 U.S. 297 (1980).

105. *Id.* at 739-40.

106. *Id.* at 741-42.

medically necessary abortions in the absence of federal funding under the Title XIX program, nor that the Amendments violated the Establishment Clause.¹⁰⁷

On appeal, in *Harris v. McRae*, the Supreme Court upheld the statutory findings of the District Court on other grounds but overturned its constitutional findings regarding Equal Protection.¹⁰⁸ The Court ruled that the "cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State."¹⁰⁹ Thus, the States were not obligated under Medicaid to provide funding for procedures for which they would not receive reimbursement from the federal government.¹¹⁰ Quoting extensively from *Maher*, the Court found no impingement of a fundamental constitutional right. The Court wrote, "although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation."¹¹¹ The Court held that the government had not placed women in poverty and therefore had no duty to mitigate the effects of poverty on the exercise of their reproductive rights.¹¹²

The First Amendment Establishment Clause also did not invalidate the Hyde Amendments. The Court found that the Amendments had "a secular legislative purpose, . . . neither advances nor inhibits religion, and . . . does not foster an excessive government entanglement with religion", therefore meeting Establishment Clause muster.¹¹³ Addressing the effect of the Hyde Amendments on the Free Exercise Clause, the Court found that the challengers/appellees lacked standing to address the issue.¹¹⁴ The appellees fell into three categories—indigent pregnant women suing on behalf of others in a similar situation, two officers of the Women's Division of the Board of Global Ministries of the United Methodist Church, and the Women's Division itself.¹¹⁵ The first category did not prove they had sought an abortion under a religious compulsion, the second category had not proven that they were pregnant or indigent, and the third category did not meet the

107. *Id.*

108. *Harris v. McRae*, 448 U.S. 297 (1980).

109. *Id.* at 308.

110. *Id.*

111. *Id.* at 316.

112. *Id.* at 316-17.

113. *Id.* at 319 (quoting *Committee for Public Educ. v. Regan*, 444 U.S. 646, 653 (1980)).

114. *Id.* at 370.

115. *Id.*

requirements for standing because they could not prove that the individual participation of any member was unimportant.¹¹⁶

Addressing the Equal Protection Clause argument, the Court held that in addition to not involving any substantive constitutional rights, the indigent women plaintiffs in the case were not members of a protected classification.¹¹⁷ The Court essentially repeated its finding in *Maher* that indigence, in itself, is simply not a suspect class.¹¹⁸ Justice Brennan again penned the dissent, reiterating his disagreements with the decision in *Maher*.¹¹⁹ Mocking the Court's reasoning that the case involved no government action interfering with a woman's right to choose, he wrote, "what the Court fails to appreciate is that it is not simply the woman's indigency that interferes with her freedom of choice, but the combination of her own poverty and the Government's unequal subsidization of abortion and childbirth."¹²⁰

Harris extended the government's right to discriminate between generally medically necessary services and medically necessary abortion services. While *Maher* had dealt with a woman's right to funding in the absence of a medical necessity, *Harris* found a legitimate government interest in choosing which medically necessary services to fund.¹²¹ As the plaintiffs challenged the amendments facially, rather than as applied, the Court did not address the issue of whether a certain set of facts would present such a compelling argument that the government could not legitimately prevent funding. This left the door open for the later findings in the *Britell* and *Doe* cases.¹²²

In 1986, the Governor of Missouri signed a bill into law that severely limited state funding for abortion.¹²³ The bill's most controversial sections included a statement that human life began at conception,¹²⁴ an equality provision for unborn children,¹²⁵ a requirement that physicians assess the gestational age of any fetus over twenty weeks gestation,¹²⁶ a prohibition on the use of public employees and facilities to perform abortions, and a prohibition on

116. *Id.* at 320-21.

117. *Id.* at 323.

118. *Id.*

119. *See id.* at 329-30 (Brennan, J., dissenting).

120. *Id.* at 333.

121. *Id.* at 324-26.

122. *See infra*, at V.

123. *See Webster v. Reprod. Health Serv.*, 492 U.S. 490, 500-01 (1989).

124. *Id.* at 501 (citing MO. REV. STAT. §§ 1.205.1(1)-(2) (1986)).

125. *Id.* (citing MO. REV. STAT. § 1.205.2 (1986)).

126. *Id.* (citing MO. REV. STAT. § 188.029 (1986)).

the use of public instrumentalities in abortion counseling except when the life of the mother was at risk.¹²⁷ In *Webster v. Reproductive Health Services*, the Supreme Court quickly disposed of the "life at conception" provision, finding that it was merely a statement of belief, had no effect on the practice of abortion, and did not implicate constitutional concerns.¹²⁸

Relying on *Maher* and *Harris*, the Court also upheld the prohibition on the use of state employees, facilities, and funds for abortions that did not involve the protection of the life of the mother.¹²⁹ In doing so, the Court rejected the argument that the prohibition unreasonably restricted access to abortion.¹³⁰ In the Court's view, the facilities prohibition did not raise any more substantial issue than the decision not to fund abortion services.¹³¹ The state did not have to support abortion through funding or facilities.¹³²

The Court similarly disposed of other objections to the statute. To avoid interfering with the doctor-patient relationship, Missouri alleged that the prohibition on funding for abortion counseling did not apply to physicians, but rather only to the state financial controllers who disbursed state funds.¹³³ Therefore, as the physicians were not adversely affected, the Court found no case or controversy before it and did not rule on the issue.¹³⁴ The Court also upheld the requirement for a physician to determine the viability of a fetus at twenty weeks, finding that it simply reflected the legitimate state concern with balancing the potential life of the fetus after the point of viability.¹³⁵ Also, the state could legitimately require determination of the viability of the fetus at twenty weeks, because viability generally begins at twenty-four weeks and four weeks error was standard in determining gestational age.¹³⁶

Post-*Webster*, Government restrictions on abortion continued to grow. In 1970, Congress passed Title X of the Public Health Services Act.¹³⁷ The Act generally provided federal funding for family planning services. The Act authorized the Secretary of

127. *Id.* (citing MO. REV. STAT. §§ 188.205, 188.210, 188.215. (1986)).

128. *Webster*, 492 U.S. at 507.

129. *Id.* at 508.

130. *Id.* at 509.

131. *Id.* at 509-10.

132. *Id.*

133. *Id.* at 512.

134. *Id.* at 511-12.

135. *Id.* at 512-20.

136. *Id.*

137. 42 U.S.C. §§ 300-300a-6 (1970).

Health, Education, and Welfare (HEW, later renamed Health and Human Services, or HHS) to grant funds or enter into contracts with public or nonprofit private parties for the purpose of improving voluntary family planning.¹³⁸ Section 1008 of the Act prohibited the funding of programs where abortion is a method of family planning.¹³⁹ In 1988, the Secretary of HHS promulgated regulations defining "family planning" exclusively as preventive services, and prohibited a project from receiving these funds because it provided counseling concerning the use of abortion as a method of family planning and provided referrals for abortion services.¹⁴⁰ The regulations further required referral to a list of providers who promote the welfare of mother and unborn child, and prohibited: weighting that list towards abortion providers; putting abortion clinics on the list; excluding health care providers who do not provide abortion; and steering clients toward particular providers who offer abortion services.¹⁴¹ The regulations also provided that Title X projects must be physically and financially separate from any prohibited abortion-related activities.¹⁴²

A group of Title X grantees and doctors who supervised Title X funds quickly challenged the facial validity of the new regulations on the grounds that they were not authorized by Title X and that they violated the First and Fifth Amendment rights of Title X clients and the First Amendment rights of Title X providers.¹⁴³ The district court rejected the petitioners' challenge and granted summary judgment to the government.¹⁴⁴ The United States Court of Appeals for the Second Circuit affirmed the decision, holding that the regulations were a permissible construction of the statute and legitimately interpreted congressional intent under the deference required by *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*¹⁴⁵

On appeal, the Supreme Court affirmed the judgments of the lower courts.¹⁴⁶ Noting that the petitioners had attacked the facial validity of the statute, the Court examined the regulations to see if, on their face, they would be constitutional as applied to a set of

138. *Id.* at §§ 300a-4(a).

139. *Id.* at §§ 300a-6.

140. 42 C.F.R. § 59.8(a)(1) (2003).

141. *Id.* at § 59.8(a)(3).

142. *Id.* at § 59.9.

143. *New York v. Bowen*, 690 F. Supp. 1261, 1263 (S.D.N.Y. 1988).

144. *Id.* at 1274.

145. *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-83 (1984); *New York v. Bowen*, 889 F.2d 401 (1989).

146. *Rust v. Sullivan*, 500 U.S. 173, 178 (1991).

individuals and if they were indeed authorized by the statute.¹⁴⁷ The Court quickly disposed of the question of whether the regulations were arbitrary and capricious. The Court found the regulations to be a valid interpretation of the statutory authorization, noting the broadness of the Section 1008 language, “[n]one of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.”¹⁴⁸ The Court found that *Chevron* requires substantial judicial deference to the agency interpreting the regulation when confronted with ambiguous language.¹⁴⁹

The legislative history of the statute also included contradictory statements of intent.¹⁵⁰ The petitioners argued that the regulations should not be accorded this deference because they reversed a long policy that permitted abortion counseling and referral.¹⁵¹ The Court rejected this argument, as it had in *Chevron*, and found that “the Secretary had amply justified his change of interpretation.”¹⁵²

Turning to the program integrity/separation portion of the regulations, which required separation of facilities, personnel, and records, the Court rejected the argument that these were contrary to the congressional intent to have Title X programs as part of a broader, comprehensive, health care system.¹⁵³ Crediting the Secretary’s argument that the separation was necessary to prevent the appearance of a government subsidy of abortion, the Court found sufficient justification for the separation in the congressional prohibition on funding abortion-related activities.¹⁵⁴

The Court next addressed the First Amendment concerns of the petitioners, who alleged that the regulations impermissibly imposed “viewpoint-discriminatory conditions on government subsidies’ and thus penaliz[e] speech funded with non-Title X monies” and discriminate on the basis of viewpoint.¹⁵⁵ Quoting *Maher*, the Court found that Section 1008 and the regulations were clearly constitutional.¹⁵⁶ The Court did not agree with the argument that the regulations impermissibly predicated receipt of a government benefit on the relinquishment of a constitutional right, i.e. freedom

147. *Id.* at 183-87.

148. *Id.* at 118 (citing 42 U.S.C. § 300a-6 (1970)).

149. *Id.* at 186-87 (citing *Chevron*, 467 U.S. at 844).

150. *Id.*

151. *Id.*

152. *Id.* at 187.

153. *Id.* at 186-87.

154. *Id.* at 190.

155. *Id.* at 192.

156. *Id.*

of speech in counseling pregnant women.¹⁵⁷ The Court instead held that the regulations were distinct from a predication on receipt of benefits in exchange for the relinquishment of a right, in that they solely represented a prohibition on spending government funds on certain activities and not a restriction on behavior.¹⁵⁸

The Court also found that, as in *McRae*, the mere denial of government funding for the exercise of a right did not constitute government action impeding the exercise of that right.¹⁵⁹ The majority also rejected the contention that the regulations impermissibly infringed on the doctor-patient relationship and deprived the Title X client of information necessary to exercise her Fifth Amendment right to "medical self-determination".¹⁶⁰ The Court distinguished its earlier decisions in *Akron v. Akron Center for Reproductive Health, Inc.*,¹⁶¹ and *Thornburgh v. American College of Obstetricians and Gynecologists*¹⁶² by noting that those cases had involved the state mandating the provision of certain information to all patients regardless of their desire to have the information.¹⁶³ In the instant case, the regulations did nothing to inhibit the free communication between physicians and patients outside the Title X setting.¹⁶⁴

Justices Blackmun, Stevens, and O'Connor dissented.¹⁶⁵ Justice Blackmun thought the Secretary had exceeded the statutory authorization and that no decision on the constitutional grounds was necessary.¹⁶⁶ He expressed strong reservations about viewpoint-based suppression of speech through the withholding of public funds.¹⁶⁷ Justice Stevens wrote separately to express his displeasure over the majority's neglect of the wording of the statute,

157. *Id.* at 192-99.

158. *Id.* at 197-99.

159. *Id.* at 201-02.

160. *Id.* at 202.

161. *Id.* at 202. The Court in *Akron* found, in relevant part, that requiring a woman's physician to engage in a lengthy and rigid lecture regarding the dangers of abortion and alternatives to abortion impermissibly interfered with the physician-patient relationship and impermissibly required more informed consent procedure than was necessary. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983).

162. *Rust*, 500 U.S. at 202-03. The Court in *Thornburgh* found, in relevant part, that the state could not require a physician to provide certain written materials to his patients seeking abortions, as those materials served to impermissibly intimidate women into continuing their pregnancy. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759 (1986).

163. *Rust*, 500 U.S. 202-03.

164. *Id.* at 203.

165. *Id.* at 207-211 (Blackmun, O'Connor, Stevens, J.J., dissenting).

166. *Id.* at 204-220 (Blackmun, J., dissenting).

167. *Id.*

arguing that the statute explicitly required disclosure of all legal options during pregnancy.¹⁶⁸ Justice O'Connor agreed with Justice Blackmun's admonition that the Court must consider statutory construction before constitutional grounds, and thought that the Secretary had overstepped the statutory authority of Section 1008.¹⁶⁹

Rust went beyond *Maher* and *McRae* in finding that the government also could not only choose not to fund abortion services, but could intervene in the doctor-patient relationship to prevent discussion of abortion as an option.¹⁷⁰ The *Rust* case seriously undermines the principles of informed consent, albeit in such a way as to give the physician an affirmative defense for failing to disclose the abortion option. Arguably, the only option available to a physician in a Title X program when confronted with an already pregnant patient who wished to terminate her pregnancy would be to discuss birth control and family planning as it related to her next child and to refer her to another provider who could at least discuss abortion. The *Rust* plaintiffs, however, again challenged the regulations facially, rather than as applied in a particular case.¹⁷¹ This again left open the possibility that a certain set of facts would so compel the Court that it would make an exception in that case or for that particular class of plaintiffs.

In sum, the line of cases from *Maher* to *Rust* supports the facial validity of government decisions to not fund abortion services. This line of precedent is not without its critics, who cite the disproportionate impact of funding policies on the poor, minorities, and the very young.¹⁷² Although even these critics generally concede that a different approach to the issue must be taken to secure favorable decisions.¹⁷³ The plaintiffs, in choosing a facial challenge, never presented the Court with the particular case of a medically necessary abortion. Thus, while finding that a blanket government decision not to fund medically necessary abortion was permissible, the Court never considered whether the circumstances of a particular case involving therapeutic abortion might be so compelling as to require government funding. The Court never found that the government required even a rational basis for the

168. *Id.* at 220-22323 (Stevens, J., dissenting).

169. *Id.* at 223-25 (O'Connor, J., dissenting).

170. *Id.* at 177-78.

171. *Id.*

172. See e.g., Eileen L. McDonough, *My Body, My Consent: Securing the Constitutional Right to Abortion Funding*, 62 ALB. L. REV. 1057 (1999).

173. *Id.* at 1061.

regulations, as the challengers had only alleged that the class to be protected was indigent,¹⁷⁴ a class not protected in earlier cases.

In choosing facial challenges in *McRae* and *Rust*, the plaintiffs took on a heavy burden. Suing on behalf of a class has certain grandeur and potential for broad social change, but neglects the critical advantages of having a detailed and particularly sympathetic set of facts to put before the court.¹⁷⁵ A case-by-case approach allows the court to take gradual steps with less chance of reversal upon appeal. As demonstrated below, this approach can succeed even in the face of unfavorable precedent, as it does not require the court to make broad declarations regarding the wisdom of legislative or regulatory policy, but rather to examine the application of a broad policy to a narrow set of circumstances.

III. STATUTORY AND REGULATORY BACKGROUND OF AIR FORCE POLICY

Title 10 of the United States Code, Section 1093, prohibits military funding for abortion services and prohibits the performance of abortions in military facilities, except to protect the life of the mother.¹⁷⁶ Air Force policy has struggled to reconcile federal court decisions protecting abortion rights, the requirements of informed consent, and the statutory prohibition on spending federal funds for abortion services. In general, as described above, *Roe v. Wade* and its Supreme Court progeny protect a woman's right to terminate a pregnancy with very few restrictions in the first trimester, with increasing potential for restrictions as the pregnancy progresses.¹⁷⁷ These decisions equally protect military women and military family members. Additionally, military physicians must obey state and professional mandates regarding informed consent.¹⁷⁸ These mandates require complete disclosure of all legal and medically appropriate options for pregnant women, including abortion. Federal law, however, prohibits the expenditure

174. *Rust*, 500 U.S. at 201-02.

175. See, e.g., *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 437 (1985). In *Cleburne*, the plaintiffs claimed that an otherwise valid zoning ordinance was unconstitutional as applied to a home for the mentally retarded, because the neutral nature of the ordinance did not prevent it from invidiously discriminating against the mentally retarded under the circumstances of the case. *Id.*

176. Pub. L. No. 98-525, Title XIV, § 1401(e)(5)(A), 98 Stat. 2492, 2618 (1985) amended by Pub. L. No. 104-106, Div A, Title VII, Subtitle D, § 738(a), (b)(1), 110 Stat. 186, 383 (1996).

177. *Roe*, 410 U.S. 113 (1973).

178. The Federal Tort Claims Act (F.T.C.A.), 28 U.S.C. § 2674 et. seq. (2003) holds military physicians to the same standards of care as civilian physicians for the purposes of tort liability.

of federal funds for abortions when the life of the mother is not at risk.¹⁷⁹ The performance of abortions in military facilities is also forbidden, unless either the life of the mother is at risk or the pregnancy is the result of rape or incest.¹⁸⁰ While the Air Force has managed to shape a facially neutral abortion policy, in practice the policy obstructs access to abortion.

A. *Informed Consent*

Several medical organizations have developed professional practice requirements mandating that, consistent with the bioethical principles of patient autonomy and informed consent, physicians must counsel women about all their options during pregnancy.¹⁸¹ General principles of informed consent, as codified in state law or developed in state common law, also require physicians to counsel pregnant women regarding all their legal and medically appropriate options.¹⁸² The American Medical Association's "Fundamental Elements of the Patient-Physician Relationship" requires that the physician provide information regarding appropriate alternatives and allow the patient to make treatment decisions.¹⁸³ Similarly, the American College of Obstetrics and Gynecology,¹⁸⁴ the American Academy of Pediatrics,¹⁸⁵ the American Academy of Family Practitioners,¹⁸⁶ and the American College of Emergency Physicians¹⁸⁷ recommend disclosure of all legal and

179. 42 U.S.C. § 300a-6 (1970).

180. Pub. L. No. 98-525, 98 Stat. 2492, 2618 (1985), amended by Pub. L. No. 104-106, Div. A, Title VII, Subtitle D, § 738(a), (b)(1), 110 Stat. 186, 383 (1996).

181. Am. Med. Ass'n Code of Med. Ethics, § E-8.08 Informed Consent, available at <http://www.ama-assn.org/ama/pub/category/2503.html> (last visited Apr. 4, 2003).

182. See, e.g., TEX. REV. CIV. STAT. art. 4590i, § 6.07 (2003).

183. Am. Med. Ass'n, *Fundamental Elements of the Patient-Physician Relationship*, §§ 1-2, available at <http://www.ama-assn.org/ama/pub/category/2510.html> (last visited Apr. 4, 2003).

184. AM. COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, CODE OF PROFESSIONAL ETHICS OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS 2, available at http://www.acog.org/from_home/acogcode.pdf (last visited Apr. 4, 2003). See, e.g., Am. College of Obstetricians and Gynecologists, *President's Gag Rule Increases Health Risks for Women Abroad, Say US Ob-Gyns*, Jan. 23, 2001, available at http://www.acog.org/from_home/newsrel.cfm (last visited Apr. 4, 2003).

185. AM. ACAD. OF PEDIATRICS, POLICY STATEMENT, COUNSELING THE ADOLESCENT ABOUT PREGNANCY OPTIONS, at <http://www.aap.org/policy/re9743.html> (last visited Apr. 4, 2003).

186. AM. ACAD. OF FAMILY PRACTITIONERS, REPRODUCTIVE DECISIONS, at <http://www.aafp.org/x7053.xml> (last visited Apr. 4, 2003).

187. AM. MED. ASS'N AM. COLLEGE OF EMERGENCY PHYSICIANS, at <http://www.ama-assn.org/ama/pub/article/7665-4671.html> (last visited Apr. 4, 2003). "Patients with decision-making capacity must give their voluntary consent to treatment after receiving appropriate and relevant information about the nature of the affliction and expected consequences of recommended treatment and treatment alternatives." *Id.* at II.B.2.

medically appropriate options to pregnant women.¹⁸⁸ Legally, a physician who fails to disclose all medically appropriate options for treatment does not facilitate a complete informed consent, commits malpractice, and may be held liable for damages, regardless of the physician's personal morality or contractual obligations.¹⁸⁹

The law may modify these duties. For instance, as described above, Title X family planning programs may not discuss abortion as a means of family planning because Title X programs provide exclusively preconception family planning services.¹⁹⁰ Arguably, this does not relieve the provider of the affirmative duty to inform the patient that the provider may not discuss issues of abortion and to refer the patient to a provider who can. While the Title X regulations prohibit participating programs from discussing abortion with their clients, physicians operating under a Title X program still must comply with the state and professional requirements of complete informed consent.

Many Air Force physicians feel the prohibition on performance of abortions and funding for them under the military system absolves them of the duty to discuss the abortion option with their patients.¹⁹¹ They also may misconstrue the Air Force policy of exempting physicians from performing abortions if they morally object to the procedure as permission to refuse to discuss abortion entirely, which is not Air Force policy.¹⁹² By its own terms, the "conscientious objection" clause is limited to the actual performance of abortions, not mere patient counseling regarding permissible options.¹⁹³

In fact, the Air Force requires Medical Group Commanders to promulgate guidance on informed consent procedures consistent

188. Other specialties have similar informed consent provisions. I chose these specialties because they most often examine and treat pregnant women.

189. For a complete discussion of these issues, see Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J. L. AND MED. 433 (1996). See also Mary Ann Becker, *The Politics of Women's Wrongs and the Bill of "Rights": A Bicentennial Perspective*, 59 U. CHI. L. REV. 453, 484-87 (1991); Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. REV. L. & SOC. CHANGE 279 (1994-95).

190. *Rust v. Sullivan*, 500 U.S. 173 (1991).

191. Interviews with Air Force physicians, Wilford Hall Med. Center (Oct. 2002). Wilford Hall is located at Lackland Air Force Base in San Antonio, Texas.

192. AFI 44-102, § 2.10.3, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>. "Medical personnel who have a personal or moral objection to abortion need not assist in the procedure unless their refusal poses life-threatening risks to the patient. NOTE: This applies only to providers directly involved in performing the abortion procedure itself." *Id.*

193. *Id.*

with state law and local practice.¹⁹⁴ As the states require disclosure of all medically appropriate alternatives through common law or statute, this implies that physicians must counsel pregnant women regarding abortion.¹⁹⁵ The Air Force also requires medical treatment facilities to create procedures for abortion referrals. Unfortunately, this policy is most likely observed in the breach.¹⁹⁶

Air Force physicians generally do not clearly understand the current policy of complete informed consent and referral, but no performance or funding, and object to certain provisions. The physicians interviewed for this paper strongly supported a physician's right to decline to discuss abortion with a patient on moral grounds.¹⁹⁷ To their credit, all physicians interviewed said that they would refer a woman to a provider willing to discuss elective termination of pregnancy if the woman inquired about it.¹⁹⁸ The physicians primarily objected to the limitation on abortion in military facilities in two respects. First, it limits a woman's access to therapeutic termination of pregnancy. All physicians interviewed felt that the military should allow therapeutic abortions in military treatment facilities.¹⁹⁹ Second, the physicians believed they were prohibited from referring a woman to any particular abortion provider. Some felt that the quality of abortion providers varied greatly, and that this referral limitation prevented their patients from getting the best quality care.²⁰⁰ All physicians felt that the frequent changes in policy had made it difficult for physicians to keep track of the current Air Force requirements regarding the policy on the termination of pregnancy.²⁰¹

B. Federal Limitations on Abortion Funding

The Air Force and TRICARE must adhere to 10 U.S.C. § 1093, the statutory prohibition on the use of federal funds to provide abortions except when the life of the mother is endangered. The statute, passed in 1984, initially read: "[f]unds available to the

194. *Id.* at § 2.37-2.39.

195. *Id.* at § 2.37-2.39, § 20.

196. Interviews at Wilford Hall Medical Center established that, while such procedures had existed in the past, physicians were generally unable to name a single MTF that currently had such procedures in place. Interviews with Air Force physicians, Wilford Hall Med. Center (Oct. 2002).

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

Department of Defense may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term."²⁰² It is important to note that the prohibition on funding does not include a "gag order" prohibiting the discussion of abortion with patients. The Air Force, along with the other military services (and perhaps not unreasonably in light of the statutory language), proceeded to ban all abortions at military facilities.²⁰³

Upon taking office, President William J. Clinton immediately reversed this decision, ordering the Secretary of Defense to permit privately funded abortions at military facilities.²⁰⁴ He wrote:

Section 1093 of title 10 of the United States Code prohibits the use of Department of Defense ('DOD') funds to perform abortions except where the life of a woman would be endangered if the fetus were carried to term. By memoranda of December 21, 1987, and June 21, 1988, DOD has gone beyond what I am informed are the requirements of the statute and has banned all abortions at United States military facilities, even where the procedure is privately funded. This ban is unwarranted. Accordingly, I hereby direct that you reverse the ban immediately and permit abortion services to be provided, if paid for entirely with non-DOD funds and in accordance with other relevant DOD policies and procedures.²⁰⁵

The Air Force now had to walk a narrow path—it had to allow both counseling and performance of abortions in military facilities when privately funded, but also had to prohibit the use of federal funds in performing them. In an attempt to implement President Clinton's policy change, the military surveyed all 44 military physicians stationed in Europe.²⁰⁶ All of them ultimately refused to perform abortions.²⁰⁷ This resistance to the performance of abortions at military facilities reflected both the more conservative bent of most military members and physicians, and the intense workload to which the military obstetricians were subjected to at the time.²⁰⁸ According to one physician stationed in Europe at the

202. 10 U.S.C.S. § 1093(a) (1984) (amended by 10 U.S.C.S. § 1093(b) (1996); Pub. L. No. 98-525, Title XIV, § 1401(e)(5)(A) (1984)).

203. AFR 160-12, § 15, *Medical Service Professional Policies and Procedures* (June 13, 1985).

204. Exec. Order 58 Fed. Reg. 6439 (1993).

205. *Id.*

206. David C. Morrison, *An Order That Didn't Take*, 26 NAT'L J. 900, 900 (Apr. 16, 1994).

207. *Id.*

208. *Id.* See also Steven J. Nider, Cultural Divide: The Military Challenge, *Blueprint* (July/Aug. 2001) at http://www.ndol.org/blueprint/2001_jul-aug/militarychallenger.html (last visited Apr. 4, 2003) (discussing a poll conducted by the Triangle Institute Security Studies

time, "We were working 80-100 hours a week at my base and there was no ability to add another service We were understaffed and offered no additional support."²⁰⁹ The physician also noted that studies had shown that ninety percent of obstetricians felt distaste at performing abortions and only performed them upon the insistence of their patients.²¹⁰ Not all physicians resisted performing abortions, however. One obstetrician recalled that a family practice physician threatened to start doing abortions himself, despite lacking expertise in the area, while another felt that the obstetricians should have been ordered to perform abortions.²¹¹ The military eventually began exploring using host nation physicians in military facilities where available.²¹² This did not resolve concerns about the illegality of abortion in many areas and the qualifications of the local physicians who would be performing them.

When the Republicans took over Congress in 1994, they passed an additional section (b) to prohibit the practice of performing "at cost" abortions in medical facilities.²¹³ Section 1093(b) now reads,

No medical treatment facility or other facility of the Department of Defense may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest.²¹⁴

The Air Force then promulgated several Air Force Instructions interpreting the new statutory prohibition. The current version of AFI 44-102, *Community Health Management*, provides:

Federal Law prohibits the use of DoD funds to pay for abortions in the Continental United States (CONUS). *EXCEPTION*: When a pregnancy would endanger a woman's life, Air Force medical personnel may induce abortion. The patient's physician and

which showed that sixty-four percent of military members self-identified as Republicans while only eight percent considered themselves Democrats). For more information regarding the military physician-patient relationship with regard to reproductive and family matters, see Patrick G. Spencer, *Military Physician and Nurses' Knowledge and Use of Modern Natural Family Planning*, 37 MASTERS ABSTR. 231 (1999), available at <http://www.usuhs.mil/gsn/nr/1996theses/spencer.html> (last visited Apr. 4, 2003).

209. E-mail communication (Oct. 18, 2002). Physician's name withheld by request.

210. *Id.*

211. *Id.*

212. Morrison, *supra* note 206, at 905.

213. 10 U.S.C.S. § 1093(b) (1996).

214. *Id.*

MDG/CC must certify in the medical record that the abortion is medically necessary.²¹⁵

The Instructions further prohibit the performance of abortions overseas, except when the pregnancy is the result of rape or incest.²¹⁶ In the case of rape or incest, the patient must still pay the rate established in the Federal Register.²¹⁷ Physicians with a conscientious objection to performing abortions do not have to do the procedure, except when the life of the mother is jeopardized by their refusal.²¹⁸ This exception, however, applies only to the personnel actually performing the abortion.²¹⁹ There is no provision excusing a physician from advising a patient about her right to an abortion for conscientious reasons.²²⁰

If an abortion is permitted, such as in cases of rape or incest, but not necessary to preserve the life of the mother, then the patient must pay for the procedure at the current rate quoted in the Federal Register.²²¹ Minors may obtain abortions only with parental consent,²²² emancipation,²²³ or the determination that the minor is "mature" by the Medical Group Commander.²²⁴ Despite the rather conservative bent of the regulations, they do require the Medical Group Commander to develop means to ensure access to abortion when the medical group itself does not provide abortion services.²²⁵ The rather vague wording of the AFI leaves open the question of whether the referral procedures apply only when the facility cannot provide abortions at all, or whether the facility must provide referrals for even elective abortions that do not result from rape or incest. As of November 2002, no medical group in the Air

215. AFI 44-102, § 2.01.1, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/afi44-102/afi44-102.pdf>.

216. *Id.* at § 2.10.2

217. *Id.* at §§ 2.10.2, 2.10.4.

218. *Id.* at § 2.10.3.

219. *Id.*

220. Indeed, as noted above, the AFI specifically requires adherence to state and local informed consent procedures which require full disclosure of the abortion option. *Id.* at § 2.10.8.

221. *Id.* at § 2.10.4.

222. *Id.* at § 2.10.6.2.

223. *Id.*

224. *Id.* at § 2.10.6.1. The Instruction gives no definition of a mature minor. Generally, Medical Group Commanders seek legal advice from the Staff Judge Advocate of the base host unit or the Medical Law Consultant for the Region. Under the Federal Tort Claims Act, 28 U.S.C. § 2674 et seq. (2003), state law applies in the United States. Under the Military Claims Act, "general principles of American law" apply at overseas bases. See 10 U.S.C. § 2733.

225. AFI 44-102 at § 2.10.7.

Force has published written guidelines for abortion referrals.²²⁶ The Air Force Consultant for Obstetrics, Dr. (Lt. Col.) Christopher Zahn, confessed that he was unaware of any regulatory requirement for referral procedures before our interview and thought that the medical groups generally did not have such processes in place.²²⁷ The AFI also requires that the Medical Treatment Facility (MTF), a term encompassing all Air Force medical offices, respect host nation laws regarding abortion, even if such laws contradict the other policies stated in the Instructions.²²⁸

The AFI next addresses issues of pregnancy in remote locations. In general, the Air Force will curtail a woman's assignment to a remote location at the twenty-fourth week of pregnancy, or immediately if the MTF cannot support prenatal care or if the pregnancy is complicated.²²⁹ In practice, this policy has significant effects in deployed locations. Similarly, a member may request reassignment to carry the pregnancy to term, but the commander need not transfer her until the twenty-fourth week.²³⁰ A member may request leave to receive an abortion, but the commander need not grant such a request, as discussed below.

Air Force Instruction 41-115, *Health Services*, clarifies and reinforces the policies set forth in AFI 44-102:

Air Force medical personnel in overseas MTFs may perform prepaid abortions only in cases where the patient is a victim of rape or incest, or if the mother's life is endangered if she carries the fetus to term. Abortions are available only when medical teams have no objections to performing this service. In CONUS, the Air Force restricts abortions to cases in which the mother's life would be endangered if she carried the fetus to term.²³¹

In essence, Air Force MTF's perform abortions only in very restricted circumstances.²³²

226. Per my review of AFPUBS, Sept. 22, 2002, at <http://www.e-publishing.af.mil>.

227. Telephone interview with Dr. (Lt. Col.) Christopher Zahn, Air Force Consultant for Obstetrics (Nov. 8, 2002). The Consultancy is an additional duty assigned to one or more of the more senior obstetricians/gynecologists in the Air Force. The Consultant generally advises the Air Force Surgeon General on policy issues in his or her field.

228. AFI 44-102, at § 2.10.8.

229. *Id.* at §§ 2.17.1-2.17.2. The Instruction does not define "complicated".

230. AFI 44-102, at § 2.17.1.

231. AFI 41-115, § 1.10, *Health Services* (Dec. 28, 2001), at <http://www.e-publishing.af.mil/pubfiles/af/41/afi41-115/afi41-115.pdf>.

232. AFI 31-205, §§ 5.4.2-5.4.3, *The Air Force Corrections System* (Apr. 9, 2001), at <http://www.e-publishing.af.mil/pubfiles/af/31/afi31-205/afi31-205.pdf> (providing for abortion referrals for prisoners and prohibiting advocacy for or against abortion in the confinement

Civilians accompanying military members receive health care at military or civilian facilities through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS, now known as TRICARE). TRICARE issued its own guidelines for payment for abortion services. The regulation states:

The statute under which CHAMPUS [TRICARE] operates prohibits payment for abortions with one single exception -- where the life of the mother would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would be endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.

NOTE: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal follow up to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.²³³

This prohibition has been recently eroded in the case of anencephalic fetuses, as will be discussed below. In general, however, the restriction on payments for abortion has been upheld in the Supreme Court on several occasions.²³⁴ As explained earlier, in the series of cases from *Maher* to *Rust*, the Court consistently has drawn a distinction between the right to have an abortion and the government's ability to deny funding for such services.²³⁵

Air Force practice in reproductive health tends to vary with the subject matter. Abortion procedures continue to be tightly restricted and abortion counseling may or may not be provided, depending on the personal views of the military physician. Despite the lack of coverage under TRICARE and similar moral objections,

facility). Arguably, prisoners have better access to abortion than non-incarcerated AF members.

233. 32 C.F.R. § 199(e)(2) (2002).

234. See, e.g., *Rust v. Sullivan*, 500 U.S. 173, 201-03 (1991); *Harris v. McRae*, 448 U.S. 297, 315 (1980); *Maher v. Roe*, 432 U.S. 464, 470-71 (1977).

235. *Id.*

the military does provide in-vitro fertilization services at several facilities. The above-quoted TRICARE/CHAMPUS coverage regulation goes on to describe covered and uncovered family planning services.²³⁶ In-vitro fertilization and other non-coital reproductive technologies are not a covered procedure under CHAMPUS.²³⁷ However, IVF and similar such procedures are often performed at a much-reduced fee-for-service basis at the following bases: Balboa Naval Medical Center, San Diego, California; Walter Reed Army Medical Center, Washington, D.C.; Wilford Hall Medical Center, San Antonio, Texas; and Tripler Army Medical Center, Honolulu, Hawaii.²³⁸ This dichotomy of policy is puzzling, considering the similarity of moral issues involved.²³⁹

In a recent interview, Dr. (Lt. Col.) Christopher Zahn, the Air Force Consultant for Obstetrics, discussed obstetrical practice and physician attitudes regarding abortion services in the Air Force.²⁴⁰ Dr. Zahn agreed that women in the Air Force face significantly higher access barriers than their civilian counterparts, primarily because of the funding and practice restrictions imposed by Congress.²⁴¹ He noted that provider attitudes and training also play a role.²⁴² Air Force-trained obstetricians do not receive training in termination of pregnancy, as none of the programs have residency rotations in this field.²⁴³ Those that receive such training in civilian residencies often have their skills atrophy over time from lack of practice in the military.²⁴⁴ In Dr. Zahn's experience, most Air Force OB-GYNs will discuss abortion with a patient, but not all will.²⁴⁵ He hoped that those who would not refer the patient to another physician, but could not guarantee that this always

236. 32 C.F.R. § 199(e)(3) (2002).

237. *Id.* at § 199.4(e)(3)(1)(B)(3).

238. Maj. Una Cuffy, *A Child of Their Own*, AIR FORCE NEWS SERV., at <http://www.af.mil/news/airman/0502/infer.html> (last visited Apr. 4, 2003). While patients in the military IVF programs do have to pay for the services they receive, they do not have to pay for any of the personnel costs, as the medical staff are paid by the Air Force. This results in a very substantial subsidy for the patient.

239. Abortion and IVF address similar moral issues in that IVF frequently results in the disposal of fertilized ova. For those who believe that life begins at conception, this is the moral equivalent of abortion.

240. Zahn interview, *supra* note 227.

241. *Id.*

242. *Id.*

243. *Id.* Dr. Zahn may have been mistaken in this respect. Providers at Wilford Hall Medical Center indicated that residents there could train at a civilian facility as an elective rotation. Of course, many civilian residency programs do not include training on abortion, either.

244. *Id.*

245. *Id.*

happens.²⁴⁶ Dr. Zahn recounted difficulties in ensuring that providers who oppose birth control refer patients to other physicians for these services, and stated with some confidence that all providers now knew their obligation to refer for these services.²⁴⁷ He also agreed with the common perception that a military physician could not refer directly to any particular abortion provider in the civilian community.²⁴⁸

Dr. Zahn did not feel that increasing Air Force women's access to civilian obstetrical care would necessarily increase their access to abortion services.²⁴⁹ Currently, an Air Force woman may elect to have an OB-GYN as her primary care physician (although access may be limited at smaller facilities) and should not have to get a non-availability slip to receive gynecological care from a civilian provider.²⁵⁰ However, TRICARE reimbursement rates are often comparatively low, limiting the number of physicians willing to take new TRICARE patients. In December 2003, all military women will be able to elect to have their obstetrical care provided in a civilian facility for a nominal cost.²⁵¹ Dr. Zahn felt that this would not necessarily increase access to abortion services, as it would only increase access for women who sought postnatal OBGYN care in the community from OBGYNs who also performed abortions.²⁵² However, in theory, seeking women's health care services in the civilian sector could lead to receive referrals or fee-for-service abortion services, increasing access to abortion services.²⁵³

In sum, Air Force policy regarding termination of pregnancy has evolved, tracking changes in the law. Currently, Air Force facilities may not provide abortion services except to preserve the life of the mother in the United States and to preserve the life of the mother or in cases of rape or incest overseas.²⁵⁴ While the Instructions governing abortion services technically provide for referral services for abortions, they do not protect access to abortion in practice.

246. *Id.*

247. *Id.*

248. *Id.*

249. *Id.*

250. *Id.* A non-availability slip is a statement from the military that the requested medical service cannot be provided within the military system. This allows the patient to receive care from a civilian provider through TRICARE.

251. *Id.*

252. *Id.*

253. *Id.*

254. See 32 C.F.R. § 199(e)(2) (2002).

IV. NATIONAL AND INTERNATIONAL AVAILABILITY OF ABORTION SERVICES

In addition to the difficulties in obtaining referrals for and coverage of abortion services, women affiliated with the Air Force face practical barriers in obtaining abortion services including hostile local laws and the absence of abortion providers. In the United States, the latter predominate, as Air Force bases are often located at a significant distance from facilities performing abortions. In general, the closer a base is to a major metropolitan area, the more available abortion services will be. Overseas, the climate for abortion seekers ranges from more permissive than the United States in most (but not all) Western European countries, to absolute hostility in most Middle Eastern countries. For a variety of reasons, the countries outside the Middle East that host the largest contingents of United States servicemembers tend to have the most permissive abortion laws. Even in these areas, however, language and cultural barriers still present significant obstacles to obtaining abortion services.

A. *In the United States - Geographical Availability as an Access Restriction.*

In the United States, several factors drove the Air Force to build many bases at distances from the cities. Unlike the Army and Navy with their long histories, the Air Force became a separate service only in 1947.²⁵⁵ While Army Air Fields, the predecessors to most modern Air Force bases, had existed prior to that time, they did not spread across the country in large numbers until the Second World War.²⁵⁶ Even then, they served primarily as training facilities to generate trained personnel for overseas service.²⁵⁷ The present-day distribution of Air Force bases in the United States arose during the Cold War, and reflected the needs of that conflict.²⁵⁸ The primary operational considerations of the time were security and proximity to the Soviet Union. Given the limited

255. The Air Force was established by the National Security Act of 1947, 50 U.S.C. 402 (2003). A brief history of the development of the Air Force is available at <http://www.airforcehistory.hq.af.mil/PopTopics/Evolution.htm>. For a more rigorous history, see WALTER J. BOYNE, *BEYOND THE WILD BLUE* (1997).

256. *Id.*

257. *Id.*

258. For background history on the development of the Air Force, and especially Strategic Air Command, see <http://www.wpafb.af.mil/museum/history/postwwii/sac.htm> (last visited Apr. 4, 2003).

range of aircraft and missiles of the day, and the relatively low population density across the northern Midwest and West, a large number of smaller bases sprung up along the Canadian border and in Alaska.²⁵⁹ Training and test facilities remain largely in the South, however. While base closings have eliminated some of the more marginal facilities, many Air Force facilities are located in low population density states where abortion services are limited.²⁶⁰ This is not to suggest that all Air Force women lack access to abortion, nor any malfeasance on the part of the Air Force, but rather to point out that a significant proportion of such women face at least some practical barriers to access.

This distribution towards areas of low population density becomes apparent by comparing the Air Force population to the state population rank by civilian population density. Examining the top 20 states by USAF enlisted census and population density, it becomes apparent that significant portions of the Air Force live in low-density areas where access might become an issue.²⁶¹

259. *Id.*

260. Eighty-four percent of all United States counties have no identifiable abortion providers. NATIONAL ABORTION FEDERATION, ACCESS TO ABORTION FACT SHEET, at <http://www.prochoice.org/Facts/Factsheets/FS5.htm> (last visited Apr. 4, 2003). Outside of metropolitan areas, the figure is ninety-seven percent. *Id.* For further demographic information, see <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

261. Air Force active duty enlisted population from the Air Force Personnel Center Demographics Website, is available at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003). Population density information from 2000 Census, is available through the State of Utah website, <http://www.governor.state.ut.us/dea/rankings/states/statedensity.pdf> (last visited Apr. 4, 2003). Abortion provider information from the Nat'l Abortion Rights Action League, is available at <http://www.naral.org/mediaresources/publications.html> (last visited Apr. 4, 2003).

STATE	USAF Population	U.S. Population Density Ranking	Percent of Counties Lacking an Abortion Provider	Increase/ Decrease in Number of Abortion Providers 1992-1996	Number of Providers 1996
Texas	46,066	29	93%	-19%	64
Florida	25,100	9	73%	-14%	114
California	19,955	13	36%	-11%	492
Arizona	11,572	37	80%	-14%	24
Virginia	14,116	15	79%	-11%	57
New Mexico	10,727	46	88%	-35%	13
Georgia	10,092	19	90%	-25%	41
Colorado	9,968	38	79%	-20%	47
North Carolina	9,648	18	74%	-31%	59
South Carolina	9,271	22	80%	-22%	14
Alaska	9,190	51	76%	-38%	8
Oklahoma	8,870	36	95%	N/A	11
Mississippi	7,942	33	96%	25%	6
Maryland	7,910	6	54%	-8%	47
North Dakota	7,433	48	98%	0%	1
Nevada	7,311	44	82%	-18%	14
Washington	7,270	26	69%	-12%	57
Nebraska	7,172	43	97%	-11%	8
Louisiana	5,925	23	92%	-12%	15
Illinois	5,707	12	90%	-19%	38

Florida and Maryland present obvious exceptions to the density issue, but the data show a disproportionate number of troops in low population density states. Population density itself only suggests an access problem, but the low and declining number of abortion providers in these states provides further proof of potential difficulties in accessing abortion services.

B. Overseas—Local Legal Restrictions

Overseas, access becomes both a legal and a practical problem. The Air Force's adherence to local anti-abortion laws, distance from abortion facilities, and the unique nature of military leave present significant access issues. While considerations of international law do not mandate adherence to local law in all situations, the Air Force has decided to forgo any treaty considerations and instead conforms to local law.²⁶² In 1999, the United Nations Population Division compiled a comprehensive database of abortion policies around the world.²⁶³ Using this information, a survey of the major regions and countries in which Air Force members serve, demonstrates a wide variety of local law and abortion availability.

The Air Force Personnel Center publishes monthly data of permanent party members²⁶⁴ stationed overseas, but does not track personnel on temporary duty, activated Reservists, and military dependents.²⁶⁵ As of February 2003, the total active duty strength of the Air Force was 363,137, 19.05 percent of which were women.²⁶⁶ Approximately, 21.01 percent of the force is stationed overseas,²⁶⁷ including in Alaska and Hawaii.²⁶⁸ Data from February 2003 shows 1,939 female officers stationed overseas²⁶⁹ and 12,733 enlisted women stationed overseas.²⁷⁰ However, this includes only active duty forces, not military family members.²⁷¹

262. AFI 44-102, § 2.10.8, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>.

263. United Nations, *Population Division, Abortion Policies: A Global Review*, at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (last visited Apr. 4, 2003).

264. Permanent party members are those assigned to a location for 180 or more days. Department of Defense Dictionary of Military and Associated Terms, at <http://www.tricare.asd.mil/administration/dodmilitary.pdf> (last visited Apr. 4, 2003).

265. Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/vbin/broker8.exe> (last visited Apr. 4, 2003).

266. *Id.* Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

267. The Air Force considers all assignments outside of the continental United States to be "overseas". Department of Defense Dictionary of Military and Associated Terms, at <http://www.tricare.asd.mil/administration/dodmilitary.pdf> (last visited Apr. 4, 2003).

268. Air Force Personnel Center Website, *supra* notes 265-66.

269. *Id.* at <http://www.afpc.randolph.af.mil/demographics/demograf/TOUR.html> (last visited Apr. 4, 2003).

270. *Id.* at <http://www.afpc.randolph.af.mil/demographics/demograf.ENLTOUR.html> (last visited Apr. 4, 2003).

271. *Id.* at <http://www.afpc.randolph.af.mil/demographics/HistMenu.htm> (last visited Apr. 4, 2003).

**Air Force Permanent Party Overseas Population:
Countries With at Least Ten USAF Members²⁷²**

COUNTRY	CENSUS
GERMANY	13,956
JAPAN	13,094
SOUTH KOREA	8,625
UNITED KINGDOM - UK	8,507
UNKNOWN/DATA MASKED	7,481
ITALY	3,989
TURKEY	1,444
PORTUGAL	916
ICELAND	562
BELGIUM	431
SPAIN	250
NETHERLANDS	221
SAUDI ARABIA	200
HONDURAS	176
GREENLAND	96
SINGAPORE	79
CANADA	73
GREECE	67
AUSTRALIA	66
EGYPT	53
NORWAY	50
KUWAIT	30
DIEGO GARCIA-BRITISH INDIAN OCEAN TERRITORY	25
THAILAND	25
BAHRAIN	20
FRANCE	20
OMAN	17
QATAR	14
ISRAEL	12
RUSSIA	11
DENMARK	10

272. Data from the Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

In addition to active duty members, significant numbers of military family members reside overseas. Data released by the Air Force Personnel Center for September 2000 shows significant (more than 25) family member populations in Australia (109), Belgium (668), Canada (121), Egypt (33), France (37), Germany (17,486), Iceland (686), Israel (26), Italy (3,995), Japan (17,722), South Korea (1,101), the Netherlands (355), Norway (71), Portugal (778), Singapore (58), Spain (317), Thailand (48), Turkey (1,324), and the United Kingdom (12,126).²⁷³ This includes a number of male family members, as Air Force Personnel Center tracks all dependents. The Air Force does not release troop strengths by location for temporary duty airmen, as such information would provide an operational benefit to the enemy.²⁷⁴ However, the Air Force has more or less permanent presence, temporary duty locations in Saudi Arabia (2), Kuwait, Turkey, and Oman, which do not generally accommodate dependents.²⁷⁵ In addition, more than 35,000 Air National Guardsmen and Air Reservists currently serve on active duty in a variety of locations throughout the world.²⁷⁶ The local laws regarding abortion vary greatly among these locations.

Western Europe's abortion policies most closely parallel those in the United States. In the United Kingdom (except for Northern Ireland and a few other areas), two physicians must agree that the pregnancy has not passed twenty-four weeks gestation, that the termination is necessary to prevent injury to the physical or mental health of the mother, that the continuation of the pregnancy would risk the life of the mother, or that there is a substantial risk that the child would be seriously handicapped.²⁷⁷ In practice, abortion is available on demand, as these provisions are interpreted liberally. While abortion is more difficult in Northern Ireland and several small island jurisdictions, it is available in some restricted circumstances, usually involving risks to the life of the mother. Britain approved the use of mifepristone, a medical abortifacient,²⁷⁸ in 1991, becoming the second country in the world to do so.²⁷⁹

273. Air Force Personnel Center Website, at http://www.afpc.randolph.af.mil/demographics/demograf/DPSART_FY00_DEPEND_3.html (last visited Apr. 4, 2003).

274. Temporary duty airmen are those assigned to a location for 179 days or fewer.

275. Air Force Personnel Center Website, at http://www.afpc.randolph.af.mil/demographics/demograf/DPSART_FY00_DEPEND_3.html (last visited Apr. 4, 2003).

276. Information as of March 2003, at <http://www.defenselink.mil> (last visited Apr. 4, 2003). Air National Guard and Air Reserve troops are usually part-time airmen called to active duty in support of intensified operations.

277. United Nations, *supra* note 263.

278. An abortifacient is "a drug or other agent that induces abortion." WEBSTER'S THIRD INTERNATIONAL DICTIONARY 5 (Philip Babcock Gove, Ph.D., ed. 1986).

279. *Id.*

Mifepristone, or RU-486, was originally developed in France as a medical alternative to surgical abortion during early pregnancy.²⁸⁰ It is now available in the United States, although not in the military.²⁸¹ From a practical standpoint, abortion is widely available and covered by the British National Health Service.

In Germany, abortion is generally available without significant restriction in the first twelve weeks of pregnancy after informational, but not persuasive, counseling and a three-day waiting period.²⁸² Abortion is actually outlawed in Germany, but the woman or physician will not be punished if the guidelines are followed.²⁸³ However, because of the time restriction and administrative difficulties, many women choose to go to the Netherlands, where abortion is virtually unrestricted.²⁸⁴ German law permits abortions after twelve weeks when the life of the mother is at risk.²⁸⁵ Because of the technical illegality of the procedure, insurance does not cover abortion.²⁸⁶

Italian law permits abortions during the first twelve weeks after a one-week reflection period, which can be waived in urgent situations.²⁸⁷ After twelve weeks, fetal genetic deficiency or a risk to the physical or mental health of the mother will justify an abortion, but it is no longer available on request.²⁸⁸ Abortions must be performed for free at a public hospital or designated private institutions. As a practical matter, abortion services are difficult to obtain because of the unavailability of facilities and physicians who are willing to perform them, in part because the Catholic Church threatens excommunication for having or performing an abortion.²⁸⁹

While these three countries host the majority of Air Force troops in Europe, there are small populations in other European countries.²⁹⁰ The local laws range from very permissive (Albania, Belgium, France, Greece, Hungary, Norway, the Netherlands, Russia) to restrictive (Iceland, Spain) to absolutely prohibitive (the

280. 1 Am Jur. 2d *Abortion and Birth Control* § 2 (2002).

281. *Doctors Use Pills in 6 Percent of Abortions*, N.Y. TIMES, Jan. 16, 2003, at A20; Tricare Handbook, *What's Not Covered*, available at <http://www.tricare.asd.mil/tricarehandbook/results.cfm?fn=1&cn=11> (last visited Apr. 4, 2003).

282. United Nations, *supra* note 263.

283. *Id.*

284. *Id.*

285. *Id.*

286. *Id.*

287. *Id.*

288. *Id.*

289. *Id.*

290. Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

Republic of Ireland, Malta).²⁹¹ Because of Europe's relatively compact size, lack of border controls within much of the European Union, and high proportion of permissive jurisdictions, women with sufficient leave time and money generally can obtain abortions within the first twelve weeks without difficulty.²⁹² Second trimester abortions present more difficult access issues, but are also available in select jurisdictions.²⁹³

Far Eastern policies tend to reflect several influences depending on the country: the preference for male children; an adopted legal philosophy respecting personal autonomy; or the influence of the Catholic Church.²⁹⁴ Australian law parallels British law rather closely, permitting abortion on demand within the first twelve weeks, although some territories require two physicians to consult and the abortion to be performed in a hospital.²⁹⁵

The Philippines forbids abortion except to preserve the life of the mother.²⁹⁶ Despite the prohibition and lengthy prison terms associated with it, abortion is apparently widely available. The Government, however, has become concerned with the connection between abortion, poverty and the lack of birth control.²⁹⁷ The Catholic Church, a major player in national politics, has consistently reinforced the legal prohibition, but the Government has not yet been moved to action.²⁹⁸

In Japan, abortion is not available on demand, but is available in the first twenty-two weeks when the physical health or economic standing of the mother may be seriously affected or the pregnancy is the result of a crime.²⁹⁹ The economic damage provision, almost unique in the world, allows a woman to obtain an abortion when having another child would negatively impact her economic status.³⁰⁰ In effect, this provision has allowed abortion whenever a woman can convince a physician to perform the procedure. Japan has a very high historical rate of abortion, thought to be the result of forbidding the prescription of the birth control pill (except for

291. United Nations, *supra* note 263.

292. *Id.* (reviewing individual country information).

293. *Id.*

294. *Id.* (analyzing United Nations data).

295. *Id.*

296. *Id.*

297. *Id.*

298. *Id.*

299. *Id.*

300. *Id.*

non-contraceptive purposes) until 1999.³⁰¹ Despite legal restrictions, access to abortion remains relatively easy in Japan.³⁰²

Korea has perhaps the most permissive laws regarding abortion, which developed in response to concerns about population growth and the cultural preference for male children.³⁰³ Abortions are available on demand in Korea during the first twenty-eight weeks of pregnancy. Women have easy access to abortion, as physicians perform most abortions in their own clinics.

China, Vietnam, and Cambodia have similarly liberal provisions, reflecting a strong governmental interest in population control.³⁰⁴ India requires only the justification of contraception failure as a basis for legal abortion.³⁰⁵

Singapore places few restrictions on abortion within the first twenty-four weeks of gestation, but abortions are limited to women who are citizens of Singapore, wives of citizens of Singapore, or women who have resided there for more than four months.³⁰⁶ Despite the booming sex tourism industry, Thailand has a surprisingly restrictive policy on abortions.³⁰⁷ The law prohibits abortions except to protect the life, physical health or mental health of the mother or when the pregnancy is the result of rape or incest.³⁰⁸ Despite criminal penalties, abortion is relatively common and the law is rarely enforced.³⁰⁹

Islamic prohibitions on abortion severely limit the availability of abortion in most Middle Eastern Countries. Turkey, a secular state, has among the most permissive laws, allowing abortion upon demand within the first ten weeks of pregnancy.³¹⁰ However, married women must obtain the consent of their husbands, unless their life is immediately at risk. After ten weeks, an abortion may be performed only to save the life or health of the woman or in cases of fetal impairment.³¹¹ Despite permissive abortion within the first ten weeks, a requirement that only obstetrician/gynecologists (or family practitioners under their supervision) perform abortions

301. *Id.*

302. *Id.*

303. *Id.*

304. *Id.*

305. *Id.*

306. *Id.*

307. *Id.*

308. *Id.*

309. *Id.*

310. *Id.*

311. *Id.*

severely limits their availability, due to a shortage of specialists in many areas of the country.³¹²

Bahrain has few time or consent restrictions on abortion, but requires the approval of a panel of physicians.³¹³ Qatar permits abortion to save the life, physical, or mental health of the woman and in cases of fetal impairment, but not for cases of rape or incest.³¹⁴ A panel of physicians must also approve the procedure.³¹⁵ In cases of fetal impairment, both spouses must agree to the abortion.³¹⁶ Saudi Arabia, host to the largest contingency of Air Force personnel in the Gulf region,³¹⁷ allows abortion only to protect the life or physical or mental health of the mother under uncoded principles of Islamic law.³¹⁸ The Government has promulgated a resolution permitting an exception within the first forty days of pregnancy. Under this resolution, a panel of three medical experts may approve an abortion if necessary to accomplish a legal benefit or to prevent an expected harm (presumably to avoid divorce or illegitimacy), but may not approve an abortion in cases of hardship in child rearing, simple cases of the parents feeling they have enough children, or for economic reasons.³¹⁹ Abortion requires the consent of the woman and her husband or guardian.³²⁰

Kuwait allows abortion only when necessary to preserve the life or health of the mother and in cases of fetal impairment.³²¹ Three Islamic physicians must approve the abortion, which may only be performed with the consent of the mother and her husband or another person standing in loco parentis.³²² Oman, a country with an increasing United States presence, permits abortion only to save the life of the mother.³²³ Despite being an extremely Westernized Middle Eastern nation, Israel permits abortion only to preserve the life or health of the mother, in cases of rape or incest, and in cases of fetal impairment.³²⁴ A woman seeking an abortion must have the approval of a committee of two physicians and a social worker, and

312. *Id.*

313. *Id.*

314. *Id.*

315. *Id.*

316. *Id.*

317. Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

318. United Nations, *supra* note 263.

319. *Id.*

320. *Id.*

321. *Id.*

322. *Id.*

323. *Id.*

324. *Id.*

must have the abortion at one of twenty-eight certified public or private hospitals. In sum, most Middle Eastern countries heavily restrict access to abortion because of the general prohibition on abortion under Islamic law.

Other areas of the world house smaller populations of airmen.³²⁵ Most South and Central American countries allow abortion only to protect the life or health of the mother and in cases of fetal impairment, rape, or incest.³²⁶ Policies range from absolute prohibitions in Chile and El Salvador to abortion on demand in Cuba and Guyana.³²⁷ African national policies on abortion generally reflect the cultural legal tradition. Egypt and Libya, as Islamic countries, prohibit abortion except to preserve the life of the woman.³²⁸ Sudan, Morocco, and Algeria permit abortion upon presentation of a health justification.³²⁹ South Africa, with its European legal tradition and rape problem, allows for abortion on demand.³³⁰ Most other African countries do not allow for abortion on demand, but permit it when there is a risk to the health of the mother or fetal impairment.³³¹ Generally, the stronger the Islamic tradition correlates with a more restrictive policy on abortion.

In sum, abortion policy and availability vary widely around the world. Common determinative factors are population pressure, a Western legal tradition, an Islamic religious and legal tradition, the strong influence of the Catholic Church, and the availability of modern medical facilities. Yet, while the majority of airmen outside the Middle East live in countries permitting abortion, significant obstacles to access remain even for these troops.

C. *Practical Restrictions—Abuse, Expense, Distance, and Regulation*

In addition to legal restrictions, Air Force women face several practical restrictions on exercising their right to an abortion, including the threat of domestic violence, expense, distance, availability of leave, and the Air Force's twenty-four week rule in

325. Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics> (last visited Apr. 4, 2003).

326. United Nations, *supra* note 263.

327. *Id.*

328. *Id.*

329. *Id.*

330. *Id.*

331. *Id.*

curtailing assignments.³³² The military services have a documented higher rate of domestic abuse than the general population.³³³ In general, pregnant women are more likely to suffer from domestic abuse, and women with unintended pregnancies have two and a half times the risk of suffering domestic violence than those with intended pregnancies.³³⁴ Military physicians, despite being the group preferred for victims to report domestic violence to, tend to recognize, document, and treat domestic violence the least effectively of any group of health providers.³³⁵ Military physicians are less likely to address women's concerns about domestic violence than any other health provider in the military medical system.³³⁶

Considering the institutional neglect for abortion referral procedures, a military woman faces a substantially worse outlook than a similarly situated woman in a civilian medical facility. A civilian woman is much more likely to receive counseling regarding domestic violence during pregnancy and to be provided the option of an abortion by her physician. As TRICARE does not cover abortion services except in the case of threat to the life of the mother, a military woman seeking an abortion must pay for it on the local economy. While an early term abortion in the United States usually runs \$200-\$400, the cost of an abortion and related care can reach several thousand dollars overseas or later in the pregnancy.³³⁷ A few states provide abortion funding for Medicaid-eligible women, but most military members and spouses do not qualify for reasons of income and alternative health insurance coverage through TRICARE.³³⁸ Distance can present substantial limitations as well. As explained above, at many United States bases, a woman would have to travel quite a distance to access abortion services. Overseas, where abortion may not be available

332. AFI 44-102, § 2.17.1, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>.

333. S.J. Brannen et al., *Spouse Abuse: Physician Guidelines to Identification, Diagnosis, and Management in the Uniformed Services*, 164 MIL. MED. 30 (1999).

334. Julie A. Gazmararian et al., *Violence and Reproductive Health: Current Knowledge and Future Research Directions*, 4 MATERNAL AND CHILD HEALTH J. 2 (2000); J. Mezey et al., *Domestic Violence and Pregnancy*, 314 BRITISH MED. J. 1295 (1997).

335. Gazmararian, *supra* note 334.

336. *Id.* This is not to say that military physicians are happy with this, or with their colleagues in general. In a 1993 RAND study, A third of military physicians rated themselves less than even somewhat satisfied with the quality of their peers. Only 19% were satisfied with salary and 27% with practice efficiency. R. Kravitz et al. *Satisfaction and Dissatisfaction in Institutional Practice: Results from a Survey of U.S. Military Physicians*. 158 MIL. MED. 41 (1993).

337. *Id.*

338. National Abortion Federation, at <http://www.prochoice.org> (last visited Apr. 4, 2003) (compiling a current list of states providing such funding).

at all, the woman may have to pay for a trip back to the United States to obtain the service.

While the Air Force provides its members with thirty days of leave a year, it does not require commanders to grant any particular leave request.³³⁹ The regulation encourages commanders to grant leave liberally, but gives them virtually unchecked power to deny or cancel leave for reasons of military necessity or for the general reason of in the interest of the Air Force.³⁴⁰ Non-emergency civilian medical care does not toll leave provisions, so a member must have accumulated enough leave time to spend when obtaining an abortion.³⁴¹ A commander may grant an emergency "advance of" leave for emergencies or urgent personal situations as determined at his or her discretion.³⁴² The emergency leave program generally provides travel expenses for overseas members to the extent necessary to return the member to the nearest point in the continental United States.³⁴³

Upon advice from a military health care provider, the commander may also grant convalescent leave as medically necessary for the member's or fetus' health and safety, a provision that does not appear to contemplate voluntary abortion.³⁴⁴ The military commander also need not release a member from a remote location until the pregnancy has progressed to twenty-four weeks of gestation.³⁴⁵ The regulations essentially give a commander the ability to block a member's access to abortion by denying leave. As a practical matter, such an action could only be effective overseas or at a remote location. However, even in the continental United States, commanders can exercise a considerable amount of power in making access to abortion difficult for a military member.

Even a military spouse or dependent can face significant obstacles. While military leave does not pose a problem for them and they do not generally accompany members in remote locations, local prohibitions, travel expenses, and language barriers can still prevent a woman from accessing abortion services, especially when confronted with opposition from a spouse or parent. A military spouse may attempt to avail herself of the Early Return of

339. AFI 36-3003, § 4.1.2, *Military Leave Program*, (Apr. 14, 2000), at <http://www.e-publishing.af.mil/pubfiles/af/36/afi36-3003/afi36-3003.pdf>.

340. *Id.*

341. *Id.*

342. *Id.* at § 6.5.

343. *Id.*

344. *Id.* at § 6.4.

345. AFI 44-102, § 2.17.1, *Community Health Management* (Nov. 17, 1999), at <http://www.e-publishing.af.mil/pubfiles/af/44/afi44-102/afi44-102.pdf>.

Dependents (ERD) program, a program that pays for a military family member's return to the United States under limited circumstances.³⁴⁶ These include situations where the military family member is embarrassing to the United States Government, prejudicial to order, morale, and discipline in the command, cannot be protected because of adverse public feeling in the area or because of force protection and anti-terrorism considerations, or has divorced the military member or had a change of custody for minors.³⁴⁷ Unfortunately, this process generally takes several weeks and necessarily involves the member's chain of command.³⁴⁸ Minor children of military members generally lack access to this program, as they cannot invoke the provision regarding divorce, leaving them in the difficult position of returning to the United States through their own resources.³⁴⁹ If the family member cannot return to the United States, she must seek an abortion from a practitioner in the local economy, which may prohibit abortion altogether, present insurmountable language barriers, or present significant transportation difficulties.

The General Accounting Office (GAO) also found deficiencies in military women's health care. In May 2002, the GAO published a report finding rough equality between the Department of Defense health plan and civilian plans in terms of women's health; however, the report questioned commanders' understanding of women's health needs and reported military women's concerns about access issues.³⁵⁰ While women had the same overall satisfaction with TRICARE as men (7.8/10), some women in overseas locations were concerned about their access to health services.³⁵¹ In particular, women were concerned about the availability and quality of the services and the English fluency of the medical personnel treating them.³⁵² These factors led to some delays in treatment until the beneficiary could return to a United States treatment facility.³⁵³ At

346. The Early Return of Dependents program is authorized by the Joint Fed. Travel Regulations 1 J.F.T.R. USJ-1, 1 (2002), available at <http://www.dtic.mil/perdiem/jftr/jftr-c5.txt> (last visited Apr. 4, 2003).

347. *Id.*

348. *Id.*

349. *Id.*

350. U.S. Gen. Acct. Off., *Defense Health Care: Health Care Benefit for Women Comparable to Other Plans*, GAO 02-602 (May 2002), at <http://www.gao.gov/new.items/d02602.pdf> (last visited Apr. 4, 2003) [hereinafter *Comparable Health Care*].

351. *Id.* at 12.

352. *Id.* at 14-15.

353. *Id.* See also, U.S. Gen. Acct. Off., *Defense Health Care: Resources, Patient Access, and Challenges in Europe and the Pacific*, GAO/HEHS-00-172 (Aug. 2000), at <http://www.defensehealth.net/reports/GAOHEHS00172.pdf> (last visited Apr. 4, 2003).

times, the remote nature of the assignment meant that the beneficiary had to engage in lengthy consultations with the State Department to find a qualified medical provider.³⁵⁴ The GAO reported problems in the United States as well, with beneficiaries in rural areas having difficulty accessing medical care, especially specialty care.³⁵⁵ While the report did not explicitly address access to abortion services,³⁵⁶ the GAO noted that “in some parts of South Dakota, a 2-hour drive is considered routine, and in Alaska, all patients are transported to the lower 48 states for certain types of care.”³⁵⁷

Women in deployed environments had even greater difficulties.³⁵⁸ Deployed women reported several problems, including limited health care services and supplies, little privacy, and concerns about whether their confidentiality would be maintained.³⁵⁹ Supplies to ensure reproductive health, including feminine hygiene products and birth control pills, were often available only in forms different from what the patient is used to.³⁶⁰ For instance, women who routinely used tampons had to change to sanitary napkins, and women using birth control pills containing a particular mix of hormones often had to change to another pill with a different hormone, or a different form of contraception entirely.³⁶¹ This could lead to increased fertility levels, a serious concern for military commanders. Women seeking obstetrical care in military treatment facilities expressed a higher level of dissatisfaction than their civilian counterparts.³⁶² Of the women surveyed, twenty-six percent expressed dissatisfaction with their obstetrical care at military treatment facilities, compared twenty-two percent for civilian facilities.³⁶³ Women specifically complained of unhappiness

354. *Id.*

355. U.S. General Accounting Office, *Military Health Care: TRICARE's Civilian Provider Networks*, GAO/HEHS-00-64R (Mar. 2000), at <http://www.gao.gov/new.items/d01620.pdf> (last visited Apr. 4, 2003) [hereinafter *Military Health Care*].

356. Abortion services are outside of TRICARE's funding purview.

357. *Military Health Care*, *supra* note 355, at 12. For instance, because TRICARE's reimbursement rates are so low, no qualified OBGYN could be found to perform amniocentesis for pregnant women in Alaska.

358. U.S. Gen. Acct. Off., *Gender Issues: Medical Support for Female Soldiers Deployed to Bosnia*, GAO/NSIAD-99-58 (Mar. 1999), at <http://www.gao.gov/archive/1999/ns99058.pdf> (last visited Apr. 4, 2003).

359. *Id.* at 8-10.

360. *Id.* at 10-11.

361. *Id.*

362. In 2000, DOD conducted a survey to determine beneficiary satisfaction with inpatient care during childbirth at 20 MTF's. GAO reports the results in GAO 02-602. *Comparable Health Care*, *supra* note 350.

363. *Id.*

with coordination of care, physical comfort, respect for their preferences, emotional support, involvement of family and friends, information and education.³⁶⁴ While the data demonstrated only a small difference in satisfaction, the results prompted Congress to pass a law allowing women to elect to have their obstetrical care at a civilian facility starting in 2003.³⁶⁵

In response to the GAO studies, the Department of Defense (DOD) self-reported concerns that military commanders did not adequately understand women's health issues.³⁶⁶ Specifically, the DOD felt some commanders lacked knowledge about what health care services were available, when this care should be accessed, and the need for such care.³⁶⁷ The DOD found that the Air Force and Army lacked programs for educating commanders on these issues, and the Navy's education efforts were not comprehensive.³⁶⁸ The DOD commented that this ignorance contributed to women's unwillingness to access women's health services, as they felt that their commanders would perceive them as seeking special treatment.³⁶⁹

While the GAO reports did not address abortion issues, the concerns expressed by military women regarding women's health issues clearly apply to access to abortion as well. The access to medical specialists issue for rural beneficiaries translates into difficulty in finding an abortion provider within a reasonable distance. Overseas, the problems finding any qualified provider are magnified because of the specialized training required to perform abortions. Finally, the DOD's own admission that military commanders do not understand women's health issues serves to underscore the access to abortion problem. If women feel they cannot speak with their supervisors regarding everyday reproductive health issues, they will have even greater reservations bringing up the issue of abortion. Ironically, the DOD's own concerns about the military readiness of female troops, primarily regarding pregnancy rates in deployed locations, are compounded by their failure to provide adequate contraception and abortion services in deployed locations.

364. *Id.*

365. National Defense Authorization Act for Fiscal Year 2002, Pub. L. No. 107-107, § 735, 115 Stat. 1012 (2002). See also Zahn Telephone Interview, *supra* note 227.

366. *Comparable Health Care*, *supra* note 350, at 14.

367. *Id.* at 16-17.

368. *Id.*

369. *Id.* at 18.

D. Conclusion

Women in and accompanying members of the Air Force face more barriers to abortion services than their civilian counterparts. In the United States, the remoteness of many Air Force facilities and the failure of many facilities to meet their regulatory obligations impedes access. Even when compared to their civilian peers in fairly remote United States locations, military women face the additional difficulties of obtaining leave and locating a provider without a referral. Overseas, statutory prohibitions on performing abortions in military facilities, and hostile or ambivalent local conditions present even greater problems. While the Air Force maintains an officially neutral policy towards abortion, individual commanders can exercise their power to actively prevent access in individual cases.

V. RECENT CHALLENGES TO CHAMPUS/TRICARE REGULATIONS

Two recent Federal District Court cases successfully challenged the CHAMPUS/TRICARE restrictions in abortion funding in the instance of anencephalic fetuses. These two challenges, one in Massachusetts and one in Washington State, addressed the rational basis of the regulations as applied in the case of a fetus that has no meaningful chance at life. While these cases were the first to directly challenge Congress' resolution of the issue in Section 1093, earlier attacks on funding and counseling issues have failed. Thus, the cases probably do not, standing alone, represent a move to reverse these earlier precedents in their entirety, but are still important as successful as-applied challenges.

A. *Anencephaly Background Information*

Anencephaly is a condition in which a fetus or child fails to develop most basic brain structures.³⁷⁰ These brain structures are necessary for the child to have more than a very short life.³⁷¹ Only thirty-two percent of anencephalic fetuses reach full term and are

370. Anencephaly itself means "no brain". WEBSTER'S THIRD INTERNATIONAL DICTIONARY 5 (Philip Babcock Gove, Ph.D., ed. 1986)

371. Center for Disease Control defines anencephaly as "a fatal birth defect that happens when the neural tube does not fully close at the top. As a result, part of the skull and brain do not form properly." Centers for Disease Control and Prevention, *Folic Acid Excite Program*, at http://www.cdc.gov/ncbddd/folicacid/excite/Files_in_use/anenc.htm (last visited Apr. 4, 2003).

born alive.³⁷² Fewer than two percent survive longer than seven days, even with intensive medical support.³⁷³ They never attain consciousness, as they lack the necessary brain structures to become self-aware.³⁷⁴

Anencephalic fetuses have a unique status, both under the law and from a bioethical standpoint. While state laws vary, parents may generally opt to terminate life support without fear of accusations of medical neglect, as the child lacks the brain structures necessary to achieve consciousness and cannot maintain circulation and respiration without substantial medical assistance.³⁷⁵ In 1984, Congress enacted the Child Abuse Prevention and Treatment Act, which required that the states set certain standards for the removal of life support from disabled children.³⁷⁶ The implementing regulations for the Act require states to prohibit the removal of life support from disabled children, with three exceptions: (1) when the infant is chronically and irreversibly comatose, (2) when the provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise futile in terms of the survival of the infant, or (3) when the provision of such treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under such circumstances would be inhumane.³⁷⁷ Because anencephalic children lack any chance of consciousness, they meet these criteria and may be removed from life support.³⁷⁸

However, parents may also insist on full resuscitation and medical support, which generally must be provided upon request by any Medicare/Medicaid certified facility under the Emergency Medical Treatment and Active Labor Act.³⁷⁹ With full life support, anencephalic children can live up to two months.³⁸⁰ They are physiologically capable of being organ donors.³⁸¹ The use of anencephalic neonates as organ donors to save other children was so controversial that the American Medical Association changed its

372. *Britell v. United States*, 204 F. Supp. 2d 182, 185 (D. Mass. 2002).

373. *Id.*

374. *Id.*

375. *Id.*

376. 42 U.S.C. §§ 5101-5107 (2003); 45 C.F.R. § 1340.15 (2003).

377. 45 C.F.R. § 1340.15 (2003).

378. For a discussion of how the regulations can be applied, see *HCA, Inc. v. Miller*, 36 S.W.3d 187 (Tx. Ct. App. 2000).

379. 42 U.S.C. § 1395dd; *In re Baby K*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994).

380. *Britell*, 204 F.Supp. 2d at 185.

381. *Id.*

position twice before coming to the conclusion that their use was ethically permissible.³⁸² Even their status as living or dead varies depending on the philosophical definition of life. Definitions that require higher brain activity tend to find that anencephalic children do not meet the requirements for life, while definitions that require only brainstem activity usually define them as alive when provided artificial respiratory and circulatory support.

Women who carry anencephalic fetuses face a heightened risk to their own health, including increased risks of placental abruption and subsequent complications.³⁸³ Most anencephalic fetuses must be artificially stimulated in order to deliver, as the fetus lacks the adrenal glands necessary to stimulate birth.³⁸⁴ This causes additional risks to the mother, including a possible allergic reaction to the induction drugs, and an increased risk of injury during the birth.³⁸⁵

B. Britell v. United States—A Successful “As Applied” Challenge to Section 1093

Against the inauspicious backdrop of *Maher, McRae, and Rust*, two recent cases successfully challenged the CHAMPUS/TRICARE funding regulation as applied to anencephalic children.³⁸⁶ The plaintiffs in both cases argued that the regulation lacked a rational basis when applied to the case of anencephalic fetuses. Both challenges were successful, and CHAMPUS/TRICARE was forced to fund the abortions.

In 1994, Maureen M. Britell was a 28-year-old housewife residing in Sandwich, Massachusetts.³⁸⁷ She was a devout Catholic.³⁸⁸ As a teenager, she even joined her parents in picketing an abortion clinic.³⁸⁹ Mrs. Britell had married an Active Guard and Reserve (AGR) F-15 pilot in the Massachusetts Air National Guard

382. Am. Med. Ass'n, *Code of Medical Ethics*, § E-2.162, at http://www.ama-assn.org/apps/pf_online/pf_online?f_n=browse&doc=policyfiles/CEJA/E-2.162.HTM (last visited Apr. 4, 2003).

383. *Britell*, 204 F. Supp. 2d at 185.

384. *Id.*

385. *Id.*

386. *Britell v. United States*, 204 F. Supp. 2d 182, 185 (D. Mass. 2002); *Doe v. United States*, C02-1657z (U.S.D.C. 2002) (Order granting Plaintiff's Motion for a Temporary Restraining Order).

387. Thanassis Cambanis, *Amid Sorrow, A Shift on Abortion Mother Back Procedure, Wins Battle Over Insurance*, BOSTON GLOBE, June 11, 2002, at B1. Mrs. Britell now campaigns full time for Voters for Choice, a pro-choice organization. *Id.*

388. *Id.*

389. *Id.*

and was thus eligible for CHAMPUS coverage as the spouse of an active duty military member.³⁹⁰

In 1994, six months into her second pregnancy, Mrs. Britell and her husband went to her doctor for a sonogram.³⁹¹ The sonogram revealed that her fetus was anencephalic.³⁹² She was also informed that she would have to end the pregnancy artificially, through abortion or induced labor at full term, as the child would not spontaneously deliver.³⁹³ Mrs. Britell discussed the matter with her husband and her priest, who advised her to terminate her pregnancy.³⁹⁴ The procedure, an induced labor abortion at New England Medical Center, required Mrs. Britell to endure thirteen hours of labor before the fetus was expelled.³⁹⁵

The procedure cost almost \$5,000. New England Medical Center submitted a claim to CHAMPUS/TRICARE for reimbursement, which was denied.³⁹⁶ The hospital sued Mrs. Britell and her husband for the cost of the procedure, and the parties eventually settled for \$4,000.³⁹⁷ In 1997, Mrs. Britell appeared before the Massachusetts Legislature to advocate against a ban on late term abortions. Later that year, on Mother's Day, as she left church, antiabortion protestors confronted her.³⁹⁸ In response to these personal attacks, she decided to advocate more strenuously, and brought suit in the Federal District Court for the District of Massachusetts, represented by a private attorney hired by The Center for Reproductive Law and Policy.³⁹⁹ She alleged that, as applied in the case of an anencephalic child with no chance at life, the regulatory prohibition on coverage for abortion contained in the CHAMPUS/TRICARE regulation violated the Due Process Clause of the Fifth Amendment.⁴⁰⁰

United States District Judge Nancy Gertner heard the case. She issued an initial decision (largely repeated in her second opinion) with four conclusions.⁴⁰¹ First, she held that *McRae* did

390. *Id.*

391. *Britell*, F. Supp. 2d at 182.

392. *Id.*

393. *Id.* at 185.

394. *Id.* at 186.

395. *Id.*

396. *Id.*

397. Sue Reinert, *Abortion Ruling Seen as a Symbolic Victory*, PATRIOT LEDGER, June 1, 2002, at 16.

398. *Cambanis*, *supra* note 387.

399. *Id.*

400. *Britell v. United States*, 150 F. Supp. 2d 211, 226 (D.C. Mass. 2002).

401. *Id.*

not prohibit an as-applied challenge to the regulation.⁴⁰² Second, she found that CHAMPUS/TRICARE's policy of funding abortion for ectopic pregnancy, as well as treatment of spontaneous, missed, or threatened abortions, was rationally related to the legitimate public interest of maternal health.⁴⁰³ Next, she felt that there were significant unbriefed legal issues "regarding the state interest advanced by denying funding for termination of anencephalic pregnancies, while allowing funding for other medically necessary pregnancy services."⁴⁰⁴ Finally, she found that there were questions of fact remaining about the age of the fetus and its impact on CHAMPUS/TRICARE's decision-making process.⁴⁰⁵ She asked the parties to submit additional briefs before she would decide the validity of the regulations.⁴⁰⁶

Two weeks later, Judge Gertner issued her final decision, finding that CHAMPUS/TRICARE lacked a rational, legitimate interest in denying coverage under the circumstances of the Britells' case.⁴⁰⁷ In the opinion, Judge Gertner restated the facts of the case and her earlier upholding of the validity of an as-applied challenge as distinct from the kind of facial challenge attempted in the *Rust* case.⁴⁰⁸ As her rationale, she cited *City of Cleburne v. Cleburne Living Center*, a case in which a facially valid zoning ordinance had been used to invidiously discriminate against a protected class (in that case, the mentally retarded).⁴⁰⁹ She went on to reject CHAMPUS' call for deference to the legislature's funding decisions, noting that in this case, the medical expenses of carrying the child to term would almost certainly have exceeded the costs of terminating the pregnancy.⁴¹⁰

Next, Judge Gertner addressed CHAMPUS' argument that the distinctions drawn in the case did not amount to "invidious discrimination" under the Equal Protection Clause.⁴¹¹ Without a finding of invidious discrimination, CHAMPUS argued, the rational basis requirement did not apply.⁴¹² Finding a lack of Supreme Court precedent on the definition of "invidious", she turned to the

402. *Id.*

403. *Id.* at 220-23.

404. *Id.* at 226.

405. *Id.*

406. *Id.*

407. *Britell*, 204 F. Supp. 2d at 182.

408. *Id.* at 187.

409. *Id.* (citing *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985)).

410. *Britell*, 204 F. Supp. 2d at 196.

411. *Id.*

412. *Id.*

common meanings, which include, "of an unpleasant or objectionable nature" and "causing harm or resentment".⁴¹³ She went on to conclude:

In any event, however one defines "invidious," there is invidious discrimination lurking here. Women of means, who can afford to obtain abortions without insurance coverage, will not be deterred by CHAMPUS' policies regarding anencephaly, while poorer women might. Such women will be forced to wait nine months before seeking medical termination of a pregnancy. And at the end, their fetuses' chances of viability will be *no greater* after nine months than they would have been in the first trimester. Indeed, since the fetuses' potential for life is ephemeral, one impact of CHAMPUS's regulation — in addition to the financial one — is to stigmatize such women for their legitimate moral choice to terminate their anencephalic pregnancies. As justification for a regulatory enactment, this function runs afoul of both law and reason.⁴¹⁴

Finally, Judge Gertner addressed CHAMPUS' concern that her decision would start society down the "slippery slope" to euthanasia.⁴¹⁵ In rejecting this argument, she found a clear distinction between anencephaly, a condition inconsistent with life, and other chromosomal or birth defects like Down's Syndrome, which might be life threatening but are not, in themselves, inconsistent with life.⁴¹⁶ She noted that the current "Baby Doe" regulations supported her view by permitting the non-treatment of anencephalic children and fetuses.⁴¹⁷

Judge Gertner concluded by finding no rational basis for failing to cover abortions of anencephalic fetuses:

There is no rational justification for CHAMPUS' refusal to fund Britell's abortion of her anencephalic fetus. Through the funding power the government seeks to encourage Britell and women similarly situated to suffer by carrying their anencephalic fetuses until they are born to a certain death. This rationale is no rationale at all. It is irrational, and worse yet, it is cruel.⁴¹⁸

413. *Id.* at 196 (quoting BLACK'S LAW DICTIONARY 480 (7th ed. 1999)).

414. *Id.* at 197.

415. *Id.*

416. *Id.* at 198.

417. *Id.*

418. *Id.*

She granted the Britell's motion for summary judgment, compelling CHAMPUS/TRICARE to pay for the abortion.⁴¹⁹ The United States has not appealed. The decision represented a toe in the door for the abortion rights lobby, but CHAMPUS/TRICARE had yet to be forced to cover an abortion of an anencephalic child in advance.

C. *Doe v. United States—Following in Britell's Footsteps*

A Washington State Federal District Court quickly adopted the *Britell* decision and applied it prospectively.⁴²⁰ Jane Doe, a 19-year-old woman married to an active duty Navy E-3,⁴²¹ found out on July 12, 2002, that her sixteen week-old fetus was anencephalic.⁴²² Her Navy physicians told her that she should abort the fetus to protect her health, but that they could not perform the procedure.⁴²³

Mrs. Doe and her husband sought to have the procedure at the University of Washington Medical Center, but could not afford it on her husband's meager Navy pay and her own salary from the Navy Exchange.⁴²⁴ The University of Washington requested payment in advance from TRICARE, which denied the request, citing the specific denial of coverage for abortion for anencephalic fetuses in the CHAMPUS regulation.⁴²⁵ Mr. and Mrs. Doe then sought assistance through the Northwest Women's Law Center and eventually reached Vanessa Soriano Power, an attorney who agreed to take the case for free.⁴²⁶ Upon discovering the *Britell* decision, Ms. Power filed a petition in Federal District Court for a temporary restraining order requiring TRICARE to cover the procedure.⁴²⁷

At a hearing on August 9, 2002, Dr. Tom Easterling, a professor of obstetrics and gynecology at the University of Washington Medical Center, testified for Mrs. Doe.⁴²⁸ Dr. Easterling provided the grim facts of anencephaly—the fetus would never achieve consciousness and has “no potential for human interaction.”⁴²⁹ He

419. *Id.*

420. *Doe v. United States*, C02-1657Z, (U.S.D.C. 2002) (Order granting Plaintiff's Motion for a Temporary Restraining Order).

421. E-3 is one of the lower enlisted ranks. Susan Paynter, *With All Hope Lost, a Legal Angel Appears*, SEATTLE POST-INTELLIGENCER, Aug. 26, 2002, at E-1; *Doe*, Order at 1.

422. *Doe*, C02-1657z at 1.

423. Paynter, *supra* note 421, at E-1.

424. *Id.*

425. *Doe*, C02-1657z at 2.

426. Paynter, *supra* note 421.

427. *Id.*

428. Carol M. Ostrom, *Judge: Navy Must Cover Woman's Abortion: Everett Mother Carrying Fetus Lacking Most of Its Brain*, SEATTLE TIMES, Aug. 13, 2002, at B1.

429. *Id.*

confirmed that Mrs. Doe faced substantial risks in continuing the pregnancy with no prospect of any gain.⁴³⁰ Another witness testified that the costs for the abortion would run \$2,500 to \$3,000.⁴³¹

District Judge Barbara Rothstein issued the order the same day.⁴³² In a short opinion, she found the Massachusetts' court's reasoning persuasive. The judge found that "[f]or the same reasons elucidated by Britell, this Court concludes that Plaintiff has made a showing of a strong likelihood of success on the merits of her claim."⁴³³ She also quickly dispensed with the requirement for irreparable harm needed for a temporary restraining order, citing four factors from Dr. Easterling's testimony: the greater health risks in continuing the pregnancy; the potential negative impact of a cesarean section; the risk of emotional devastation; and a greater financial cost.⁴³⁴

The United States appealed the order immediately, but the United States District Court denied reconsideration.⁴³⁵ United States District Judge Thomas Zilly said the "balance of hardships in this case tips sharply' in favor of the pregnant woman."⁴³⁶ The Department of Justice attorneys replied that the law "reflects a congressional determination that taxpayer dollars should not be used to facilitate abortion in any way (absent a threat to the life of the mother) - even temporarily."⁴³⁷ Before Mrs. Doe's attorneys had a chance to reply to the Government's writ, however, the United States Court of Appeals for the Ninth Circuit also denied the appeal.⁴³⁸

D. Effects of the Britell and Doe Decisions

While the *Britell* and *Doe* decisions do undermine the strength of Section 1093 and the CHAMPUS regulations, they will most likely not open the door to broader military funding of non-therapeutic abortion. *Maher*, *McRae*, and *Rust* all support government restrictions on funding for abortion, and *Rust* supports

430. *Id.*

431. *Id.*

432. *Doe*, C02-1657z at 2.

433. *Id.* at 3.

434. *Id.* at 3-4.

435. Carol M. Ostrom, *Navy Must Pay for Abortion; Sailor's Wife is Carrying Fetus Missing Most of its Brain*, SEATTLE TIMES, Aug. 17, 2002, at B2.

436. *Id.*

437. *Id.*

438. *Id.*

a rather strong intervention into the counseling aspects of physician-patient relationship. While the two recent decisions should be viewed as limited, they do have some practical effect.

Arguably, the findings in *Doe* and *Britell* could be used to compel coverage for abortions of anencephalic fetuses of active duty women in the Districts concerned, or by adoption in other Districts. These rulings clearly extend to the funding of medical care outside of military treatment facilities. They do not go so far as to require performance of abortions in military facilities when the woman's life is not in danger. Still, a not insignificant number of airmen and military families are stationed in Western Washington and Massachusetts. Recent AFPC data show about 1,250 active duty Air Force women in Washington and about 230 in Massachusetts.⁴³⁹ The 2000 census data list 9,029 military dependents in Washington and 2124 military dependents in Massachusetts.⁴⁴⁰ While the United States will almost certainly appeal the disposition in the *Doe* case, for the moment military members and spouses who live in these Districts, and who face or have faced the expenses of the abortion of an anencephalic child, have at least a limited opportunity to seek compensation. For women who live outside the federal court districts, the fact that two separate districts are in agreement holds out some hope that the policy can be expanded.

For the moment, the cases present little practical hope for military affiliated women overseas seeking therapeutic abortions because the scope does not extend beyond the federal court districts involved. At best, these women could use the decisions to support internal appeals of denial of coverage for abortions of anencephalic children. Given that these appeals are heard in the Government-friendly arena of CHAMPUS/TRICARE, they will almost certainly be unsuccessful. However, should the *Britell* and *Doe* cases be extended to include therapeutic abortions in non-life-threatening cases, these women could realize some practical benefit.

The facts of the cases do not lend themselves to extension to other types of therapeutic abortions. The *Britell* reasoning explicitly considers the complete lack of any chance at life for the fetus.⁴⁴¹ The Government's interest in protecting life can not, therefore, outweigh the woman's interests in protecting her health.

439. Air Force Personnel Center Website, at <http://www.afpc.randolph.af.mil/demographics/demograf/ENLSTATES.html> and <http://www.afpc.randolph.af.mil/demographics/demograf/OFFSTATES.html> (last visited Apr. 4, 2003).

440. Air Force Personnel Center Website, at http://www.afpc.randolph.af.mil/demographics/demograf/DPSART_FY00_DEPEND_3.html (last visited Apr. 4, 2003).

441. *Britell*, 204 F. Supp. 2d 182, 183 (2002).

When even a chance of life exists for the fetus, the Government has the rational basis required to support the decision not to fund the procedure. Thus, the rulings in *Britell* and *Doe* do not support a more general application to instances where some chance of life exists for the fetus.

E. Legislative Action

The access problems faced by military-affiliated women in overseas locations recently have attracted congressional interest. In June 2002, Senators Patty Murray of Washington and Olympia Snowe of Maine introduced an amendment⁴⁴² to the Defense Authorizations Act⁴⁴³ to repeal Section 1093(b).⁴⁴⁴ The amendment essentially reverses the 1996 changes to Section 1093 by striking section (b), the section preventing the performance of abortions in military hospitals.⁴⁴⁵ Sen. Sam Brownback of Kansas spoke against the amendment. He pointed out that a similar amendment had failed in 2000, reminded the Senate that military physicians generally refuse to perform abortions, and noted that the services all had policies requiring them to observe the laws of the host nation regarding abortion.⁴⁴⁶ Thus, the amendment would have no practical effect.⁴⁴⁷ The amendment passed the Senate on a vote of 52-40, but the House bill had no such provision. The Conference Committee eventually reconciled the two versions, eliminating the provision allowing abortions in military facilities.⁴⁴⁸

While this bill, as passed by the Senate, would have eliminated the statutory prohibition on performing abortions, it would by no means have ensured access for women overseas. As noted by Sen. Brownback, most military physicians exercised their regulatory right not to perform abortions after President Clinton's order in 1993.⁴⁴⁹ As military physicians continue to be more conservative than their civilian counterparts, there seems little reason to believe their attitudes have changed over the intervening years. Thus even

442. S. Amend. 109th Cong. 3927, § 708, CONG. REC. S5829 (2002) (Sen. Murray), available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d107:SP03927>: (last visited Apr. 4, 2003).

443. National Defense Authorization Act for Fiscal Year 2003, S. 2514, 109th Cong. (2002), available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d107:SN02514>: (last visited Apr. 4, 2003).

444. Carl Hulse, *Senate Votes To Let Soldiers Overseas Pay For Abortion*, N.Y. TIMES, Jun. 22, 2002, at A8.

445. See 10 U.S.C. § 1093(b) (2003).

446. S. Amend. 3927, 109th Cong., 148 CONG. REC. S5829-30 (2002) (passed the Senate).

447. *Id.*

448. H.R. 4546, 109th Cong., Conf. Rep. No. 107-772 (2002).

449. S. Amend. 3927, 109th Cong., 148 CONG. REC. S5829-30 (2002) (passed the Senate).

without Section 1093(b), military women would continue to have greater access issues than civilians.

At the time this article was sent to print, the United States Senate had passed a ban on partial birth abortions and the House was about to vote on the bill.⁴⁵⁰ President George Bush has indicated that he will sign the bill if it passes both houses of Congress.⁴⁵¹ As the bill, as presented in the House, does not contain language allowing for a partial birth abortion to protect the health of a woman, it is likely to be overturned in that regard.⁴⁵² It is also susceptible to challenge as lacking constitutional authorization under the reasoning of *United States v. Lopez*, as it attempts to use the Commerce Clause to an issue with questionable applicability to interstate commerce.⁴⁵³ Partial birth abortion is one method of delivering an anencephalic fetus, although not the only one.

VI. CHALLENGES AND POLICY CHANGES REGARDING MILITARY WOMEN AND ABORTION

The Air Force faces risk of legal challenge regarding its abortion policy, but could easily address most access concerns through regulatory changes. The prohibition on therapeutic abortions is susceptible to challenge under the *Stenberg* and *Casey* "undue burden" analysis, especially for women overseas.⁴⁵⁴ Even without judicial challenges, the Air Force should consider minor changes to its policies on leave and Early Return of Dependent to address the obvious disparities in access to abortion services faced by Air Force women.

A. Possible Legal Challenges

An as-applied challenge to Section 1093 might succeed for a woman seeking a therapeutic abortion overseas. *Roe*, *Casey*, and *Stenberg* all support a woman's right to a therapeutic abortion in the third trimester, even when there is no threat to the life of the woman.⁴⁵⁵ Additionally, the cases, especially *Stenberg*, hold that a

450. 108th Congress, S. 3, H.R. 760 status, available at <http://thomas.loc.gov> (last visited Apr. 4, 2003).

451. Statement of the President Regarding Partial Birth Abortion, March 13, 2003, available at <http://www.whitehouse.gov/news/releases/2003/03/20030313-3.html> (last visited Apr. 4, 2003).

452. *Stenberg*, 530 U.S. at 931.

453. *United States v. Lopez*, 514 U.S. 549 (1995).

454. *Stenberg*, 530 U.S. at 931.

455. *Id.*; *Casey*, 505 U.S. at 901; *Roe*, 410 U.S. at 113 (1973).

facially neutral regulation may unduly burden a specific woman's right to seek an abortion.⁴⁵⁶ While Section 1093 facially applies only to abortions in military treatment facilities and appears to leave open the possibility of an off-base abortion, the realities of overseas service foreclose this option in many circumstances. Another potentially successful attack would be to challenge the prohibition on therapeutic abortions in overseas military treatment facilities as lacking a compelling basis, given the presence of exceptions for cases of rape or incest.

The practical obstacles faced by women overseas differ substantially from those in the United States. As discussed above, overseas women may face insurmountable obstacles, both legal and practical, to an abortion on the local economy. By framing the question as an as-applied challenge, a woman could argue that the prohibition on therapeutic abortions in military treatment facilities effectively forecloses her only option for an abortion and unnecessarily risks her health. While this argument has been rejected in the United States, in overseas areas the circumstances differ substantially. Exacerbating the increased barriers faced by women overseas, the Air Force bears some portion of fault for putting the woman in the situation, as the Air Force presumably assigned her or her family member there. Combining these facts with the lack of any Supreme Court precedent against an as-applied challenge to a therapeutic abortion, a sympathetic court might rule in the woman's favor.

In such a challenge, a plaintiff could argue that the United States has no compelling interest in prohibiting therapeutic abortions in military treatment facilities. If she could prove her only practical option was to seek an abortion at the military treatment facility because of hostile local conditions, she could then rely on *Stenberg* to support her case. The relevant portion of *Stenberg's* holding boils down to the proposition that the government cannot discriminate between the life and the health of the mother in making abortion policy.⁴⁵⁷ Both are sufficient to override even the compelling nature of the governmental interest in protecting fetal life.

Challenges to military policies from military members face significant legal obstacles. Both the *Feres* bar and the Federal Tort Claims Act discretionary function exception block a traditional tort

456. *Stenberg*, 530 U.S. at 931.

457. *Id.* at 921-22.

suit.⁴⁵⁸ However, *Frontiero v. Richardson* supports military women's access to the court to seek redress for discriminatory policies.⁴⁵⁹ In this case, a female Air Force lieutenant successfully challenged a federal law that discriminated against male dependants of active duty members.⁴⁶⁰ A case challenging the military's leave policy as discriminatory as applied to pregnant women seeking abortions should therefore at least have a hearing in federal court.

Exacerbating the situation, a military woman's commander holds veto power over her ability to get leave to have an abortion, limited only by his determination of military necessity and the best interests of the Air Force.⁴⁶¹ By virtue of command authority, a commander has a power over a woman that the federal courts do not permit her husband, partner, or even parents to have.⁴⁶² The regulation is facially neutral, but does not provide for mandatory grants of leave.⁴⁶³ Even approval for convalescent leave ultimately lies in the commander's hands.⁴⁶⁴ Unlike a judicial bypass for a minor, no statutory authorization exists for a judicial bypass of the commander's decision. Her sole avenue of redress is through the chain of command. As noted by the GAO report on Kosovo, that chain of command has proven itself to be uninformed regarding the needs of women's health.⁴⁶⁵

Arguably, the Air Force might owe an affirmative duty to assist women in exercising their reproductive freedoms. Despite the language in *Harris* and *Rust* concerning the government's lack of any duty to facilitate the exercise of constitutional rights, the Supreme Court has held in other circumstances that the government may not unduly inhibit the exercise of those rights. Therefore, according to the Second Circuit, in the unique circumstances of military service, the government must assist a member of the military in the exercise of those rights.⁴⁶⁶ In *Everson v. Board of Education*, the Supreme Court wrote, "Neither [a state nor the federal government] can force nor influence a person to go

458. *Feres v. United States*, 340 U.S. 135 (1950); 28 U.S.C. § 2680(a) (2003).

459. *Frontiero v. Richardson*, 411 U.S. 677 (1973).

460. *Id.* at 690-91.

461. AFI 36-3003, § 6.1 *Military Leave Program* (Apr. 14, 2000), at <http://www.publishing.af.mil/pubfiles/af/36/afi36-3003/afi36-3003.pdf> (last visited Apr. 4, 2003).

462. *Casey*, 505 U.S. at 901.

463. AFI 36-3003, at § 4.1.2.

464. AFI 36-3003, at § 6.4.

465. U.S. Gen. Acct. Off., *Gender Issues: Medical Support for Female Soldiers Deployed to Bosnia*, GAO/NSIAD-99-58 (March 1999), at <http://www.gao.gov/archive/1999/ns99058.pdf> (last visited Apr. 4, 2003).

466. *Katkoff v. Marsh*, 755 F.2d 223 (2d Cir. 1984).

to or to remain away from church against his will or force him to profess a belief or disbelief in any religion."⁴⁶⁷ In *Katkoff v. Marsh*, the Second Circuit upheld the constitutionality of the military chaplaincy.⁴⁶⁸ Judge Mansfield wrote for the Court, noting:

if the Army prevented soldiers from worshipping in their own communities by removing them to areas where religious leaders of their persuasion and facilities were not available it could be accused of violating the Establishment Clause *unless* it provided them with a chaplaincy since its conduct would amount to inhibiting religion.⁴⁶⁹

No case explicitly extends the reasoning of *Katkoff* to the exercise of reproductive rights in the military, but the analogy is clear. In removing women from an environment in which they could readily obtain an abortion, the military has arguably affirmatively denied them a constitutional right and must therefore provide an affirmative remedy.

Crafting a judicial remedy for the access problem presents difficulties. In any given case, a court could order the command to grant the woman leave. This would both impinge on the usual prerogatives of the executive branch and leave the underlying problem unsettled. A court order requiring the Air Force to grant leave to any pregnant woman requesting leave to have an abortion would put the court in the position of dictating policy to the military, which the courts have quite reasonably been reluctant to do.⁴⁷⁰ Invalidating Section 1093 to the extent that it prohibits abortions in military facilities would not surmount the problem of finding a physician willing to perform the abortion. Thus, the courts are not the ideal place to solve this problem.

B. Possible Statutory and Regulatory Changes

A better solution would be to change Section 1093 or the leave regulations. In light of *Stenberg*, Section 1093 appears to be on shaky ground with regard to governmental discriminations between the life and the health of the mother in making abortion policy.⁴⁷¹ While the military gains some measure of protection by claiming that the statute merely regulates health insurance, the realities of

467. *Everson v. Board of Education*, 330 U.S. 1, 15 (1947).

468. *Katkoff*, 755 F.2d at 237.

469. *Id.* at 232.

470. *See, e.g.*, *Chappell v. Wallace*, 462 U.S. 296 (1983).

471. *Stenberg*, 530 U.S. at 931.

overseas service often mean that military health care is the only available health care. In addition, while military obstetricians do not support providing elective termination services, they do support providing therapeutic termination services. A change to Section 1093 and its affiliated regulations to allow therapeutic abortions would adequately address the unique access issues faced by Air Force women, at least with regard to protecting their health.

In the absence of Congressional action on the issue, the Air Force could amend the leave and emergency leave instructions to explicitly address the needs of pregnant women seeking abortions. Requiring commanders to grant medical leave to women seeking abortions, when available in the local economy, and emergency leave to return to the United States when services are not available, would prevent at least active duty Air Force women from suffering a disproportionate burden interference with their reproductive freedoms because of their service. Military family members present a more difficult problem.

The current regulatory approach to military family members does not adequately address their needs. The Early Return of Dependents program does not help much, as it was not designed for this purpose and the Air Force cannot unilaterally change it. At present, the only real solution a commander can offer is revoking command sponsorship, which effectively banishes the family member back to the United States indefinitely. A regulation providing travel funding for elective medical treatment in the United States could effectively enhance dependent access to reproductive services. Such a regulation, however, should not rely on any discretionary decision of the military member or his or her commander.

VII. CONCLUSION

Air Force women still face significant obstacles in exercising their right to abortion services. The Air Force, while publicly maintaining a neutral stance on abortion rights, has failed to provide adequate practical safeguards to ensure that military and military family members can exercise this right. The Air Force's continued lack of interest in enforcing the requirement for a referral procedure undermines women's access to abortion. The most reasonable solution to this problem would be to simply adhere to the standard stated in the AFI, and to provide written guidance for abortion referrals in the form of a Medical Group Instruction. While the Air Force has no affirmative duty to support abortion in

any given case, its medical group commanders have the regulatory duty to back this up with an appropriate referral system.

While recent cases have expended CHAMPUS funding for abortions in the case of anencephalic fetuses, these cases do not extend funding to all therapeutic abortions. Further, while current legislation might eventually permit abortions in overseas military facilities, it would not provide staff willing to perform abortions, the critical facet of the problem. CHAMPUS and Air Force policy will likely remain static on abortion rights. Enforcement of this policy should adjust to protect the reproductive rights of Air Force women.

Finally, regulatory changes could effectively enhance Air Force women's access to abortion. For active duty members, minor changes to the leave and emergency leave regulations would offer airmen seeking abortion services the opportunity to access these services in the United States. A more comprehensive funding travel regulation for elective medical procedures in the United States could adequately protect the access rights of military family members seeking abortion services. By enacting such regulatory changes, the Air Force could effectively reduce, although not eliminate, the increased barriers to access faced by military women.