

NOTES

PHYSICIAN MENS REA: APPLYING *UNITED STATES* v. *RUAN* TO STATE ABORTION STATUTES

Mary Claire Bartlett*

In June 2022 the Supreme Court decided two unrelated cases, Dobbs v. Jackson Women’s Health Organization and Ruan v. United States, each with significant implications for the criminal regulation of doctors. Dobbs removed abortion’s constitutional protection; in its wake, many states passed criminal statutes banning the procedure except in medical emergencies. The vagueness of those emergency exceptions, however, has produced a chilling effect among abortion providers who fear criminal exposure from exercising medical judgment. How the mens rea required to convict abortion providers under these statutes is codified and construed will be critical to understanding the scope of their criminal exposure when exercising medical discretion.

In Ruan, the Court clarified the mens rea required to convict doctors under the Controlled Substances Act (CSA), adopting a subjective standard over the Government’s proposed objective one. Although Ruan and Dobbs address unrelated areas of medical practice, the common law, constitutional, and pragmatic principles underpinning the Court’s adoption of a subjective mens rea standard for the CSA are instructive for state courts interpreting the new abortion bans. After recounting the history of prescription drug regulation and comparing states’ efforts to regulate abortion with the federal effort to regulate drugs, this Note argues that state courts interpreting emergency exceptions to state abortion bans should adopt, like the Ruan Court, a subjective mens rea standard. This standard will not only curb the bans’ chilling effect on lifesaving obstetric care but also mitigate constitutional vagueness concerns and comport with common law’s preference for scienter.

INTRODUCTION	1700
I. PHYSICIAN MENS REA UNDER FEDERAL DRUG STATUTES—THE LONG ROAD TO <i>RUAN</i>	1702

* J.D. Candidate 2024, Columbia Law School. I am grateful to Professor Daniel C. Richman for his generous guidance and support on this project. Special thanks also to Jackson Springer, Andrew Straky, Kristin Bergeson McCalpin, Celeste Kearney, and Margaret Hassel for their helpful feedback on earlier drafts, and to the entire staff of the *Columbia Law Review* for their editorial support. All errors are my own.

A.	The Harrison Act of 1914	1703
B.	The Controlled Substances Act	1707
1.	The Rise of Opioids for Long-Term Pain Management and the Opioid Crisis	1709
2.	Enforcement Efforts Against Doctors	1710
3.	The Chilling Effect and the Supreme Court’s Response..	1712
4.	<i>Ruan</i> ’s Implications for Abortion Statutes	1717
II.	THE NEW ABORTION FRONTIER	1718
A.	Mens Rea for Abortion Providers Before <i>Dobbs</i>	1720
B.	Criminal Jeopardy for Doctors After <i>Dobbs</i>	1724
1.	Mens Rea in the Post- <i>Dobbs</i> Abortion Legislation	1725
2.	The Implications of Objective Mens Rea Standards in Abortion Prosecutions	1727
3.	Applying <i>Ruan</i> to State Abortion Statutes	1732
	CONCLUSION	1734
	APPENDIX A	1736
	APPENDIX B	1746

INTRODUCTION

In June 2022, the United States Supreme Court decided two unrelated cases implicating the use of criminal liability to regulate actions taken by doctors in the ordinary course of their practice. Both cases involved highly charged issues that have lingered for decades. The first and more noteworthy, *Dobbs v. Jackson Women’s Health Organization*,¹ dismantled the federal constitutional right to an abortion set out in *Roe v. Wade* and its progeny.² The Court’s conclusion that there is no constitutionally protected right to an abortion allows individual states to regulate the practice, and there has since been a frenzy of state legislative activity criminalizing abortions in circumstances in which abortions had previously been protected.³ Those state laws prohibiting abortions vary widely, but all provide an emergency exception in some form to permit abortions “necessary” to protect the life or health of the pregnant

1. 142 S. Ct. 2228 (2022).

2. 410 U.S. 113 (1973) (recognizing a constitutional right to abortion during the first trimester without state interference), overruled by *Dobbs*, 142 S. Ct. 2228; see also *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (reaffirming but reframing the right established in *Roe*), overruled by *Dobbs*, 142 S. Ct. 2228.

3. See *Abortion Ruling Prompts Variety of Reactions From States*, Associated Press (July 21, 2022), <https://apnews.com/article/supreme-court-abortion-ruling-states-a767801145ad01617100e57410a0a21d> [<https://perma.cc/6KLV-RRY7>] (providing an “overview of abortion legislation and the expected impact of the court’s decision in every state”).

person.⁴ The vagueness of that exception and the imprecise judgment required to apply it create considerable concern among abortion providers, who fear criminal exposure from the exercise of their medical discretion.⁵ Moving forward, the scope of criminal liability for providers in the abortion context will rest in part on how the mens rea requirements of the various state statutes are codified and construed.

Two days after announcing *Dobbs*, the Supreme Court decided *Ruan v. United States*, which unanimously put to rest conflicting interpretations of the mens rea requirement of § 841 of the Controlled Substances Act (CSA).⁶ That federal statute prohibits prescriptions for controlled substances “[e]xcept as authorized”;⁷ an “authorized” prescription is defined in attendant regulations as one “for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.”⁸ After the passage of the CSA in 1970, courts disagreed about whether the mens rea required to impose criminal liability on doctors who prescribe drugs covered by the CSA is an objective or subjective one. In other words, must the Government show only that a doctor’s prescription “was *in fact* not authorized, or must the Government prove that the doctor *knew* or *intended* that the prescription was unauthorized?”⁹ A unanimous Court adopted the subjective standard, and the majority held that the Government must prove beyond a reasonable doubt that the defendant knew that they were acting in an unauthorized manner.¹⁰ The Court concluded that an objective standard would make a defendant’s criminal liability turn on “the mental state of a hypothetical ‘reasonable’ doctor, not on the mental state of the defendant.”¹¹

4. See, e.g., Ala. Code § 26-23H-4 (2023) (allowing abortions only when deemed “necessary in order to prevent a serious health risk to the unborn child’s mother”); see also *infra* section II.B (discussing the statutory language of state laws criminalizing abortion, which uniformly contain emergency exceptions).

5. See J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion*, N.Y. Times (July 20, 2022), <https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html> (on file with the *Columbia Law Review*) (noting doctors’ concerns that the decision to terminate a pregnancy in a medical emergency “has become fraught with uncertainty and legal risk”).

6. 142 S. Ct. 2370 (2022).

7. 21 U.S.C. § 841(a) (2018).

8. 21 C.F.R. § 1306.04(a) (2023).

9. *Ruan*, 142 S. Ct. at 2375.

10. *Id.* at 2375 (holding that, once the defendant invokes the authorization exception, “the Government must prove beyond a reasonable doubt that the defendant knew that he or she was acting in an unauthorized manner, or intended to do so”). The concurrence, written by Justice Samuel Alito, joined by Justice Clarence Thomas, and joined in part by Justice Amy Coney Barrett, would have instead held that the authorization exception established an affirmative defense under which the defendant, to avoid conviction, must prove he acted in “subjective good faith” by a preponderance of the evidence. *Id.* at 2389 (Alito, J., concurring in the judgment).

11. *Id.* at 2381 (majority opinion).

Although *Ruan* and *Dobbs* address unrelated areas of medical practice, the legal saga that culminated in the adoption of a subjective mens rea standard for the CSA is instructive for state courts as they interpret the new statutes that criminalize abortions. This Note first explores the circumstances that led the federal government to enact the CSA, the vacillating and politically charged history of its enforcement against doctors, and the reasons why the Court concluded that criminal liability for dispensing drugs in this context requires a subjective mens rea standard.

Next, the Note turns to the abortion context, describing the history of therapeutic abortions,¹² the *Dobbs* decision, and the regulatory outburst that followed. It compares the states' efforts to regulate abortion with the federal effort to regulate drugs and explores the challenges in both contexts of using criminal law to regulate medical treatment.¹³ It also provides the first comprehensive review of the mens rea language contained in the nation's strictest abortion bans. The Note concludes by arguing that state courts interpreting statutes with emergency exceptions should adopt, as the *Ruan* Court did for the CSA, a subjective mens rea standard. Such a standard is critical for three reasons: (1) It protects patients by preventing overdeterrence of critical, often lifesaving, medical care; (2) it protects medical professionals by shielding them from criminal liability when hazy legal standards and a politically charged environment make it extremely difficult for them to determine the legality of an abortion; and (3) it mitigates the constitutional vagueness concerns presented by the statutes.

I. PHYSICIAN MENS REA UNDER FEDERAL DRUG STATUTES— THE LONG ROAD TO *RUAN*

The CSA supplanted and consolidated into one regulatory regime all preexisting federal criminal statutes regulating drug distribution, including the Harrison Act of 1914, which specifically regulated unlawful prescriptions by doctors.¹⁴ The exercise of federal authority over drug

12. The term “therapeutic abortion” refers to an abortion “induced when pregnancy constitutes a threat to the physical or mental health of the mother.” Therapeutic Abortion, Merriam-Webster, <https://www.merriam-webster.com/medical/therapeutic%20abortion> [https://perma.cc/FX9W-RPJ4] (last visited Aug. 28, 2023).

13. The fact that the CSA is a federal law and that abortion statutes are state laws is not a significant distinction for purposes of this Note. The similarity that makes them comparable for this discussion is the fact that both the CSA and state abortion laws are criminal statutes implicating mens rea requirements for doctors engaged in the ordinary course of their practice.

14. Harrison Act, Pub. L. No. 63-223, § 2(a), 38 Stat. 785, 786 (1914); see also Thomas M. Quinn & Gerald T. McLaughlin, The Evolution of Federal Drug Control Legislation, 22 Cath. U. L. Rev. 586, 593, 605 (1973) (“[The CSA] repealed almost all prior federal drug legislation and created a new and comprehensive scheme for federal drug control . . . [that] governed both narcotics and dangerous drugs.”).

prescriptions is unusual, both because the regulation of medical treatments is overwhelmingly left to the states¹⁵ and because criminal liability is so rarely used to regulate treatment falling squarely within the ordinary scope of a doctor's practice.¹⁶ In areas where criminal sanctions are imposed for performing medical procedures, the applicable statutes frequently impose a complete ban on providing the service.¹⁷ An outright prohibition sidesteps most of the mens rea complexities in enforcement because the provider is on clear notice that the procedure is illegal and the prosecution turns on whether the doctor knowingly provided it. Since the passage of the Harrison Act, however, the federal government has criminalized doctors' distribution of drugs in certain circumstances while permitting it in others, thus creating the legal challenge of distinguishing between lawful and unlawful prescriptions.

A. *The Harrison Act of 1914*

The challenge of delineating the boundary of lawful treatment is evident from the federal government's first foray into regulating drugs in 1914 under the Harrison Act.¹⁸ A lack of federal precedent for regulating medical practice raised enough doubts about Congress's constitutional

15. See Robert I. Field, Regulation of Health Care in the United States: Complexity, Confrontation and Compromise, 16 *Anais do Instituto de Higiene e Medicina Tropical*, supp. 3, 2017, at S61, S62 (Port.) (explaining how the states have "jurisdiction over health care" in our federalist government).

16. See Scott J. Schweikart, What's Wrong With Criminalizing Gender-Affirming Care of Transgender Adolescents?, 25 *AMA J. Ethics* E414, E417 (2023), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2023-05/hlaw2-2306.pdf> [<https://perma.cc/7SD5-6284>] (noting how the government allows civil tort law to regulate physician practice "in most . . . cases").

17. Complete bans on certain medical treatments, such as those prohibiting medically assisted suicide, the prescription of medical marijuana, or the provision of gender-affirming care, are more common and are not the topic of this Note. See, e.g., *id.* (describing the recent legislation in Arkansas and Alabama prohibiting physicians from providing gender-affirming care to minors). The key distinction between total bans on medical treatment and the regulations that *are* the topic of this Note—namely, those governing controlled substance prescriptions and emergency abortions—is that the former create a bright-line rule for doctors to follow. In contrast, current criminal regulation of drug prescriptions and abortions carves out circumstances in which the course of treatment *is* legal and leaves it up to doctors to decide whether those circumstances are present.

18. The impetus for the Harrison Act was an unusual combination of domestic concerns over nonmedical uses of opium and a movement to regulate the drug at the international level. See Kurt Hohenstein, Just What the Doctor Ordered: The Harrison Anti-Narcotic Act, the Supreme Court, and the Federal Regulation of Medical Practice, 1915–1919, 26 *J. Sup. Ct. Hist.* 231, 240 (2001) (noting that "several medical and political professionals were [pushing] opium regulation" domestically while, at the same time, opium "had become a major source of tension" internationally); Rufus G. King, The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick, 62 *Yale L.J.* 736, 736 (1953) (noting that Congress passed the Harrison Act "partly to carry out a treaty obligation, but mainly to aid the states in combatting a local police problem which had gotten somewhat out of hand" (footnote omitted)).

authority to do so that Congress styled the statute as a regulatory tax measure and assigned enforcement responsibility to the Treasury Department.¹⁹ The statute imposed taxes, as well as registration and reporting obligations, on the manufacture, sale, and distribution of opium and other drugs.²⁰ It allowed a registered physician to lawfully dispense opioids only if prescribed “in good faith” in the “the course of his professional practice.”²¹ Possession or distribution of opioids by unregistered physicians or those prescribing outside the course of their professional practice was unlawful.²² The Act imposed a fine of up to \$2,000 and a prison sentence of up to five years for violations.²³

Because it failed to provide clear guidance as to the legal contours of “in the course of [one’s] . . . professional practice,” the Harrison Act’s novel intrusion into local medical practice with threats of felony charges sparked panic and confusion among physicians and druggists nationwide.²⁴ And the prosecution statistics suggest they were right to be worried. Shortly following enactment, narcotics agents, in partnership with U.S. Attorneys’ Offices, began arresting and prosecuting doctors for unlawful prescriptions or for failing to report under the law’s provisions.²⁵ Primarily targeting medical professionals, U.S. Attorneys prosecuted over 77,000 violations in the first fourteen years of the Act, constituting “the most comprehensive general criminal enforcement of any law against medical professionals in U.S. history.”²⁶

What energized the prosecutors’ zeal was arguably less the widespread lawlessness of doctors than political disagreement with the medical profession over how to treat the nation’s growing population of people struggling with substance use disorders (SUDs).²⁷ Many doctors—with

19. See Hohenstein, *supra* note 18, at 232–33 (“In the early 1900s, the regulation of medical practice was exclusively a state function. The issuance of medical licenses and management of disciplinary actions against doctors and druggists was regulated by state boards of examiners, if at all.”).

20. See *id.* at 231–33.

21. Harrison Act, Pub. L. No. 63-223, § 2(a), 38 Stat. 785, 786 (1914) (noting that Harrison Act restrictions do not apply to the distribution of drugs “to a patient by a physician . . . registered under this Act in the course of his professional practice”); *id.* § 8 (allowing possession of drugs by patients if “prescribed in good faith by a physician . . . registered under this Act”).

22. *Id.* § 1.

23. *Id.* § 9.

24. See Hohenstein, *supra* note 18, at 233 (noting that physicians “[a]ll across the country [were] wary of the law and uncertain of the rules of compliance”).

25. *Id.*

26. *Id.* at 232, 245. By 1928, the average sentence for Harrison Act violations was one year and ten months. See *id.* at 245.

27. See David F. Musto, *The American Disease: Origins of Narcotic Control* 122–23 (Oxford Univ. Press 3d ed. 1999) (1973) (“From the first days of the Harrison Act, revenue agents began to arrest physicians and druggists who provided drug supplies to [people with SUDs] via ‘prescriptions’ . . .”); Hohenstein, *supra* note 18, at 244 (“Initially, the Treasury officials attacked maintenance doctors who regularly prescribed doses of narcotics to

support from the medical profession—were engaging in maintenance treatment by prescribing narcotics to people with SUDs to manage, rather than cure, their habit.²⁸ The federal government and public, however, viewed maintenance treatment as “a convenient and profitable activity by physicians . . . without any pretense of [a] cure.”²⁹ Public opinion had also soured on people with SUDs generally based on the prevailing view that they were not sick patients in need of treatment but rather “dope fiends” predisposed to commit crimes.³⁰ Eager to use the Harrison Act to eliminate maintenance treatment, the government did not distinguish between doctors prescribing opioids to people with SUDs in good or bad faith. That indiscriminate enforcement agenda was premised on the belief that prescriptions to people with SUDs could not be good-faith medical practice as a matter of law,³¹ despite the medical profession’s strong belief in the usefulness of maintenance treatment for those struggling with SUDs.³²

Although some lower courts found that prosecutors’ targeting of maintenance treatment exceeded the federal government’s constitutional power, the Supreme Court ruled otherwise, reinstating two indictments against doctors accused of prescribing to people with SUDs in *Webb v. United States*³³ and *United States v. Behrman*.³⁴ Both cases involved flagrant physician abuse,³⁵ but in *Behrman* the Government specifically asked the Court to hold that, “irrespective of the physician’s intent or belief,” maintenance treatment violated the Act.³⁶ The Court upheld the Government’s indictment, although its opinion stressed the excessive

addicted patients as a medical regimen to maintain, rather than cure, their habit.”); King, *supra* note 18, at 739–40 (describing the targeting of maintenance doctors).

28. See Hohenstein, *supra* note 18, at 244 (“In 1915, maintenance as a medical treatment was widely accepted by the medical community.”).

29. Musto, *supra* note 27, at 125.

30. See King, *supra* note 18, at 737 (noting the “great public hullabaloo about the ‘dope menace’ [that] swept the country”); A.R. Lindesmith, “Dope Fiend” Mythology, 31 J. Am. Inst. Crim. L. & Criminology 199, 199–208 (1940) (describing the prevalent stereotype of the “dope-crazed killer” or the “dope fiend rapist” that has led to the treatment of people with SUDs as criminals).

31. See Musto, *supra* note 27, at 129 (suggesting maintenance treatment was not viewed as “compatible with medical practice in good faith”).

32. See, e.g., Arthur L. Blunt, Letter to the Editor, *The Harrison Drug Law*, Day Book (Chi.), Sept. 1, 1915, at 24 (recounting the success of the “gradual reduction method” for treating people with SUDs, through which the author, a doctor, cured 750 people, and lamenting how the “wrong enforcement” of the Harrison Act has made the treatment criminal).

33. 249 U.S. 96 (1919).

34. 258 U.S. 280 (1922).

35. In *Webb*, the defendant indiscriminately sold 4,000 opioid prescriptions to patients with SUDs over eleven months for fifty cents apiece. 249 U.S. at 98. In *Behrman*, the defendant had provided a person with a SUD, in just one sitting, with enough heroin, morphine, and cocaine for 3,000 standard injections. 258 U.S. at 288–89.

36. Brief on Behalf of the United States at 18, *Behrman*, 258 U.S. 280 (No. 582).

quantities prescribed instead of explicitly adopting the Government's proposed legal rule.³⁷ Nonetheless, the Government viewed the decision as a win, leaving doctors as targets for prosecutors.³⁸ Narcotics clinics closed, and the medical profession withdrew "totally and irrevocably" from the treatment of people with SUDs.³⁹

Just six years later, the Court clarified in *Linder v. United States* that a registered physician *can* act "in the ordinary course" of their professional practice when the physician writes prescriptions to people with SUDs "in good faith."⁴⁰ Despite the Court's clarification, the government remained suspicious of physicians prescribing to people with SUDs, and physicians remained fearful of investigation.⁴¹ As legal historian David Musto describes, "The social and economic position of the registered physician was so sensitive, trials so time-consuming, and appeals so long and costly, that hostile agents could make cases against physicians with impunity and nearly ruin them whether charges were warranted or not."⁴² Unsurprisingly, even post-*Linder*, doctors remained "in retreat," and untreated people with SUDs turned to the black market for their substances.⁴³

The Harrison Act's first few decades thus serve as an example of how aggressive criminal regulation of a medical treatment can chill—or even eliminate—the provision of that treatment even when legal. Few would have disagreed at the time of the Act's passage that there was a legitimate addiction crisis to be addressed, and even the medical profession agreed that unscrupulous physicians were contributing to the problem.⁴⁴ The government's response, however, had the unfortunate consequence of "driv[ing] from the field of drug treatment not only the unethical 'script doctor' but the legitimate doctor as well."⁴⁵ The chilling effect was strong because the law was vague, which made it hard for physicians to discern where to draw the line between legal and illegal treatment, and because the regulated treatment was highly politicized, which incentivized political

37. *Behrman*, 258 U.S. at 289 (emphasizing the 3,000 doses of narcotics prescribed).

38. King, *supra* note 18, at 744 (noting the Narcotics Division's perception that the *Behrman* decision broadened its enforcement power).

39. *Id.*

40. 268 U.S. 5, 18 (1925).

41. See Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 St. Louis U. J. Health L. & Pol'y 231, 262 (2008) ("Despite the ruling in *Linder*, . . . [p]hysicians, even those prescribing within legal bounds, became fearful of narcotics agents."); King, *supra* note 18, at 748 ("[T]he Federal Narcotics Bureau [remained] undeterred in its own lusty applications of the Act.").

42. Musto, *supra* note 27, at 185.

43. King, *supra* note 18, at 748.

44. See Hohenstein, *supra* note 18, at 248 (noting the "growing movement among the medical profession to clean up its own act" because most recognized that "abuses *were* occurring").

45. Quinn & McLaughlin, *supra* note 14, at 595.

actors to target individual physicians regardless of the legitimacy of their conduct.

B. *The Controlled Substances Act*

In 1970, Congress repealed the Harrison Act and several other federal drug statutes and replaced them with the CSA.⁴⁶ The CSA is a comprehensive statutory scheme that separates controlled substances into five schedules based on their potential for abuse, addictive nature, and medical purpose and provides different prohibitions for prescribing and distributing drugs in each schedule.⁴⁷ Like the Harrison Act, the CSA also imposes tracking and registration requirements on all individuals involved in the legal distribution of controlled substances.⁴⁸ The statute's enforcement was delegated to the Justice Department's Drug Enforcement Administration (DEA).⁴⁹

The CSA states that, “[e]xcept as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally . . . to manufacture, distribute, or dispense . . . a controlled substance.”⁵⁰ According to attendant regulations, authorized distributions include those issued “for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.”⁵¹ Like the Harrison Act, neither the CSA nor any attendant regulations from a federal agency define “legitimate medical purpose” nor explain what constitutes “the usual course of professional practice.”⁵²

Almost immediately after the Act's passage, a physician challenged the legality of his prosecution under § 841(a)(1) of the CSA, culminating in the 1975 case of *United States v. Moore*, one of the few Supreme Court decisions addressing physician prosecutions under the CSA before *Ruan*.⁵³

46. See *id.* at 605 (“The [CSA] repealed almost all prior federal drug legislation and created a new and comprehensive scheme for drug control.”). Between 1922 and 1970, Congress passed additional federal drug statutes to supplement the Harrison Act, such as the Marihuana Tax Act of 1937, the Opium Poppy Control Act of 1942, the Narcotics Manufacturing Act of 1960, and certain amendments to the Federal Food, Drug, and Cosmetic Act regulating depressants, stimulants, and hallucinogens. These statutes were repealed and replaced by the CSA as well. See *id.* at 599–605.

47. See Hoffmann, *supra* note 41, at 264.

48. See *id.*

49. See *id.*

50. 21 U.S.C. § 841(a)(1) (2018).

51. 21 C.F.R. § 1306.04(a) (2023).

52. See Hoffmann, *supra* note 41, at 274. Case law in several circuits has clarified that “professional practice” refers to “generally accepted medical practice.” See, e.g., *United States v. Birbragher*, 603 F.3d 478, 485 (8th Cir. 2010); *United States v. Vamos*, 797 F.2d 1146, 1151 (2d Cir. 1986); *United States v. Norris*, 780 F.2d 1207, 1209 (5th Cir. 1986).

53. 423 U.S. 122 (1975). The other case was *Gonzales v. Oregon*, 546 U.S. 243 (2006), in which a physician was prosecuted under the CSA for dispensing drugs for assisted suicide. Physician-assisted suicide was authorized under state law but prohibited as an illegitimate medical purpose by a CSA interpretive rule issued by the U.S. Attorney General.

In that case, the Court rejected Dr. Thomas Moore's argument that he was per se exempted from prosecution under § 841(a)(1) because he was an "authorized" prescriber.⁵⁴ Instead, the Court held that "registered physicians can be prosecuted under § 841 when their activities fall outside the usual course of professional practice" and declined to endorse a scheme that allowed a registered physician to act as a "drug 'pusher'" with relative impunity.⁵⁵

The Court likewise rejected Moore's argument that, even if he could be prosecuted under § 841(a)(1), his conduct did not violate the provision.⁵⁶ The record showed that Moore had indiscriminately prescribed massive quantities of methadone to people with SUDs without properly examining them.⁵⁷ The Court upheld his conviction, not based on its own interpretation of what conduct lies "outside the usual course of professional practice," but rather because Moore's prescriptions did not comport with the regime for treating people with SUDs recently set forth in 1974 by Congress in the Narcotic Addict Treatment Act (NATA).⁵⁸ Thus, with the help of NATA, the Court provided some clarity as to what constitutes "legitimate medical purpose" when treating addiction. But outside the addiction context, the contours of "legitimate medical purpose"—and the mens rea required to convict doctors when they strayed from it—remained grievously unclear.⁵⁹

Id. at 252–54. The Court held that the U.S. Attorney General lacked the power to declare illegitimate a medical standard for care and treatment of patients that was specifically authorized under state law. Id. at 258.

54. *Moore*, 423 U.S. at 131 ("We take a different view and hold that only lawful acts of registrants are exempted."). Moore instead contended that registered physicians could only be prosecuted under §§ 842 and 843 of the CSA, which specifically mention "registrants" and carry significantly lesser penalties. See *United States v. Moore*, 505 F.2d 426, 429 (D.C. Cir. 1974) (noting that violators of § 842 are subject to a \$25,000 fine and at most one year in prison, violators of § 843 to a \$30,000 fine and at most four years, and violators of § 841 to a \$25,000 fine and up to 15 years). The Court of Appeals had agreed with Moore, reasoning that Congress intended to regulate registered physicians through "a system of administrative controls" with only "modest penalt[ies]," and reserved the severest penalties under § 41(a)(1) for those who seek to "avoid regulation entirely by not registering." Id. at 430.

55. *Moore*, 423 U.S. at 124, 136–38.

56. Id. at 143–45.

57. Id. at 126. In just two years, Moore wrote 11,169 prescriptions covering 800,000 methadone tablets. Id.

58. See id. at 144 (noting how the limits of approved practice for methadone treatment are "particularly clear" and Moore was neither authorized to conduct the treatment nor compliant with the relevant procedures); see also Narcotic Addict Treatment Act of 1974, Pub. L. No. 93-281, 88 Stat. 124 (codified at 21 U.S.C. § 802 (2018)) (regulating maintenance treatment).

59. Hoffmann, *supra* note 41, at 276 ("While [NATA] helped clarify what constituted 'legitimate medical practice' when treating [people with SUDs], the phrase remains undefined outside of that context. Another contentious issue in prosecuting these cases arises in establishing the mens rea necessary to convict under section 841.").

1. *The Rise of Opioids for Long-Term Pain Management and the Opioid Crisis.* — While opioids have long been prescribed to treat addiction and acute pain, they were not employed to combat long-term pain until the 1960s, when doctors discovered they were highly effective for treating terminally ill cancer patients.⁶⁰ By the late 1990s, opioids became the standard of care for treating not just severe cancer pain but many other forms of chronic pain.⁶¹ The use of opioids to treat chronic pain became so ingrained that, under the Federation of State Medical Boards' guidelines, doctors could be disciplined for *under*prescribing them to patients in need.⁶² As a result, physicians prescribed opioids at higher rates and dosages than ever before;⁶³ between 1990 and 1995, opioid prescriptions increased by two to three million yearly.⁶⁴

In 1995, the FDA approved OxyContin, a time-release opioid analgesic, which quickly became the most prescribed Schedule II narcotic in the country.⁶⁵ Well-meaning and ill-intentioned doctors alike wrote liberal prescriptions for the drug, and the excess supply facilitated the diversion and sale to recreational users and people struggling with SUDs.⁶⁶ The increase in people addicted to prescribed opioids soon provoked a rise in illicit heroin trafficking, providing people with SUDs with a significantly cheaper alternative. What resulted was an epidemic of both heroin and opioid abuse and, consequently, increased overdose deaths between 2000 and 2014.⁶⁷ And beginning in 2013, other especially potent synthetic opioids, including fentanyl, produced most of the country's

60. Id. at 266.

61. Id. at 267–69.

62. Id. at 269–70 (recounting how the Federation's guidelines left the impression that undertreating pain was substandard care). Over the years, physicians have in fact been held civilly liable for undertreatment of pain. See, e.g., Maria L. La Ganga & Terence Monmaney, Doctor Found Liable in Suit Over Pain, L.A. Times (June 15, 2001), <https://www.latimes.com/archives/la-xpm-2001-jun-15-mn-10726-story.html> (on file with the *Columbia Law Review*) (detailing a \$1.5 million jury verdict against a doctor for the undertreatment of his patient's pain).

63. See Hoffmann, *supra* note 41, at 270 n.291 (noting how, as of 2008, “[m]ore physicians [we]re prescribing Schedule II narcotics to a larger number of patients, and the dosages prescribed to these patients ha[d] increased markedly” over the preceding decade).

64. Stephen A. Bernard, Paul R. Chelminski, Timothy J. Ives & Shabbar I. Ranapurwala, Management of Pain in the United States—A Brief History and Implications for the Opioid Epidemic, 11 *Health Servs. Insights*, 2018, at 2, <https://doi.org/10.1177/1178632918819440> (on file with the *Columbia Law Review*).

65. Hoffmann, *supra* note 41, at 234, 273. The DEA defines Schedule II drugs as those “with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.” Drug Scheduling, DEA, <https://www.dea.gov/drug-information/drug-scheduling> [<https://perma.cc/CQ5R-9HPZ>] (last visited Oct. 5, 2023).

66. Marcia L. Meldrum, The Ongoing Opioid Prescription Epidemic: Historical Context, 106 *Am. J. Pub. Health* 1365, 1366 (2016).

67. Between 2000 and 2014, overdoses involving heroin and prescription opioids increased 200%. Id.

overdoses.⁶⁸ Over 150 people a day died from overdoses caused by fentanyl and other synthetic opioids between 2015 and 2020.⁶⁹

It is hard to overstate the devastating impact of opioid abuse in this country. The human toll has been staggering—more than 500,000 opioid-involved deaths since 2000⁷⁰—as has the economic one—costing the United States nearly \$1.5 trillion in 2020 alone.⁷¹ Unsurprisingly, a crisis of this magnitude has garnered intense desire by both law enforcement and the public to hold accountable those responsible for fueling it.⁷² Doing so is challenging because, in addition to unlawful domestic distribution, a large supply of opioids—particularly fentanyl—enters illegally from abroad.⁷³ While enforcement efforts have taken many forms, unscrupulous doctors have been a central target, much like during the addiction crisis of the early twentieth century.

2. *Enforcement Efforts Against Doctors.* — As OxyContin’s popularity skyrocketed in the early 2000s, DEA agents detected widespread “diversion of the drug from legitimate users to [people with SUDs].”⁷⁴ They also noticed links between OxyContin and overdose deaths, pharmacy robberies, and other crimes.⁷⁵ At the same time, the DEA faced political criticism for not having made a measurable difference in the illegal drug supply in the country and wanted a “new front” for its battle.⁷⁶ Consequently, the agency turned its attention to the physicians and pharmacists responsible for the overprescription of OxyContin,⁷⁷ targeting

68. Fentanyl Facts, CDC, <https://www.cdc.gov/stopoverdose/fentanyl/index.html> [<https://perma.cc/7MNR-NE3H>] (last updated June 27, 2023) (“Fentanyl and other synthetic opioids are the most common drugs involved in overdose deaths.” (citing Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV & Nicole L. Davis, Drug and Opioid-Involved Overdose Deaths—United States, 2017–2018, 69 *Morbidity & Mortality Wkly. Rep.* 290, 290–97 (2020))).

69. *Id.*

70. CBO, *The Opioid Crisis and Recent Federal Policy Responses* 6 (2022), <https://www.cbo.gov/system/files/2022-09/58221-opioid-crisis.pdf> [<https://perma.cc/E9BZ-YGRX>].

71. Joint Econ. Comm. Democrats, *The Economic Toll of the Opioid Crisis Reached Nearly \$1.5 Trillion in 2020*, at 1–2 (2022), https://www.jec.senate.gov/public/_cache/files/67bcd7f4232-40ea-9263-f033d280c567/jec-cost-of-opioids-issue-brief.pdf [<https://perma.cc/X29H-WZGT>].

72. See *infra* notes 74–81 and accompanying text (describing law enforcement efforts); *infra* note 119 (describing desire for increased physician accountability).

73. See Seth Adam Meinero, *Danger in Milligrams and Micrograms: United States Attorneys’ Offices Confront Illicit Fentanyls*, 66 *U.S. Att’y’s Bull.*, July 2018, at 5, 9 (noting that Chinese companies are the primary source of illicit fentanyl in the United States).

74. Hoffmann, *supra* note 41, at 273.

75. *Id.*

76. *Id.* at 234 (internal quotation marks omitted) (quoting Ronald T. Libby, *Cato Inst., Pol’y Analysis No. 545, Treating Doctors as Drug Dealers: The DEA’s War on Prescription Painkillers* 4 (2005), <https://www.cato.org/sites/cato.org/files/pubs/pdf/pa545.pdf> [<https://perma.cc/W8EZ-VZT5>]).

77. *Id.* at 273.

professionals operating “pill mills” that issued excessive opioid prescriptions to people with known SUDs or to sellers for personal profit.⁷⁸

Over the years, the Justice Department has launched a series of enforcement campaigns aimed at those professionals.⁷⁹ For example, in 2017, then-Attorney General Jeff Sessions announced the formation of the Opioid Fraud and Abuse Detection Unit, which uses data analytics to identify and prosecute health care professionals diverting or dispensing prescription opioids for illegitimate purposes.⁸⁰ The program looks for statistical outliers—pharmacists and physicians that prescribe and dispense at rates far exceeding their peers—because, in the words of Sessions, “[f]raudsters might lie, but the numbers don’t.”⁸¹ In his announcement, Sessions issued a clear warning to doctors and pharmacists: “If you are a doctor illegally prescribing opioids for profit . . . we are coming after you.”⁸²

Without a public tracking database, it is difficult to pinpoint the exact number of physicians who have been investigated, arrested, or prosecuted as part of these enforcement campaigns.⁸³ One recent study, which tried to capture all the opioid-related cases brought against physicians using a comprehensive search of media reports, identified only 372 cases between

78. See, e.g., *id.* at 242 (recounting an indictment containing fifty drug-related charges against a doctor who allegedly ran a “pill mill” from his office).

79. In 2001, the DEA announced the OxyContin Action Plan, through which it targeted doctors, pharmacists, and dentists by pledging to scrutinize the distribution of prescription opioids as if they were non-prescription street drugs. See *id.* at 280 (describing the plan); *id.* at 234 (noting that the plan “raised the level of scrutiny DEA applied to opioid analgesic use to the level applied to non-prescription street drugs such as cocaine, heroin, and marijuana”). In 2004, the agency developed the National Action Plan, targeting “key sources of OxyContin and other opioids, including medical professionals it considers unscrupulous.” *Id.* at 281 (internal quotation marks omitted) (quoting Melina Ammann, *The Agony and the Ecstasy: How the OxyContin Crackdown Hurts Patients in Pain*, Reason (Apr. 2003), <https://reason.com/2003/04/01/the-agony-and-the-ecstasy-2/> [<https://perma.cc/6U7D-RPZR>]).

80. Press Release, DOJ, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017), <https://www.justice.gov/opa/pr/attorney-general-sessions-announces-opioid-fraud-and-abuse-detection-unit> [<https://perma.cc/8YMW-MXRU>].

81. Jeff Sessions, Att’y Gen., Remarks at “West Virginia on the Rise: Rebuilding the Economy, Rebuilding Lives” (Sept. 21, 2017), <https://www.justice.gov/opa/speech/attorney-general-sessions-delivers-remarks-west-virginia-rise-rebuilding-economy> [<https://perma.cc/P4YY-HU3Q>].

82. Press Release, DOJ, *supra* note 80. Over the years, the media has amplified and encouraged this aggressive enforcement rhetoric against physicians, creating yet “[a]nother [b]out of [d]rug [h]ysteria.” Ronald T. Libby, *Cato Inst., Pol’y Analysis No. 545, Treating Doctors as Drug Dealers: The DEA’s War on Prescription Painkillers* 7 (2005), <https://www.cato.org/sites/cato.org/files/pubs/pdf/pa545.pdf> [<https://perma.cc/W8EZ-VZT5>].

83. Hoffmann, *supra* note 41, at 236.

1995 and 2019.⁸⁴ The number of DEA investigations over the years has been far larger, however, with 861 DEA investigations of doctors in 2001 alone.⁸⁵ While the number of actual prosecutions may seem low, particularly when compared to more than 77,000 medical professionals prosecuted in the early years of the Harrison Act,⁸⁶ these prosecutions have sent similar shock waves through the medical profession.⁸⁷

3. *The Chilling Effect and the Supreme Court's Response.* — The volume of prescription opioids has shrunk dramatically in recent years,⁸⁸ and the government's highly publicized arrests and prosecutions have been cited as a primary contributor to the declining prescription rates.⁸⁹ For a profession otherwise regulated by state medical boards and medical malpractice suits, the threat, however small, of criminal prosecution under the CSA and its punitive sentencing scheme fundamentally changes the risk calculus for doctors involved in the pain management field and those considering entering it.⁹⁰

To the extent that the downturn reflects a reduction in pill mills and unscrupulous prescription activity, it should be lauded as criminal deterrence in action. There is evidence to suggest, however, that the arrests have also chilled the provision of legal pain treatment by frightening physicians out of adequately treating patients with chronic pain or out of the field of pain management entirely.⁹¹ A 2001 study of California primary care doctors found that forty percent felt that fear of investigation affected how they treated chronic pain.⁹² In recent years, reports of the “chilling effect” have only proliferated. In some states today, waits to see a pain management specialist have increased to a year or

84. Julia B. Berman & Guohua Li, Characteristics of Criminal Cases Against Physicians Charged With Opioid-Related Offenses Reported in the US News Media, 1995–2019, 7 *Inj. Epidemiology*, no. 50, 2020, at 1, 1–2, <https://doi.org/10.1186/s40621-020-00277-8> [<https://perma.cc/YC6E-B8BA>]. The study does not differentiate between charges brought by state versus federal authorities.

85. Hoffmann, *supra* note 41, at 236.

86. See *supra* text accompanying note 26.

87. See Jeffrey A. Singer & Trevor Burrus, Cato Inst., Cops Practicing Medicine: The Parallel Histories of Drug War I and Drug War II, at 2–3 (2022), https://www.cato.org/sites/cato.org/files/2022-11/Singer_Cops%20Practicing%20Medicine_web_0.pdf [<https://perma.cc/N3N4-B9LB>] (comparing enforcement experiences and reactions under the Harrison Act and the CSA).

88. See *id.* at 17 (“The [opioid] prescription rate is now below the 2002 rate . . .”).

89. See Libby, *supra* note 82, at 3 (“[A] significant reason pain is undertreated—and increasingly so—is the government’s decision to prosecute pain doctors who it says overprescribe prescription narcotics.”).

90. See *id.* (explaining how the “highly publicized indictments and prosecutions have frightened many physicians out of the field of pain management”).

91. See *id.* (noting there are “only a few thousand doctors in the country who are still willing to risk prosecution and ruin in order to treat patients suffering from severe chronic pain”).

92. See *id.*

longer,⁹³ causing patients to drive “extraordinary distances to find or continue seeing doctors.”⁹⁴ Many physicians, “fearful of the financial and legal peril in prescribing opioids,” have stopped prescribing them altogether,⁹⁵ or they have pawned off their patients to other doctors to write the prescriptions.⁹⁶ But the exact scale of any chilling effect is difficult to know. While the significant reduction in opioid prescriptions is clear, it is not clear how much of that decline reflects the correction of past abuses versus the chilling of legitimate medical care.

One of the primary complaints from physicians is the ambiguity of the “legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice” language in the CSA regulation.⁹⁷ The Supreme Court’s decision in *United States v. Moore*,⁹⁸ which relied largely on NATA, provided only modest clarity given the case’s flagrant facts, and the Court has not expounded on the issue since.⁹⁹ The courts of appeals have likewise provided little help, declining to adopt a “preestablished list of prohibited acts”¹⁰⁰ or “specific guidelines”¹⁰¹ in favor of a more nebulous “case-by-case approach.”¹⁰²

93. Josh Bowers & Daniel Abrahamson, Cato Inst., Pol’y Analysis No. 894, *Kicking the Habit: The Opioid Crisis and America’s Addiction to Prohibition 10* (2020), https://www.cato.org/sites/cato.org/files/2020-06/PA894_doi.pdf [<https://perma.cc/H6AA-U3YH>].

94. Terrence McCoy, ‘Unintended Consequences’: Inside the Fallout of America’s Crackdown on Opioids, *Wash. Post* (May 31, 2018), <https://www.washingtonpost.com/graphics/2018/local/impact-of-americas-opioid-crackdown> (on file with the *Columbia Law Review*).

95. *Id.*

96. See Ohio State Univ. Moritz Coll. of L., *Ruan v. United States: Implications for Criminal Law, Health Care, and Beyond*, YouTube, at 31:20–32:32 (Sept. 23, 2022), https://www.youtube.com/watch?v=__EGfB0sCDk (on file with the *Columbia Law Review*). This panel discussion features physician Martin Fried, M.D., who recounts receiving many referrals for opioid prescriptions from colleagues who did not want to prescribe them out of fear of legal culpability.

97. See 21 C.F.R. § 1306.04(a) (2023); Hoffmann, *supra* note 41, at 284 (noting how disagreement over what constitutes “legitimate medical practice” is often “[a]t issue in many of the cases brought against physicians prescribing opioids”).

98. 423 U.S. 122 (1975).

99. See *supra* text accompanying notes 56–59.

100. *United States v. Volkman*, 797 F.3d 377, 386 (6th Cir. 2015) (citing *United States v. Kirk*, 584 F.2d 773, 784 (6th Cir. 1978)).

101. *United States v. August*, 984 F.2d 705, 713 (6th Cir. 1992) (citing *Kirk*, 584 F.2d at 784).

102. *Volkman*, 797 F.3d at 386 (citing *Kirk*, 584 F.2d at 784). In 2005, in response to concerns from stakeholders about the chilling effect of its investigations, the DEA sought to provide clarity to frightened physicians by eliciting questions from them and other interested persons to address in a future policy document. The resulting policy statement, however, simply articulated what the courts had been saying for years: that “it is not possible to expand on the phrase ‘legitimate medical purpose in the usual course of professional practice’ . . . [to] address all the varied situations physicians might encounter. . . . [O]ne cannot provide an exhaustive and foolproof list of ‘do and don’ts.’” Hoffmann, *supra* note 41, at 282–84 (internal quotation marks omitted) (quoting Dispensing

Another cause for concern for doctors is the mens rea requirement for conviction under § 841(a)(1) of the CSA. When the defendant is a lay person, the mens rea requirement is simply that the violation—the distribution of a controlled substance—must be knowing or intentional.¹⁰³ Prosecuting a physician, however, requires proof of an added component: that the prescription was without a legitimate medical purpose or outside the usual course of the doctor’s professional practice.¹⁰⁴ Courts of appeals have split on what mens rea attaches to that component, a question that significantly affects the proof required for convicting physicians. In June 2022, however, almost fifty years after the CSA was passed, the Supreme Court in *Ruan* finally clarified the appropriate mens rea for convicting physicians under the statute.

Prior to *Ruan*, the Fourth, Tenth, and Eleventh Circuits had adopted an objective mens rea standard in applying the “usual course of professional practice” language.¹⁰⁵ The Tenth Circuit held that the Government could convict a physician by proving that he “issued a prescription that was objectively not in the usual course of professional practice . . . regardless of whether he [subjectively] believed he was doing so.”¹⁰⁶ The Eleventh Circuit agreed, holding that “[w]hether a defendant acts in the usual course of his professional practice must be evaluated based on an objective standard, not a subjective standard.”¹⁰⁷ In so holding, the Eleventh Circuit eliminated a physician’s subjective good faith as a complete defense to conviction because it “failed to include the objective standard by which to judge the physician’s conduct.”¹⁰⁸ The Fourth Circuit similarly ruled that the inquiry into the physician’s good faith “must be an objective one.”¹⁰⁹ Thus, in three circuits, the statute’s “knowingly or intentionally” language only attached to the actus reus—the act of writing the prescription—which, as one scholar noted, was easily met “unless the prescriber [wrote it] in their sleep.”¹¹⁰

Controlled Substances for the Treatment of Pain, 71 Fed. Reg. 52,716, 52,717, 52,719 (Sept. 6, 2006)).

103. See 21 U.S.C. § 841(a) (2018) (specifying the mens rea of “knowingly or intentionally” for CSA violations).

104. See *id.* (exempting “authorized” drug prescriptions from CSA coverage); 21 C.F.R. § 1306.04(a) (2023) (defining “authorized” prescriptions as those issued “for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice”).

105. See *United States v. Khan*, 989 F.3d 806, 825 (10th Cir. 2021); *United States v. Ruan*, 966 F.3d 1101, 1166 (11th Cir. 2020); *United States v. Hurwitz*, 459 F.3d 463, 479 (4th Cir. 2006).

106. *Khan*, 989 F.3d at 825.

107. *Ruan*, 966 F.3d at 1166 (alteration in original) (internal quotation marks omitted) (quoting *United States v. Joseph*, 709 F.3d 1082, 1097 (11th Cir. 2013)).

108. *Id.*

109. *Hurwitz*, 459 F.3d at 479.

110. Kelly K. Dineen Gillespie, *Ruan v. United States*: “Bad Doctors,” Bad Law, and the Promise of Decriminalizing Medical Care, 2021–2022 *Cato Sup. Ct. Rev.* 271, 301.

When the Court granted certiorari in *Ruan*, the medical profession responded aggressively, filing numerous amicus briefs outlining the objective standard's chilling effect on legitimate pain treatment. As the National Pain Advocacy Center wrote, "erroneous judicial interpretations of the Controlled Substances Act (CSA) . . . overly deter [physicians] from prescribing [pain] medication[] and keep them from exercising the best medical judgment for their patients."¹¹¹ Another organization, Physicians Against Abuse, argued that the objective standard simply created a "war of experts," in which criminal liability depends on who hired the "more believable, more charismatic" expert.¹¹²

At issue in *Ruan* were two cases from the Tenth and Eleventh Circuits¹¹³ that were consolidated on appeal. Both involved doctors with licenses to prescribe controlled substances who had been convicted of distributing opioids in violation of § 841.¹¹⁴ The doctors argued that their prescriptions were lawful because they fell within § 841's "as authorized" exception, allowing prescriptions for "a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."¹¹⁵ The issue before the Court was whether, in such prosecutions, the Government is required to prove that a defendant subjectively knew that his prescriptions fell outside the scope of his prescribing authority. In a result that surprised many court-watchers, the Court rejected the mens rea standard proposed by the Government, which would have required proof only that the defendant failed to make an "objectively reasonable good-faith effort" to act within his prescribing authority, and instead concluded that the statute requires proof of the defendant's actual knowledge of his lack of authority.¹¹⁶

In his opinion for the Court, Justice Stephen Breyer reasoned that the statute's "knowingly or intentionally" language applies to the "except as authorized" clause even though that proviso is not an element of the crime.¹¹⁷ He concluded that the proviso functioned "sufficiently like an element" to justify requiring the Government to prove the defendant's subjective mens rea for several reasons.¹¹⁸ Those reasons include the

111. Brief for Amicus Curiae National Pain Advocacy Center in Support of Petitioners at 1, *Ruan v. United States*, 142 S. Ct. 2370 (2022) (Nos. 20-1410, 21-5261), 2021 WL 6138191.

112. Brief Amicus Curiae for Physicians Against Abuse in Support of Petitioner (Corrected) at 6, *Ruan*, 142 S. Ct. 2370 (No. 20-1410), 2022 WL 478202.

113. See *United States v. Khan*, 989 F.3d 806 (10th Cir. 2021); *Ruan*, 966 F.3d 1101.

114. Dr. Ruan and Dr. Kahn were sentenced to twenty and twenty-five years in prison, respectively, and Dr. Ruan was ordered to pay millions of dollars in restitution and forfeiture. See *Ruan*, 142 S. Ct. at 2375–76.

115. 21 U.S.C. § 841(a) (2018); 21 C.F.R. § 1306.04(a) (2023).

116. *Ruan*, 142 S. Ct. at 2381.

117. *Id.* at 2376.

118. *Id.* at 2380. Justice Alito, in a concurrence joined in full by Justice Thomas and in part by Justice Barrett, concluded that because the "as authorized" language was not an element of the crime, it should be treated as an affirmative defense and that, in accordance

critical role that being authorized plays in distinguishing “morally blameworthy conduct from socially necessary conduct,” the seriousness of the crime and its penalties, and the vague and general language contained in the regulation defining a doctor’s prescription authority.¹¹⁹ Justice Breyer thus concluded that to prosecute a doctor for illegal prescriptions under § 841, the Government must prove beyond a reasonable doubt not only that the doctor knowingly or intentionally wrote the prescriptions but also that the doctor did so knowing that they were acting without authorization.¹²⁰

Justice Breyer recognized that the regulation defines the scope of a doctor’s authorization using objective criteria, such as “legitimate medical purpose” and “usual course” of a doctor’s medical practice.¹²¹ But he concluded that those objective terms do not turn the statute’s mens rea requirement into an objective one. According to Justice Breyer, those objective criteria provide a standard against which courts and juries can measure the credibility of the defendant’s professed belief that their prescription was authorized, but § 841 nonetheless requires the defendant to have actually known that they lacked authorization.¹²² The Court’s decision has been widely lauded by doctors and scholars concerned with how the fear of criminal punishment has affected legitimate pain treatment.¹²³

with common law principles, “the defendant had the burden of production and persuasion.” *Ruan*, 142 S. Ct. at 2387 (Alito, J., concurring in the judgment). Notwithstanding their differences about who bears the burden of proving authorization or lack thereof under the CSA, the concurrence and the majority agree that a subjective, rather than an objective, mens rea standard applies to a defendant relying on the authorization exception. See *id.* at 2389 (“I would thus hold that a doctor who acts in subjective good faith in prescribing drugs is entitled to invoke the CSA’s authorization defense.”).

119. *Id.* at 2380 (majority opinion).

120. *Id.* at 2382 (requiring that a defendant know their conduct was “unauthorized” to sustain a conviction under § 841). Justice Alito argued that the Court should not have addressed the Government’s burden of proof with respect to the authorization exception because the Court did not grant certiorari on that question, nor did the parties brief it. *Id.* at 2383–84 (Alito, J., concurring in the judgment). In keeping with his view that the authorization exception is best treated as an affirmative defense, however, Justice Alito concluded that there was no reason to conclude that Congress “intended to impose a burden on the Government to disprove all assertions of authorization beyond a reasonable doubt.” *Id.* at 2384. He noted that the “usual rule is that affirmative defenses must be proved ‘by a preponderance of the evidence.’” *Id.* at 2387 (quoting *Dixon v. United States*, 548 U.S. 1, 17 (2006)).

121. *Id.* at 2382 (majority opinion) (internal quotation marks omitted) (quoting 21 C.F.R. § 1306.04(a) (2021)).

122. *Id.* (“As we have said before, ‘the more unreasonable’ a defendant’s ‘asserted beliefs or misunderstandings are,’ especially as measured against objective criteria, ‘the more likely the jury . . . will find that the Government has carried its burden of proving knowledge.’” (alteration in original) (quoting *Cheek v. United States*, 498 U.S. 192, 203–04 (1991))).

123. See, e.g., Maia Szalavitz, A Recent Supreme Court Ruling Will Help People in Pain, *Sci. Am.* (Sept. 19, 2022), <https://www.scientificamerican.com/article/a-recent->

4. *Ruan's Implications for Abortion Statutes.* — The sensibilities that drove the Court to its conclusion in *Ruan* have implications for abortion statutes in the post-*Dobbs* era. Central to its analysis is the criminal law principle that, with few exceptions, “wrongdoing must be conscious to be criminal.”¹²⁴ Thus, criminal statutes are presumed to target those with a “culpable mental state”—that is, defendants who know that what they are doing is wrong.¹²⁵ According to *Ruan*, the presumption that a criminal statute should include a scienter element is especially applicable to statutes, such as § 841, that carry severe penalties, including life imprisonment and substantial fines.¹²⁶

Other components of *Ruan's* rationale are also particularly relevant to the abortion context, in which, like the CSA, statutes seek to criminalize conduct that, under different circumstances, would be socially desirable. *Ruan* concluded that when the same conduct by a doctor can either be “socially beneficial” or criminal depending on the circumstances, the mens rea for conviction should be actual knowledge that the charged conduct is wrong.¹²⁷ That requirement not only comports with criminal law’s intention to target persons of “vicious will” but it also reduces the chilling effect on doctors’ legitimate services.¹²⁸ The *Ruan* Court observed that the need for a scienter requirement increases when the line dividing

supreme-court-ruling-will-help-people-in-pain/ [https://perma.cc/J6MV-SL6X]. Less pleased, however, will be those who believe doctors are underprosecuted relative to their culpability, given that *Ruan* only makes it harder to convict physicians under § 841. Even before the Court’s ruling in *Ruan*, some suggested that federal prosecutors had not been aggressive enough in targeting the relatively small group of doctors responsible for significant contributions to the opioid crisis. See Karly Newcomb, Defying “Do No Harm”: Doctors Are Fueling the Opioid Crisis With Limited Criminal Repercussions, 11 *Crim. L. Prac.* 59, 59–60 & n.5 (2021) (noting the “inadequate prosecutorial responses” to the “minority” of doctors “illegally prescribing opioids and contributing to [the] crisis”). Justice Breyer addressed this concern by noting that “the Government, of course, can prove knowledge through circumstantial evidence.” *Ruan*, 142 S. Ct. at 2382. Such circumstantial evidence, termed by lower courts as “red flags,” might include: patients traveling from geographically distant locations to the doctor’s office; incomplete or no medical exams to verify alleged pain; failure to offer alternatives, such as non-opioid-based pain management; the absence of a gradual increase from less addictive pain medications to opioids; patients without medical insurance paying cash for each visit; a high number of pills prescribed; and doctors who write and fill prescriptions themselves for cash. See Bingzi Hu, Physician’s Potential Criminal Liability for Prescribing Medications, *Law. Monthly* (June 30, 2020), <https://www.lawyer-monthly.com/2020/06/physicians-potential-criminal-liability-for-prescribing-medications/> [https://perma.cc/7L7Q-JBBY] (citing *United States v. Joseph*, 709 F.3d 1082, 1104 (11th Cir. 2013); *United States v. Katz*, 445 F.3d 1023, 1031 (8th Cir. 2006)).

124. *Ruan*, 142 S. Ct. at 2376 (citing *Elonis v. United States*, 575 U.S. 723, 734 (2015)). The Court acknowledges that there are some strict liability crimes that “fall outside the scope of ordinary scienter requirements.” *Id.* at 2378. Such crimes, however, are generally “regulatory or public welfare offense[s] that carr[y] only minor penalties.” *Id.*

125. *Id.* at 2377.

126. *Id.* at 2378.

127. *Id.* at 2377.

128. *Id.* at 2376.

wrongful and innocent conduct is not susceptible to clear guidelines—an absence of clarity that is frequently present when potential criminal conduct involves medical judgment.¹²⁹

Though not explicitly, Justice Breyer may have also been motivated by constitutional principles, including a line of cases reading a heightened mens rea requirement into statutes that may otherwise be unconstitutionally vague under the Due Process Clause.¹³⁰ In these cases, the Court reasons that requiring evidence of specific intent to violate a statute mitigates any concern that the statute’s vagueness deprived defendants of fair warning that their conduct was illegal.¹³¹ In the context of the CSA, requiring physicians to subjectively know that their prescriptions were not for a “legitimate medical purpose” or were not issued in the “usual course of professional practice” ensures that defendants will not be surprised by their criminal exposure, even when precise definitions of the quoted terms are unavailable. As argued below, the same constitutional argument applies in the abortion context, where subjective knowledge could also mitigate the due process concerns posed by the new abortion bans.¹³²

In sum, the *Ruan* Court concluded that if a statute seeks to impose severe criminal sanctions on doctors for actions that resemble their lawful professional activity, and if the statute cannot provide a clear line dividing legal from illegal conduct, the mens rea required for conviction should be subjective knowledge that one’s behavior is illegal. Nowhere do those factors, which are so instrumental in the *Ruan* Court’s decision, present themselves more clearly than in cases regulating doctors providing emergency abortion services.

II. THE NEW ABORTION FRONTIER

In *Ruan*’s same Term, the Supreme Court decided *Dobbs v. Jackson Women’s Health Organization*.¹³³ In *Dobbs*, the Court returned the regulation of abortion to the states without constitutional limitation,¹³⁴ thus

129. *Id.* at 2377.

130. See *id.* at 2380 (noting that the statute’s “vague, highly general language . . . support[s] applying normal scienter principles to the ‘except as authorized’ clause”).

131. See *Boyce Motor Lines, Inc. v. United States*, 342 U.S. 337, 342 (1952) (“Th[e] requirement of the presence of culpable intent as a necessary element of the offense does much to destroy any force in the argument that application of the Regulation would be so unfair that it must be held invalid.”); *Screws v. United States*, 325 U.S. 91, 102 (1945) (“The requirement that the [violative] act must be willful or purposeful . . . does relieve the statute of the objection that it punishes without warning an offense of which the accused was unaware.”).

132. See *infra* section II.B (arguing for subjective mens rea requirements in the abortion context to address vagueness concerns).

133. 142 S. Ct. 2228 (2022).

134. See *id.* at 2243 (“It is time to heed the Constitution and return the issue of abortion to the people’s elected representatives.”).

beginning another era of criminal regulation of doctors' medical judgments—this time, in the highly politicized realm of abortion. Trigger statutes in several states immediately went into effect, and state legislatures began drafting new statutes significantly curtailing access to abortions.¹³⁵ While the new state statutes vary significantly, they all recognize that abortion is legal in one context: medical emergencies to save the life or health of the pregnant person.¹³⁶ Thus, in all fifty states, physicians can legally perform abortions in emergency circumstances when the pregnant person's life is at risk.¹³⁷ But just as in the drug context, a physician's treatment decision can give rise to criminal liability if the government disputes its necessity.

In many ways, the criminal regulation of drug prescriptions and abortion services presents a similar risk of chilling the provision of legal and efficacious health care to patients. The politicization of the abortion issue, the county-by-county (rather than federal) enforcement scheme, and the desire in some corners to eliminate abortion completely, however, arguably put abortion providers in an even more vulnerable position than their opioid-prescribing colleagues. Despite *Ruan's* contemporaneous reminder that subjective mens rea standards can diminish the chilling effect on criminalized medical judgments, many of the new abortion statutes do not create such a standard and, on their face, embrace an objective one.¹³⁸ This Part argues that, with the guidance provided by *Ruan*, state courts should apply the subjective mens rea requirement that their statutes accord to the actus reus of the crime to the emergency exception as well. Such a construction comports with the longstanding principles of criminal law, accommodates the Fourteenth Amendment's notice requirements, and helps ensure that patients receive the lifesaving care they need.

This Part begins with a brief explanation of how courts construed the mens rea requirement for prosecuting abortion providers in the pre-*Dobbs* era. Like today's post-*Dobbs* era, this period also featured state abortion laws containing life-of-the-mother exceptions. But such laws were passed—and interpreted by courts—against the backdrop of a constitutional right to abortion outlined in *Roe* and *Casey*.

135. Abortion Ruling Prompts Variety of Reactions From States, *supra* note 3 (detailing the legislative activity in each state post-*Dobbs*).

136. Michael Scherer & Rachel Roubein, More Republicans Push for Abortion Bans Without Rape, Incest Exceptions, *Wash. Post* (July 15, 2022), <https://www.washingtonpost.com/politics/2022/07/15/abortion-exceptions-republicans/> (on file with the *Columbia Law Review*) (last updated July 16, 2022) (noting that all abortion bans that have gone into effect since *Dobbs* “include an exception for life of the [pregnant person]”).

137. See *id.*

138. See *infra* section II.B (describing state abortion statutes that use objective language in their emergency exceptions).

This Part then turns to *Dobbs*, which removed the constitutional protections of *Roe* and *Casey* and prompted the passage of new abortion statutes. Looking at the twenty strictest criminal abortion bans passed in the wake of *Dobbs*, including those banning abortions after fifteen weeks of pregnancy or earlier, this Part examines those statutes' emergency exceptions and any statutory language suggesting that an objective mens rea requirement might apply to them.¹³⁹ In this post-*Dobbs* era, these statutes will no longer be scrutinized by courts as regulations of a constitutionally protected right but instead simply as criminal statutes regulating medical judgment. In this new interpretive posture, the constitutional rights of the doctor as a potential criminal defendant and the common-law principles of criminal law espoused in *Ruan* will take center stage. This Part concludes by arguing that both of these considerations should lead state courts to apply statutes' subjective mens rea requirements to their emergency exceptions.

A. *Mens Rea for Abortion Providers Before Dobbs*

Immunity from criminal prosecution for physicians performing abortions to protect the health and life of the pregnant person, also known as therapeutic abortions, has a long history in the common law.¹⁴⁰ As states began to codify abortion bans, they largely incorporated this common-law exception, either through explicit carve-outs for therapeutic abortions or through mens rea provisions requiring that a doctor act "maliciously" in performing an abortion to warrant criminal prosecution.¹⁴¹ The Model Penal Code, drafted in 1962, also recognized therapeutic exceptions to criminal abortion when there was grave risk to the physical or mental health of the pregnant person, and similar statutes existed in at least twelve states as of the time the Court decided *Roe*.¹⁴²

139. See *infra* Appendix A (providing the relevant statutory language of all twenty state statutes criminally banning abortion after fifteen weeks or earlier, with Oklahoma's statute intentionally excluded because it provides for only civil, rather than criminal, penalties for violations).

140. See Monica E. Eppinger, *The Health Exception*, 17 *Geo. J. Gender & L.* 665, 693 (2016) (noting that "therapeutic intent doctrine became the standard statement of the common law on abortion" in seventeenth-century England). This immunity generally came in the form of a therapeutic defense, shielding the good-faith provider from homicide prosecution in the unfortunate event of a patient's death. *Id.*

141. See *id.* at 721–22. In the nineteenth and twentieth centuries, the law deferred heavily to medical professionals' judgment of the "medical necessity" of an abortion under these exceptions. While in some ways this reliance narrowed the applicability of the defense to more "technical grounds," it also at times led to its expansion. For example, as sociology and public health experts exposed the link between socioeconomic status and health, doctors began to view a patient's poverty as a social indicator for abortion under statutory health exceptions. With the rise in attention to psychiatry, protecting mental health was similarly invoked to justify abortions under the same exceptions. See *id.* at 739–40.

142. See Geoffrey R. Stone, *The Road to Roe*, *Litigation*, Fall 2016, at 43, 45.

The Court's decision in *Roe* fundamentally altered the legal landscape for abortion by recognizing for the first time the fundamental right to an abortion. The case has, however, been characterized as (and criticized for) being more of an ode to physician autonomy than to patient liberty.¹⁴³ Specifically, the Court held that during the first trimester of a pregnancy, states must leave physicians "free to determine, without regulation by the State, that, in [their] medical judgment, the patient's pregnancy should be terminated."¹⁴⁴ After the first trimester but before fetal viability, the Court permitted abortion regulations, but only those that "reasonably relate[d] to the preservation and protection of maternal health."¹⁴⁵ After the fetus became viable, however, a state could "go so far as to proscribe abortion" except when "it is necessary, in appropriate medical judgment, for the preservation of the life or health of the [pregnant patient]."¹⁴⁶

Roe did not preempt all state regulation of abortion; it simply created a constitutional right that state statutes could not disturb within its parameters. As states passed abortion regulations, some of which included criminal penalties for doctors, courts contended with the issue of what mens rea standards state laws could incorporate without running afoul of *Roe*. The Supreme Court's opinions in cases largely written by Justice Harry Blackmun, the author of the *Roe* majority opinion, left a legacy notable for its insistence on mens rea standards that defer to doctors' subjective medical judgment about whether to perform an abortion.

The first example, *Doe v. Bolton*, was decided on the same day as *Roe* in another Justice Blackmun opinion.¹⁴⁷ *Doe* was a void-for-vagueness challenge to a statute making abortion a crime except when it is "based upon [the physician's] best clinical judgment that an abortion is necessary."¹⁴⁸ Far from finding the term "necessary" unconstitutionally vague, the Court instead praised the law for giving physicians room to consider "all factors . . . relevant to the well-being of the patient" and to make their "best medical judgment."¹⁴⁹ The Court effectively concluded that the vagueness of the term "necessary" did not put doctors in unfair jeopardy because the statute deferred to their subjective judgment.

143. See, e.g., Andrea Asaro, The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion, 6 Harv. Women's L.J. 51, 53 (1983) ("Unfortunately, . . . [Justice] Blackmun subsumed the [pregnant person's] right to privacy within the ambit of the doctor-patient relationship, and ultimately subordinated [their] interest to the physician's.").

144. *Roe v. Wade*, 410 U.S. 113, 163 (1973), overruled by *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

145. *Id.*

146. *Id.* at 163, 165.

147. 410 U.S. 179 (1973), abrogated in part by *Dobbs*, 142 S. Ct. 2228.

148. *Id.* at 191 (internal quotation marks omitted) (quoting Ga. Code § 26-1202(a) (1968)).

149. *Id.* at 192.

Another constitutional challenge to a state statute reached the Supreme Court six years after *Roe*, providing the Court with its first chance to address the specific issue of mens rea in a criminal abortion statute. The provision at issue in *Colautti v. Franklin* was section 5(a) of Pennsylvania's Abortion Control Act, which required every person who performs an abortion to first determine whether the fetus is or "may be" viable.¹⁵⁰ If the answer was yes, the statute then prescribed a standard of care for the abortion procedure.¹⁵¹ Under section 5(d), a physician who failed to abide by the standard of care when the fetus was viable was subject to the same criminal liability that would have applied had the fetus been murdered.¹⁵² Plaintiffs challenged the viability determination requirement as unconstitutionally vague.¹⁵³

The *Colautti* Court sided with plaintiffs in another opinion written by Justice Blackmun. The Court's concerns were centered on the ambiguity of the statute that could create criminal jeopardy for doctors without scienter.¹⁵⁴ The Court reasoned that the statute's lack of a mens rea requirement was particularly inappropriate here due to the "uncertainty of the viability determination itself"¹⁵⁵ and the likelihood that "experts will disagree over whether a particular fetus . . . has advanced to the stage of viability."¹⁵⁶ Because of this lack of clarity, the Court characterized the statute as "little more than 'a trap for those who act in good faith.'"¹⁵⁷ According to the Court, imposing strict liability for a decision so fraught "could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment."¹⁵⁸ Without articulating a required mens rea standard, the Court's decision in *Colautti* made clear that the mens rea requirement in an abortion law has the ability both to save the statute from a vagueness challenge¹⁵⁹ and to quell the chilling

150. 439 U.S. 379, 380 n.1 (1979) (internal quotation marks omitted) (quoting 35 Pa. Stat. and Cons. Stat. Ann. § 6605(a) (Purdon 1977) (repealed 1982)), abrogated in part by *Dobbs*, 142 S. Ct. 2228.

151. See *id.* ("[T]he abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive . . ." (internal quotation marks omitted) (quoting 35 Pa. Stat. and Cons. Stat. Ann. § 6605(a) (repealed 1982))).

152. See *id.* at 394–95 (describing how section 5(d) made Pennsylvania's criminal homicide law applicable to physicians who failed to comply with section 5(a)).

153. *Id.* at 389 ("The attack mounted by the plaintiffs-appellees upon § 5(a) . . . [is that it is] unconstitutionally vague because it fails to inform the physician when his duty to the fetus arises, and because it does not make the physician's good-faith determination of viability conclusive.").

154. See *id.* at 390 (finding the viability determination requirement ambiguous and its uncertainty "aggravated by the absence of a scienter requirement").

155. *Id.* at 395.

156. *Id.* at 396.

157. *Id.* at 395 (quoting *United States v. Ragen*, 314 U.S. 513, 524 (1942)).

158. *Id.* at 396.

159. In *Gonzales v. Carhart*, the Court reiterated the importance of mens rea in void-for-vagueness challenges, basing part of its decision to uphold the Partial-Birth Abortion Ban

effect that the law may have on the free exercise of a doctor's medical judgment.¹⁶⁰

In 1992, the Court revisited the constitutional right to abortion in *Casey*, abandoning *Roe's* trimester framework in favor of an "undue burden" standard.¹⁶¹ Under *Casey*, states were free to enact abortion regulations "designed to foster the health of a [pregnant person] seeking an abortion" before fetal viability so long as "they [did] not constitute an undue burden" on abortion access.¹⁶² After fetal viability, the state was free to regulate abortion to the same extent as under *Roe*.¹⁶³

Many states viewed *Casey* as an opportunity to further discourage abortions and passed laws placing a variety of procedural hurdles in the way of obtaining one.¹⁶⁴ Lower courts grappled with how the mens rea provisions of these new laws interacted with the constitutional principles espoused in *Casey* and its antecedents. In 1995, the Eighth Circuit considered a challenge to an abortion law provision that imposed criminal liability on providers without a scienter requirement.¹⁶⁵ Echoing *Colautti*, the Eighth Circuit expressed concern about the chilling effect that such a provision can have on a provider's willingness to perform even lifesaving abortions.¹⁶⁶ It held that that chilling effect created an undue burden on abortion access under *Casey* and struck down the provision.¹⁶⁷ A Michigan appeals court instead relied on *Roe* and *Doe* in reading a subjective mens rea standard into its state's emergency exception provision, reasoning that those cases stood for the need to accord adequate deference to the

Act of 2003, 18 U.S.C. § 1531 (2018), against a void-for-vagueness challenge on the "intent that must be proved to impose liability." 550 U.S. 124, 149 (2007).

160. Lower courts have since recognized that the decision that an abortion is necessary to save the life of the pregnant person is as "fraught with uncertainty" as the viability determination, making subjective mens rea equally important in that context. See, e.g., *People v. Higuera*, 625 N.W.2d 444, 461 (Mich. Ct. App. 2001) (Jansen, J., concurring in part and dissenting in part) (internal quotation marks omitted) (quoting *Women's Med. Pro. Corp. v. Voinovich*, 130 F.3d 187, 205 (6th Cir. 1997)).

161. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876 (1992) ("[T]he undue burden standard is the appropriate means of reconciling the State's interest with the [pregnant person's] constitutionally protected liberty."), overruled by *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

162. *Id.* at 878.

163. See *id.* at 879 (reaffirming *Roe's* standard for post-viability abortion regulation).

164. See Deepa Shivaram, *Roe Established Abortion Rights. 20 Years Later, Casey Paved the Way for Restrictions*, NPR (May 6, 2022), <https://www.npr.org/2022/05/06/1096885897/roe-established-abortion-rights-20-years-later-casey-paved-the-way-for-restricti> [<https://perma.cc/H382-R3FF>] (noting that the "grey area" of what was an undue burden "opened the door for states to pass laws" that created procedural hurdles in the abortion-seeking process).

165. See *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452 (8th Cir. 1995).

166. See *id.* at 1465 (holding that, due to the statute's lack of a scienter requirement, the provision creating criminal liability would impose an undue burden by chilling the willingness of physicians to perform lifesaving abortions).

167. See *id.*

physician's exercise of their medical judgment.¹⁶⁸ Other state statutes had combined subjective and objective mens rea elements and were struck down as unconstitutionally vague and inhibitory of constitutionally protected rights.¹⁶⁹ In contrast, courts largely upheld statutes that left the determination of a medical emergency necessitating an abortion up to the subjective discretion of the doctor.¹⁷⁰ Taken together, these lower court decisions show a more consistent preference for a subjective mens rea standard for evaluating medical judgments, as well as a greater attention to the chilling effect on doctors, than was evident in the drug prescription context prior to *Ruan*.

B. *Criminal Jeopardy for Doctors After Dobbs*

Dobbs's elimination of abortion's constitutional right status removed what had been the foundation of abortion jurisprudence for almost a half-century. While *Roe* framed abortion as a medical decision in which physician judgment should reign supreme,¹⁷¹ *Dobbs* embraces it as a political one in which "the people," through their elected representatives, determine the scope of abortion access.¹⁷² And in the absence of a constitutional right, the limits on what can be legislated are few.¹⁷³

168. See *People v. Higuera*, 625 N.W.2d 444, 449 (Mich. Ct. App. 2001) (acknowledging that while the statute does not specify whether the mens rea requirement is subjective or objective, it must conform with *Roe* and *Do*e and "accord adequate deference to the physician's exercise of his medical judgment").

169. See, e.g., *Women's Med. Pro. Corp. v. Voinovich*, 130 F.3d 187, 203–06 (6th Cir. 1997), abrogated in part by *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022) (finding a medical emergency exception in a statute banning post-viability abortions unconstitutionally vague because it required both that a physician subjectively "believe that the abortion is necessary and [that] his belief must be objectively reasonable to other physicians"); *Summit Med. Assocs., P.C. v. James*, 984 F. Supp. 1404, 1447 (M.D. Ala. 1998) (striking down a medical emergency exception that required a physician to entertain "a subjective belief that the abortion is necessitated by a medical emergency" that was then "assessed under an objective standard of reasonableness" as vague and inhibitory of "constitutionally-protected rights"), rev'd in part on other grounds sub nom. *Summit Med. Assocs., P.C. v. Pryor*, 180 F.3d 1326 (11th Cir. 1999).

170. See, e.g., *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 534 (8th Cir. 1994) (upholding North Dakota's definition of medical emergency because it allowed the physician to rely on their own "best clinical judgment" in determining whether an emergency exists and because the statute contained a scienter requirement); *Jane L. v. Bangerter*, 809 F. Supp. 865, 878–79 (D. Utah 1992) (upholding a statute that "conditions liability upon intentional abortion of a fetus when the physician knew that a serious medical emergency was not present," thus allowing "the subjective good faith judgment of an attending physician . . . [to] constitute a defense to a criminal charge under the Act").

171. See *supra* notes 143–144 and accompanying text.

172. *Dobbs*, 142 S. Ct. at 2243 ("It is time to heed the Constitution and return the issue of abortion to the people's elected representatives."); *id.* at 2305 (Kavanaugh, J., concurring) ("The Constitution . . . leaves the [abortion] issue for the people and their elected representatives to resolve . . .").

173. There is some suggestion, even from conservative jurists, that an abortion ban without an exception for the life of the pregnant person could not pass even the rational

Approached from the perspective of the now-defunct *Casey*, there can be no undue burden on a right that does not exist.

Yet the abortion jurisprudence around *Roe* and *Casey* protected not only abortion rights but also doctors as the administrators of those rights. *Roe* elevated doctors to the center of abortion decisions.¹⁷⁴ *Doe* praised deference to them.¹⁷⁵ *Colautti* protected them from unclear rules, and *Casey* made doctors' concerns part of the undue burden determination.¹⁷⁶ This deference to doctors in their roles as abortion providers now appears to be gone. The doctrinal protections for doctors derived from due process and criminal law principles, however, are independent of abortion's constitutional status and remain intact. This section reviews the statutory language of recent statutes and describes how their lack of clarity creates criminal jeopardy for doctors. It then explains how the reasoning of *Ruan*, as applied to abortion statutes, allows state courts to protect the rights of doctors, mitigate constitutional vagueness concerns, and preserve the foundational principles of our criminal law.

1. *Mens Rea in the Post-Dobbs Abortion Legislation.* — Some states, having anticipated *Roe*'s demise, already had abortion statutes on the books that immediately took effect once *Roe* was overturned.¹⁷⁷ *Dobbs* also prompted a flurry of new legislation, with over 100 bills restricting access to abortion introduced in 2022 alone.¹⁷⁸ As of September 2023, fifteen states have outlawed abortions at all stages of pregnancy with limited exceptions, and eleven more have outlawed abortions after a specified gestation period with similarly limited exceptions.¹⁷⁹ The most common

basis test that all statutes must pass to survive constitutional challenge. See *Roe v. Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting) (“If the Texas statute were to prohibit an abortion even where the [pregnant person’s] life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective”); see also *Dobbs*, 142 S. Ct. at 2305 n.2 (Kavanaugh, J., concurring) (citing to Justice Rehnquist’s dissent in *Roe*).

174. See *supra* notes 143–144 and accompanying text.

175. See *supra* notes 147–149 and accompanying text.

176. See *supra* notes 150–158 and accompanying text.

177. Larissa Jimenez, 60 Days After *Dobbs*: State Legal Developments on Abortion, Brennan Ctr. for Just. (Aug. 24, 2022), <https://www.brennancenter.org/our-work/research-reports/60-days-after-dobbs-state-legal-developments-abortion> [<https://perma.cc/8FZ3-VTZS>] (highlighting the trigger bans in effect in Arkansas, Mississippi, Missouri, Oklahoma, and South Dakota).

178. *Id.* There have also been significant efforts by state legislatures to protect abortion access, with sixteen states passing legislation to that effect before and in response to *Dobbs* as of August 2022. *Id.*

179. Tracking Abortion Bans Across the Country, N.Y. Times, <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html> (on file with the *Columbia Law Review*) (last visited Aug. 2, 2023) (showing Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin banning abortions at any stage of pregnancy; and Arizona, Florida, Georgia, Iowa, Montana, Nebraska, North Carolina, Ohio, South Carolina, Utah, and Wyoming banning abortions after a certain gestational period). A few of these bans are currently being challenged through litigation efforts, and some have been temporarily blocked by courts. See *id.*

exception, found in even the strictest bans passed since *Dobbs*, are abortions performed in medical emergencies to save the life or health of the pregnant person.¹⁸⁰ To understand the scope of these exceptions, the following section looks to their statutory language rather than case law, given the limited pre-*Dobbs* mens rea doctrine developed in this area.

One of the most daunting types of the recent statutes—from the perspective of both the medical professionals performing emergency abortions and the patients seeking them—are those that, based on their plain language, seem to adopt an objective mens rea standard for assessing the legality of an emergency abortion.¹⁸¹ Alabama’s statute, for example, outlaws “intentional[]” abortions under all circumstances, except if “an attending physician . . . determines that an abortion is necessary in order to prevent a serious health risk to the unborn child’s mother.”¹⁸² The statute then defines such a health risk as when, “[i]n *reasonable medical judgment*, the child’s mother has a condition that so complicates her medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function.”¹⁸³ In a criminal prosecution of an abortion

180. See *infra* Appendix A, which provides excerpts from the twenty strictest state abortion statutes, ranging from complete bans to bans after a fifteen-week gestational period, and their medical emergency exceptions. In addition to being the gestational limit upheld in *Dobbs*, the fifteen-week mark roughly represents the middle ground of gestational limits being adopted by states. See *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2242 (2022) (describing Mississippi’s law); Tracking Abortion Bans Across the Country, *supra* note 179 (showing states adopting gestational limits ranging from six to twenty-four weeks). Oklahoma’s ban, though one of the nation’s strictest, is not included because it provides for only civil, not criminal, liability for physicians. See Okla. Stat. tit. 63, § 1-731.4 (2023).

181. Not all states adopt this approach. The Missouri legislature, for example, crafted its emergency exception explicitly as an affirmative defense that a doctor must raise and prove by a preponderance of the evidence standard to avoid conviction. See Mo. Ann. Stat. § 188.017 (West 2023) (“The defendant shall have the burden of persuasion that the [affirmative] defense is more probably true than not.”). Idaho and Tennessee legislatures also originally structured their emergency exceptions as affirmative defenses, but both states have since amended their laws to include explicit exceptions due to outcry from the medical profession. Sheryl Gay Stolberg, As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers, *N.Y. Times* (Sept. 6, 2023), <https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html> (on file with the *Columbia Law Review*) (last updated Sept. 7, 2023) (noting that the Idaho legislature “eliminated an affirmative defense provision” to try to “address doctors’ concerns” about being prosecuted); Anita Wadhvani, Gov. Bill Lee Signs Law Carving Out Narrow Exceptions to Tennessee Abortion Ban, *Tenn. Lookout* (Apr. 28, 2023), <https://tennesseelookout.com/2023/04/28/gov-bill-lee-signs-law-carving-out-narrow-exceptions-to-tennessee-abortion-ban/> [<https://perma.cc/HW6Y-7SUW>] (describing Tennessee’s switch to an explicit emergency exception after doctors spoke out “about the chilling effect of the [original] law”). While the affirmative defense approach is different from the objective mens rea approach that is the focus of this Note, it has clearly raised similar chilling effect issues among medical providers.

182. Ala. Code § 26-23H-4 (2023).

183. *Id.* § 26-23H-3(6) (emphasis added).

provider under this statute, there is unlikely to be a dispute about whether the abortion was “intentional[],” which is the statute’s specified mens rea for the actus reus; but if the court does not apply that mens rea to the emergency exception as well, the case will instead turn on whether the physician’s assessment of the patient’s condition was objectively “reasonable,” without regard for the physician’s subjective intent.

Florida, Georgia, Kentucky, Louisiana, Nebraska, North Carolina, North Dakota, South Carolina, Texas, West Virginia, and Wisconsin employ identical “reasonable medical judgment” language to define the medical emergency exceptions in their statutes.¹⁸⁴ Other statutes—such as the one in Arkansas—provide no indication within their medical-emergency exception as to whether a physician’s medical judgment will be assessed objectively or subjectively.¹⁸⁵ While these laws will no longer be evaluated under the standards of *Roe* and *Casey*, which shielded the free exercise of medical judgment from legal liability to protect access to a constitutional right,¹⁸⁶ they certainly run counter to the foundational principles of constitutional and criminal law embodied in *Ruan*, which unanimously rejected an objective mens rea standard for convicting doctors under the CSA.¹⁸⁷

2. *The Implications of Objective Mens Rea Standards in Abortion Prosecutions.* — The objective mens rea provisions contained in many criminal abortion statutes are curious given the judicial skepticism that such standards have been met with in the past. As the Court noted in *Colautti*, using analogous reasoning to that in *Ruan*, subjective mens rea provisions are particularly important when the criminally regulated decision is itself an uncertain endeavor and presents a high likelihood that even “experts will disagree” on the answer.¹⁸⁸ Since the *Dobbs* decision came down, members of the medical profession have highlighted the ambiguities inherent in determining whether a medical emergency necessitates an abortion. When asked in an *NPR* interview if there is a “very clear line that would define a life in peril when we’re talking about ending a pregnancy and preserving the life of the [patient],” Dr. Lisa Harris, a Michigan obstetrician, answered, “There are some situations where it is clear what that means, but in most situations, it’s

184. See *infra* Appendix A.

185. Ark. Code Ann. § 5-61-403(3) (2023) (defining “[m]edical emergency” as “a condition in which an abortion is necessary to preserve the life of a pregnant woman,” without any reference to the required mental state of the decisionmaker other than that the abortion itself be “purpose[ly]” performed).

186. See *supra* notes 143–146 and accompanying text (discussing *Roe*); *supra* notes 161–163 and accompanying text (discussing *Casey*).

187. See *supra* note 10 and accompanying text.

188. See *Colautti v. Franklin*, 439 U.S. 379, 396 (1979) (holding that criminal liability for determinations over which “experts will disagree” could deter doctors from performing medically advisable abortions).

not”¹⁸⁹ Harris added, “[Many] pregnant [people] who will suffer irreparable harm or die in the context of pregnancy . . . may not be in an acute emergency in [the] very moment” that the doctor sees them but have conditions, such as pregnancy-induced hypertensive disorder, preeclampsia, or eclampsia, that could later result in deadly strokes.¹⁹⁰ Ectopic pregnancies, which are the leading cause of maternal mortality in the first trimester,¹⁹¹ can seem similarly stable, but in the event of a rupture can turn “catastrophic.”¹⁹² All these conditions, while extremely dangerous, do not present a certain risk of immediate death but may well lead to death in the absence of timely medical intervention.¹⁹³ In the aftermath of *Dobbs*, anecdotal reports suggest widespread physician hesitancy about the legally permissible time to intervene in these scenarios, and as a result, patients are traveling—sometimes hundreds of miles—to states with more liberal abortion access to receive more immediate care.¹⁹⁴ The burden that this chilling effect places on patients to travel to faraway states for lifesaving abortion care disproportionately impacts low-income patients, especially patients of color, for whom the travel costs can be prohibitive.¹⁹⁵

189. Melissa Block, Some Abortions Are Necessary to Save the Life of a Patient, NPR (July 2, 2022), <https://www.npr.org/2022/07/02/1109557947/some-abortions-are-necessary-to-save-the-life-of-a-patient> [<https://perma.cc/YN59-VTRU>].

190. *Id.*

191. Kellie Mullany, Madeline Minneci, Ryan Monjazeb & Olivia C. Coiado, Overview of Ectopic Pregnancy Diagnosis, Management, and Innovation, 19 *Women’s Health*, 2023, at 1, 1, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10071153/pdf/10.1177_17455057231160349.pdf [<https://perma.cc/5H8Q-QQRF>].

192. Block, *supra* note 189.

193. See *id.* (“[T]here are a long list of conditions where someone may be OK in the moment, but they might not be later.”).

194. See, e.g., Lauren Coleman-Lochner, Carly Wanna & Elaine Chen, Doctors Fearing Legal Blowback Are Denying Life-Saving Abortions, Bloomberg L. (July 12, 2022), <https://news.bloomberglaw.com/health-law-and-business/doctors-fearing-legal-blowback-are-denying-life-saving-abortions> (on file with the *Columbia Law Review*); Doctors Refusing Potentially Life-Saving Abortion Treatment Over Legal Fears, ABC News (Aug. 24, 2022), <https://abcnews.go.com/US/doctors-refusing-potentially-life-saving-abortion-treatment-legal/story?id=88791452> [<https://perma.cc/ZY9F-5D3J>]; Eleanor Klibanoff, Doctors Report Compromising Care Out of Fear of Texas Abortion Law, Tex. Trib. (June 23, 2022), <https://www.texastribune.org/2022/06/23/texas-abortion-law-doctors-delay-care/> [<https://perma.cc/CQ5S-WGPV>].

195. See Doctors Refusing Potentially Life-Saving Abortion Treatment Over Legal Fears, *supra* note 194 (interviewing an abortion provider who has experienced an “influx of patients” from neighboring states with abortion bans but only those “that can afford childcare, . . . gas money, . . . [and] to take time off of work”); see also Priya Pandey, A Year After *Dobbs*: People With Low Incomes and Communities of Color Disproportionately Harmed, CLASP (June 23, 2023), <https://www.clasp.org/blog/a-year-after-dobbs-people-with-low-incomes-and-communities-of-color-disproportionately-harmed/> [<https://perma.cc/R74D-DCT6>] (noting how *Dobbs* has “made abortion out of reach for many, especially people of color, people who work low-wage jobs, people who live in rural areas, people with undocumented status, and people with LGBTQIA+ identities”).

Our legal system has long deemed objective standards of reasonableness appropriate for civil liability like malpractice, where the goal is to compensate damage to a patient, and where insurance spreads the risk over the entire medical profession.¹⁹⁶ Objective standards also make sense where clear guidance about appropriate conduct is available from the statute itself or from guidelines available to the doctor. Not only do no such guidelines currently exist in the emergency abortion context, but medical professionals also generally oppose writing them out of concern for downplaying the varying risks facing individual patients.¹⁹⁷ Given the range of possible conditions and the specifics of each patient, Harris explained that “there is no one-size-fits-all law or guideline that could possibly meet everybody’s needs.”¹⁹⁸ As the Court recognized in *Ruan*, conditioning criminal liability—with the possibility of lengthy prison sentences—on an objective reasonableness standard rather than on a physician’s subjective good-faith judgment in such ambiguous situations ignores the critical principles that separate criminal and civil law.¹⁹⁹

The highly politicized—and for some, religious—nature of the abortion issue makes an objective mens rea standard even less tenable in this context. While the moral outrage stemming from the opioid epidemic and the past public anger over treatment of persons with SUDs have certainly influenced the government’s drug enforcement agenda, it is hard to imagine a topic more politicized, and one that inflames more passions, than abortion. Unlike a drug prescription, an emergency abortion impacts not only the patient but also a potential life, and for many the performance of an abortion is as morally outrageous as murder.²⁰⁰ An evaluation—by a local district attorney, juror, or expert—of a doctor’s decision that necessarily balanced the risk to the patient’s life

196. See B. Sonny Bai, *An Introduction to Medical Malpractice in the United States*, 467 *Clinical Orthopaedics & Related Rsch.* 339, 340 (2009) (noting that “the most commonly used standard in tort law,” including in medical malpractice, is “that of a so-called ‘reasonable person’”).

197. For example, in an article by the American College of Obstetricians and Gynecologists seeking to help practitioners understand and navigate medical emergency exceptions in abortion bans post-*Dobbs*, the organization asserts that it is not only “impossible to create an inclusive list of conditions that qualify as ‘medical emergencies,’” but also “dangerous” to attempt to do so. Instead, the organization “strongly reaffirms that it is critical for clinicians to be able to use and rely upon their expertise and medical judgment.” *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, Am. Coll. of Obstetricians & Gynecologists (Aug. 15, 2022), <https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions> [<https://perma.cc/FDV9-MNKM>].

198. Block, *supra* note 189.

199. See *Ruan v. United States*, 142 S. Ct. 2370, 2377 (2022).

200. See *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2304 (2022) (Kavanaugh, J., concurring) (“On the one side, many pro-choice advocates forcefully argue that the ability to obtain an abortion is critically important for women’s personal and professional lives, and for women’s health. . . . On the other side, many pro-life advocates forcefully argue that a fetus is a human life.”).

against the interest of the fetus cannot avoid the reviewers' preexisting beliefs on abortion, informed by their normative or religious values. Statutes with objective standards that require doctors to conform to how a "reasonable" doctor would weigh the maternal and fetal interests at stake to avoid criminal liability completely ignore the subjectivity inherent in evaluating this highly contentious treatment decision.

Additionally, while doctors' protections that emanated from abortion's status as a constitutional right have now been lost, other constitutional doctrines, such as void for vagueness, remain applicable and counsel against adopting objective standards for emergency exception provisions. Historically, constitutional vagueness challenges in the abortion context have been argued in two ways. First, they have been brought as facial attacks against abortion regulations whose vagueness made abortion providers unsure about how to comply with their requirements; litigants argued, often successfully,²⁰¹ that this hesitancy on the part of doctors in turn constituted an undue burden on the constitutional right to terminate one's pregnancy under *Casey*.²⁰² Given that *Dobbs* overturned *Casey*, however, challenges to vague abortion regulations based on the chilling effect that their ambiguity may have had on a person's right to terminate their pregnancy are now foreclosed.

The second type of void-for-vagueness challenge, however, is unaffected by *Dobbs* and is grounded in the notice requirements of the Fourteenth Amendment's Due Process Clause. The doctrine requires that laws must provide "fair warning" of what conduct is prohibited and sufficient standards to prevent "arbitrary and discriminatory enforcement."²⁰³ To survive a vagueness challenge, a statute must give "relatively clear guidelines" as to wrongful conduct.²⁰⁴ Courts are least tolerant of vagueness in laws imposing criminal, rather than civil, liability because the "consequences of imprecision are qualitatively [more] severe."²⁰⁵ They have also recognized that a "scienter requirement may mitigate a law's vagueness."²⁰⁶

201. See, e.g., *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 130 (3d Cir. 2000) ("[T]he vast majority of courts have enjoined the enforcement of [partial-birth abortion bans] because they are unconstitutionally vague and impose an undue burden on women who seek to have an abortion.").

202. See, e.g., *Memphis Ctr. for Reprod. Health v. Slatery*, 14 F.4th 409, 434 (6th Cir. 2021) (noting that, due to an abortion law's "ambiguity and uncertainty, many abortion providers might well choose to steer clear of anything that could possibly be construed as prohibited conduct," creating an undue burden on a right "deemed fundamental under the Constitution"), vacated, 18 F.4th 550 (6th Cir. 2021) (en banc) (mem.).

203. *Vill. of Hoffman Estates v. Flipside*, 455 U.S. 489, 498 (1982) (internal quotation marks omitted) (quoting *Grayned v. City of Rockford*, 408 U.S. 104, 108–09 (1972)).

204. *Posters 'N' Things, Ltd. v. United States*, 511 U.S. 513, 525 (1994).

205. *Flipside*, 455 U.S. at 499.

206. *Id.* Doctors prosecuted under § 841 of the CSA have brought these void-for-vagueness challenges over the years, arguing that the statute and its attendant regulations, as applied to doctors, fail to provide a "definite standard by which practitioners can measure

Since *Roe*, the Supreme Court has heard only one void-for-vagueness challenge—*Doe v. Bolton*, discussed above—that specifically pertained to the emergency exception to an abortion ban.²⁰⁷ Under the challenged law, abortion was a crime unless deemed “necessary” based on the doctor’s “best clinical judgment.”²⁰⁸ The Court declined to find the word “necessary” unconstitutionally vague, primarily because the text of the statute clearly left its definition up to the doctor’s discretion in the moment.²⁰⁹ The Eighth Circuit similarly upheld a medical emergency exception against challenges to the vagueness of the words “major bodily function,” “immediate,” and “grave” because the law explicitly allowed physicians to rely on their “best clinical judgment” in determining their meaning.²¹⁰ The Eighth Circuit made clear the importance of the subjective standard to its ruling: “[T]he reference to doctor’s clinical judgment saves the statute from vagueness.”²¹¹ Most recently, the Idaho Supreme Court decided the first void-for-vagueness challenge to an emergency exception in a post-*Dobbs* abortion statute. In upholding the law, the court similarly relied on the fact that the provision uses a “clearly” subjective standard.²¹²

In contrast, some lower courts have struck down as unconstitutionally vague medical emergency provisions that impose an objective standard of reasonableness onto emergency determinations.²¹³ For example, the Sixth

their conduct.” *United States v. Brickhouse*, No. 3:14-cr-124, 2016 WL 2654259, at *3 (E.D. Tenn. Mar. 30, 2016). In bringing their challenges, petitioners often tried to analogize to abortion cases, such as *Colautti*, in which statutes were found unconstitutionally vague. See *id.* at *4. Not a single court, however, has held § 841 to be vague as applied to registered medical professionals. *Id.* at *5 (citing *United States v. Orta-Rosario*, 469 F. App’x 140, 143–44 (4th Cir. 2012); *United States v. Birbragher*, 603 F.3d 478, 488 (8th Cir. 2010); *United States v. Lovern*, 590 F.3d 1095, 1103 (10th Cir. 2009); *United States v. DeBoer*, 966 F.2d 1066, 1068–69 (6th Cir. 1992); *United States v. Rosenberg*, 515 F.2d 190, 197 (9th Cir. 1975); *United States v. Collier*, 478 F.2d 268, 270–72 (5th Cir. 1973)).

207. 410 U.S. 179 (1973). In one case decided before *Roe*, the Court rejected a void-for-vagueness challenge to the word “health” in an emergency exception of a criminal abortion statute. The Court did not broach the topic of physician mens rea but found that the word “health” did not create jeopardy for doctors because it could be read broadly. See *United States v. Vuitch*, 402 U.S. 62, 71 (1971).

208. *Doe*, 410 U.S. at 191 (internal quotation marks omitted) (quoting Ga. Code Ann. § 26-1202(a) (1968) (current version at Ga. Code Ann. § 16-12-141 (2023))).

209. *Id.* at 192.

210. *Fargo Women’s Health Org. v. Schafer*, 18 F.3d 526, 534 (8th Cir. 1994).

211. *Id.*

212. *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1203 (Idaho 2023).

213. See, e.g., *Women’s Med. Pro. Corp. v. Voinovich*, 130 F.3d 187, 204–05 (6th Cir. 1997) (striking down as vague an abortion statute with subjective and objective elements to its medical emergency definition but no scienter requirement), abrogated in part by *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022); *Summit Med. Assocs., P.C. v. James*, 984 F. Supp. 1404, 1447 (M.D. Ala. 1998) (striking down a medical emergency exception that required a physician to entertain “a subjective belief that the abortion is necessitated by a medical emergency,” which was then “assessed under an objective standard of reasonableness” as vague and inhibitory of “constitutionally-protected rights”), *rev’d in part*

Circuit struck down a statute allowing post-viability abortions only in medical emergencies determined in “good faith and in the exercise of reasonable medical judgment.”²¹⁴ Due to the objective component of the exception and the fact that the treatment decision is “fraught with uncertainty,” the Court held that “[a] physician simply does not know against which standard his conduct will be tested and his liability determined.”²¹⁵ The inclusion of the mens rea “purposely” elsewhere in the statute did not address the court’s concerns, as it “[went] to the performance of the abortion, not to the determination of medical necessity.”²¹⁶ Though these cases were decided pre-*Dobbs*, some of their elements still apply with equal force today because they rely on constitutional and criminal law principles that were unaffected by the *Dobbs* decision.

Under these precedents, the new abortion statutes employing mixed or purely objective standards in their emergency exceptions are vulnerable to void-for-vagueness challenges, but a subjective mens rea requirement could save them. Given that courts try to read statutes in a way that renders them constitutional if reasonably possible,²¹⁷ the vagueness risks associated with these statutes provide a constitutional basis for state courts to apply, as *Ruan* did, the subjective mens rea requirement set out for the actus reus to the emergency exception as well.

3. *Applying Ruan to State Abortion Statutes.* — *Ruan* is useful in establishing subjective mens rea standards for abortion prosecutions across the country in three important respects. First, the decision reminds us that when faced with vague criminal laws—whether federal or state—both our constitutional and common law traditions favor scienter. Though *Ruan* is ostensibly a statutory interpretation decision, the common law canons of construction explicitly relied on by the Court in *Ruan* reflect principles very similar to the due process concerns that undergird the void-for-vagueness doctrine. The void-for-vagueness doctrine springs from the Fourteenth Amendment’s notice requirement,²¹⁸ while the common law

on other grounds sub nom. *Summit Med. Assocs., P.C. v. Pryor*, 180 F.3d 1326 (11th Cir. 1999).

214. *Voinovich*, 130 F.3d at 204 (quoting Ohio Rev. Code Ann. § 2919.16(F) (1995)).

215. *Id.* at 205–06.

216. *Id.* at 206 (emphasis omitted).

217. See, e.g., *Immigr. & Naturalization Serv. v. St. Cyr*, 533 U.S. 289, 299–300 (2001) (“[I]f an otherwise acceptable construction of a statute would raise serious constitutional problems, and where an alternative interpretation of the statute is ‘fairly possible,’ . . . we are obligated to construe the statute to avoid such problems.” (quoting *Crowell v. Benson*, 285 U.S. 22, 62 (1932))), superseded by statute on other grounds, REAL ID Act of 2005, Pub. L. No. 109-13, 119 Stat. 302, as recognized in *Nasrallah v. Barr*, 140 S. Ct. 1683, 1690 (2020).

218. See, e.g., *Welch v. United States*, 136 S. Ct. 1257, 1261–62 (2016) (“[T]he void-for-vagueness doctrine[] [is] a doctrine that is mandated by the Due Process Clauses of the Fifth Amendment (with respect to the Federal Government) and the Fourteenth Amendment (with respect to the States).”).

principle that a criminal defendant must “know” their conduct is unlawful ensures only those who understand the line between good and bad will suffer prosecution.²¹⁹ Whether understood through a common law or constitutional lens, *Ruan* models compliance with both doctrines and provides state courts ample bases to adopt subjective mens rea requirements when interpreting their new abortion bans.

Second, *Ruan*’s analysis is useful because of both contextual and textual similarities between the CSA and state abortion statutes. Contextually, as explained throughout this Note, both operate in situations in which courts have acknowledged that delineating between doctors’ lawful and unlawful conduct is neither inherently easy nor susceptible to clear guidelines;²²⁰ in which conduct of doctors that is otherwise permissible under different circumstances is criminalized;²²¹ in which severe penalties are imposed for conduct determined to be illegal;²²² and in which socially desirable conduct by doctors can be chilled as a result.²²³

Textually, both the CSA and most state abortion statutes are written, broadly speaking, as flat prohibitions followed by exceptions for the circumstances in which the prohibited treatment is allowed. More particularly, both the CSA and many state abortion statutes contain an actus reus, a subjective mens rea that applies to the actus reus, and an exception defined with reference to language typically construed as objective (e.g., “legitimate medical purpose,” “reasonable medical

219. See, e.g., *Morissette v. United States*, 342 U.S. 246, 250 (1952) (“[Scienter requirements are] as universal and persistent in mature systems of law as belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil.”).

220. Compare *Ruan v. United States*, 142 S. Ct. 2370, 2378 (2022) (noting that it is “often difficult to distinguish [the issuing of invalid prescriptions] from . . . socially acceptable . . . conduct” (internal quotation marks omitted) (quoting *United States v. U.S. Gypsum Co.*, 438 U.S. 422, 441 (1978))), with *Voinovich*, 130 F.3d at 205 (“The determination of whether a medical emergency or necessity exists . . . is fraught with uncertainty . . .”).

221. Compare 21 U.S.C. § 841(a)(1) (2018) (outlawing the distribution of controlled substances “[e]xcept as authorized”), with Ala. Code § 26-23H-4 (2023) (outlawing abortion “except . . . [if] necessary in order to prevent a serious health risk to the unborn child’s mother”). See *infra* Appendix B for a complete side-by-side comparison of these statutes.

222. Compare *Ruan*, 142 S. Ct. at 2375–76 (noting that both physicians convicted under § 841(a)(1) were sentenced to over twenty years), with Tex. Health & Safety Code Ann. § 170A.004 (West 2023) (making illegal abortion ending in the fetus’ death a first-degree felony), and Tex. Penal Code § 12.32 (West 2023) (providing that first-degree felonies are punishable by up to life in prison).

223. Compare *Ruan*, 142 S. Ct. at 2378 (discussing the CSA’s risk of “punishing . . . beneficial conduct that lies close to, but on the permissible side of, the criminal line”), with *Colautti v. Franklin*, 439 U.S. 379, 396 (1979) (discussing how a state abortion law “could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment”).

judgment”).²²⁴ Because of the way legislatures wrote both the CSA and state abortion laws, the exception is not technically an element of the crime even though it separates lawful from unlawful behavior. *Ruan* concluded that the exception, while not an element, functions “sufficiently like an element” that it should include the same mens rea requirement as the statute’s actus reus, notwithstanding any grammatical awkwardness.²²⁵ *Ruan* also concluded that the objective language found in the provisions defining the exception simply provided the objective professional standards against which a jury can evaluate the credibility of the doctor’s professed belief that their conduct was lawful.²²⁶ Because most state abortion statutes follow an almost identical structure to that of the CSA, state courts can apply *Ruan*’s textual analysis to those laws to reach a similar conclusion—that doctors must *knowingly, intentionally, deliberately* (or whatever subjective standard the statute employs) contravene reasonable medical judgment before facing criminal penalties for performing emergency abortions.

And third, the long road to *Ruan*—a path marked by doctors’ fearful retreat from regulated treatments when faced with uncertain criminal exposure²²⁷—should serve as a cautionary tale as states enter this new phase of abortion regulation. The history of federal drug enforcement against doctors has shown that when guilt depends not on one’s subjective intent but on hazy legal standards defined after the fact through expert testimony, doctors pull back on regulated treatments and patients are left behind. If they ignore the historical missteps that led to *Ruan*, states regulating abortion today risk repeating the mistakes of their federal counterparts and causing physicians to fearfully evade therapeutic abortions, with catastrophic consequences for their patients.

CONCLUSION

Medical emergency exceptions in abortion laws to protect the life or health of the pregnant person have been a constant in the abortion history of this country—first, as a matter of common law; next, as a constitutional requirement under *Roe* and *Casey*; and now, as a statutory feature in all fifty states.²²⁸ Despite the long history of these exceptions, however, the post-*Dobbs* era is the first time in fifty years that the existence and scope of therapeutic abortion exceptions depend entirely upon the will of state legislatures.

224. See *infra* Appendix B for a side-by-side comparison of the CSA, 21 U.S.C. § 841 (emphasis added), along with its promulgating regulation, 21 C.F.R. § 1306.04(a) (2023) (emphasis added), and Ala. Code § 26-23H-3 to -4 (emphasis added).

225. *Ruan*, 142 S. Ct. at 2380.

226. *Id.* at 2382.

227. See *supra* section I.A.

228. See *supra* Part II (describing this progression).

Polls show that, in the abstract, carve-outs for therapeutic abortions in abortion bans remain extremely popular among the American public.²²⁹ In practice, however, there is far less consensus about the circumstances under which those exceptions should apply. In fact, since *Dobbs* was decided, conservative lawmakers have expressed concern that the exceptions create loopholes through which illegal abortions occur.²³⁰ While such skepticism is not new,²³¹ state laws can now reflect that skepticism without fear of running afoul of *Roe* or *Casey*. Whether or not lawmakers actually intend to chill the performance of therapeutic abortions, their statutes will nonetheless have that effect.

The foundational principles—both constitutional and common law—underlying criminal law should remain independent of the whims of abortion politics. Even in a context fraught with political overtones, criminal laws must provide fair warning of the prohibited conduct and, except in rare cases, punish only those with a guilty mind. *Ruan* rose to this challenge, albeit in a political context less charged than the national abortion debate; state abortion laws with vague standards and objective mens rea requirements fall short of the mark. The politics of abortion have polarized the nation and distorted the operation of many of its institutions, but courts should not allow abortion politics to undermine the time-honored meaning of guilt in American criminal law.

229. See Mary Ziegler, *Why Exceptions for the Life of the Mother Have Disappeared*, *The Atlantic* (July 25, 2022), <https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582/> (on file with the *Columbia Law Review*) (last updated Aug. 2, 2022) (“[A] recent Pew Research Center poll found that 73 percent of Americans favored legal abortion if a woman’s life or health was *at risk*.”).

230. See *id.* (discussing the skepticism of conservative lawmakers).

231. See *id.* (noting that the skepticism of therapeutic abortions dates back to the 1960s, when therapeutic abortions based on the pregnant person’s mental health proliferated).

APPENDIX A: STATE STATUTES BANNING ABORTION
AFTER FIFTEEN WEEKS OR EARLIER

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
Ala.	Ala. Code § 26-23H-4 (2023).	<p>§ 26-23H-4.</p> <p>(a) It shall be unlawful for any person to <u>intentionally</u> perform or attempt to perform an abortion <i>except as provided for by subsection (b)</i>.</p> <p>(b) An abortion shall be permitted if an attending physician licensed in Alabama determines that an abortion <i>is necessary in order to prevent a serious health risk to the unborn child's mother</i>.</p>
	Ala. Code § 26-23H-3(6) (2023).	<p>§ 26-23H-3.</p> <p>(6) <i>Serious Health Risk to the Unborn Child's Mother</i>. In <u>reasonable medical judgment</u>, the child's mother has a condition that so complicates her medical condition that it <i>necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function</i>.</p>
Ariz.	Ariz. Rev. Stat. Ann. § 13-3603 (2023).	<p>§ 13-3603.</p> <p>A person who provides, supplies or administers to a pregnant woman, or procures such woman to take any medicine, drugs or substance, or uses or employs any instrument or other means whatever, with <u>intent thereby to procure the miscarriage of such woman</u>, <i>unless it is necessary to save her life</i>, shall be punished by imprisonment in the state prison for not less than two years nor more than five years.</p>
Ark.	Ark. Code Ann. § 5-61-404 (2023).	<p>§ 5-61-404.</p> <p>(a) A person shall not <u>purposely</u> perform or attempt to perform an abortion <i>except to save the life of a pregnant woman in a medical emergency</i>.</p>

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
	Ark. Code Ann. § 5-61-403 (2023).	§ 5-61-403. (3) “ <i>Medical emergency</i> ” means a condition in which an abortion is <i>necessary to preserve the life of a pregnant woman</i> whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself
Fla.	Fla. Stat. Ann. § 390.0111 (West 2023).	§ 390.0111. (1) . . . A physician may not <u>knowingly</u> perform or induce a termination of pregnancy if the physician determines the gestational age of the fetus is more than 6 weeks unless one of the following conditions is met: (a) Two physicians certify in writing that, in <u>reasonable medical judgment</u> , the termination of the pregnancy is <i>necessary to save the pregnant woman’s life</i> or avert a <i>serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman</i> other than a psychological condition. (b) The physician certifies in writing that, in <u>reasonable medical judgment</u> , there is a <i>medical necessity</i> for legitimate emergency medical procedures for termination of the pregnancy to <i>save the pregnant woman’s life</i> or avert a <i>serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman</i> other than a psychological condition, and another physician is not available for consultation.

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
Ga.	Ga. Code Ann. § 16-12-141 (2023).	§ 16-12-141. (b) No abortion is authorized or shall be performed if an unborn child has been determined . . . to have a detectable human heartbeat except when: (1) A physician determines, in <u>reasonable medical judgment</u> , that a <i>medical emergency</i> exists
Idaho	Idaho Code § 18-622 (2023).	§ 18-622. (1) Except as provided in subsection (2) of this section, every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion (2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section: . . . (i) The physician determined, in <u>his good faith medical judgment and based on the facts known to the physician at the time</u> , that the abortion was <i>necessary to prevent the death of the pregnant woman</i> .
Ind.	Ind. Code Ann. § 16-34-2-1 (West 2023).	§ 16-34-2-1. (a) Abortion shall in all instances be a criminal act, except when performed under the following circumstances: . . . (A) for reasons based upon the professional, medical judgment of the pregnant woman's physician, if either: (i) the abortion is necessary when <u>reasonable medical judgment</u> dictates that performing the abortion is <i>necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life</i>

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
Ky.	Ky. Rev. Stat. Ann. § 311.772 (West 2023).	§ 311.772. (3)(a) No person may <u>knowingly</u> : . . . 2. Use or employ any instrument or procedure upon a pregnant woman <u>with the specific intent</u> of causing or abetting the termination of the life of an unborn human being. (4) The following shall not be a violation of subsection (3) of this section: (a) For a licensed physician to perform a <i>medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death</i> due to a physical condition, or <i>to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman.</i>
La.	La. Stat. Ann. § 40:1061 (2023).	§ 40:1061. C. . . . No person may <u>knowingly</u> use or employ any instrument or procedure upon a pregnant woman <u>with the specific intent</u> of causing or abetting the termination of the life of an unborn human being. F. It shall not be a violation of Subsection C of this Section for a licensed physician to perform a <i>medical procedure necessary in reasonable medical judgment to prevent the death or substantial risk of death</i> due to a physical condition, or <i>to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman.</i>
Miss.	Miss. Code Ann. § 41-41-45 (2023).	§ 41-41-45. (2) No abortion shall be performed or induced in the State of Mississippi, <i>except in the case where necessary for the preservation of the mother's life</i> or where the pregnancy was caused by rape.

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
		<p>(4) Any person, except the pregnant woman, who <u>purposefully</u>, <u>knowingly</u> or <u>recklessly</u> performs or attempts to perform or induce an abortion in the State of Mississippi, <i>except in the case where necessary for the preservation of the mother's life</i> or where the pregnancy was caused by rape, upon conviction, shall be punished by imprisonment in the custody of the Department of Corrections for not less than one (1) year nor more than ten (10) years.</p>
Mo.	Mo. Ann. Stat. § 188.017 (West 2023).	<p>§ 188.017.</p> <p>2. . . . [N]o abortion shall be performed or induced upon a woman, <i>except in cases of medical emergency</i>. Any person who <u>knowingly</u> performs or induces an abortion of an unborn child in violation of this subsection shall be guilty of a class B felony, as well as subject to suspension or revocation of his or her professional license by his or her professional licensing board.</p> <p>3. It shall be an affirmative defense for any person alleged to have violated the provisions of subsection 2 of this section that the person performed or induced an abortion because of a <i>medical emergency</i>. The defendant shall have the burden of persuasion that the defense is more probably true than not.</p>

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
Neb.	Neb. Rev. Stat. § 71-6915 (2023).	§ 71-6915. (2) Except as provided in subsection (3) of this section, it shall be unlawful for any physician to perform or induce an abortion (3) It shall not be a violation of subsection (1) or (2) of this section for a physician to perform or induce an abortion in the case of: (a) <i>Medical emergency</i>
	Neb. Rev. Stat. § 71-6914 (2023).	§ 71-6914. (3) (a) <i>Medical emergency</i> means any condition which, in <u>reasonable medical judgment</u> , so complicates the medical condition of the pregnant woman as to <i>necessitate the termination of her pregnancy to avert her death</i> or for which a delay in terminating her pregnancy will create a <i>serious risk of substantial and irreversible physical impairment of a major bodily function</i> .
N.C.	Abortion Laws, ch. 14, sec. 1.2, § 90-21.81A, 2023 N.C. Sess. Laws.	§ 90-21.81A. (a) Abortion.—It shall be unlawful after the twelfth week of a woman’s pregnancy to advise, procure, or cause a miscarriage or abortion.
	Abortion Laws, ch. 14, sec. 1.2, § 90-21.81B, 2023 N.C. Sess. Laws.	§ 90-21.81B. [I]t shall not be unlawful to advise, procure, or cause a miscarriage or an abortion in the following circumstances: (1) When a qualified physician determines there exists a <i>medical emergency</i> .
	Abortion Laws, ch. 14, sec. 1.2, § 90-21.81, 2023 N.C. Sess. Laws.	§ 90-21.81. (5) <i>Medical emergency</i> .—A condition which, in <u>reasonable medical judgment</u> , so complicates the medical condition of the pregnant woman as to <i>necessitate the immediate abortion of her pregnancy to avert her death</i> or for which a delay will create

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
		<i>serious risk of substantial and irreversible physical impairment of a major bodily function</i>
N.D.	N.D. Cent. Code § 12.1-19.1-02 (2023).	§ 12.1-19.1-02. It is a class C felony for a person . . . to perform an abortion.
	N.D. Cent. Code § 12.1-19.1-03 (2023).	§ 12.1-19.1-03. This chapter does not apply to: 1. An abortion deemed <i>necessary</i> based on <u>reasonable medical judgment</u> which was intended to <i>prevent the death</i> or a <i>serious health risk to the pregnant female</i> .
	N.D. Cent. Code § 12.1-19.1-01 (2023).	§ 12.1-19.1-01. . . . 4. “ <u>Reasonable medical judgment</u> ” means a medical judgment that would be made by a <u>reasonably prudent physician</u> who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved. 5. “ <u>Serious health risk</u> ” means a condition that, in <u>reasonable medical judgment</u> , complicates the medical condition of the pregnant woman so that it <i>necessitates an abortion to prevent substantial physical impairment of a major bodily function</i> , not including any psychological or emotional condition.
S.C.	S.C. Code Ann. § 44-41-630 (2023).	§ 44-41-630. (B) Except as [otherwise] provided . . . , no person shall perform or induce an abortion on a pregnant woman <u>with the specific intent of causing or abetting an abortion</u> if the unborn child’s fetal heartbeat has been detected A person who violates this subsection is guilty of a felony

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
	S.C. Code Ann. § 44-41-640 (2023).	§ 44-41-640. (A) It is not a violation of Section 44-41-630 if an abortion is performed or induced on a pregnant woman due to a <i>medical emergency</i> or is performed to <i>prevent the death of the pregnant woman</i> or to <i>prevent the serious risk of a substantial and irreversible impairment of a major bodily function</i>
	S.C. Code Ann. § 44-41-610 (2023).	§ 44-41-610. (9) “ <i>Medical emergency</i> ” means in <u>reasonable medical judgment</u> , a condition exists that has complicated the pregnant woman’s medical condition and <i>necessitates an abortion to prevent death or serious risk of a substantial and irreversible physical impairment of a major bodily function</i> (13) “ <u>Reasonable medical judgment</u> ” means a medical judgment that would be made by a <u>reasonably prudent physician</u> who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.
S.D.	S.D. Codified Laws § 22-17-5.1 (2023).	§ 22-17-5.1. Any person who administers to any pregnant female or who prescribes or procures for any pregnant female any medicine, drug, or substance or uses or employs any instrument or other means <u>with intent thereby to procure an abortion</u> , unless there is <u>appropriate and reasonable medical judgment</u> that performance of an abortion is <i>necessary to preserve the life of the pregnant female</i> , is guilty of a Class 6 felony.

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
Tenn.	Tenn. Code Ann. § 39-15-213 (2023)	<p>§ 39-15-213.</p> <p>(b) A person who performs or attempts to perform an abortion commits the offense of criminal abortion.</p> <p>(1) Notwithstanding subsection (b), a person who performs or attempts to perform an abortion does not commit the offense of criminal abortion if the abortion is performed or attempted by a licensed physician in a licensed hospital . . . [and]:</p> <p>(A) The physician determined, using <u>reasonable medical judgment, based upon the facts known to the physician at the time</u>, that the abortion was <i>necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman</i></p>
Tex.	Tex. Health & Safety Code Ann. § 170A.002 (West 2023).	<p>§ 170A.002.</p> <p>(a) A person may not <u>knowingly</u> perform, induce, or attempt an abortion.</p> <p>(b) The prohibition under Subsection (a) does not apply if: . . .</p> <p>(2) in the exercise of <u>reasonable medical judgment</u>, the pregnant female on whom the abortion is performed, induced, or attempted has a <i>life-threatening physical condition</i> aggravated by, caused by, or arising from a pregnancy that <i>places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function</i> unless the abortion is performed or induced</p>

State	Statute(s)	Relevant Text <i>(medical emergency exceptions italicized and mens rea underlined for emphasis)</i>
W. Va.	W. Va. Code Ann. § 16-2R-3 (LexisNexis 2023).	§ 16-2R-3. (a) An abortion may not be performed or induced or be attempted to be performed or induced unless in the <u>reasonable medical judgment</u> of a licensed medical professional: . . . (3) A <i>medical emergency</i> exists.
	W. Va. Code Ann. § 16-2R-2 (LexisNexis 2023).	§ 16-2R-2. “ <u>Reasonable medical judgment</u> ” means a medical judgment that would be made by a licensed medical professional who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.
Wis.	Wis. Stat. & Ann. § 940.15 (2023).	§ 940.15. (2) Whoever <u>intentionally</u> performs an abortion after the fetus or unborn child reaches viability, as determined by <u>reasonable medical judgment</u> of the woman’s attending physician, is guilty of a Class I felony. (3) Subsection (2) does not apply if the abortion is <i>necessary to preserve the life or health of the woman</i> , as determined by <u>reasonable medical judgment</u> of the woman’s attending physician.

APPENDIX B: COMPARISON OF THE CONTROLLED SUBSTANCES ACT AND
THE ALABAMA HUMAN LIFE PROTECTION ACT

<p>Controlled Substances Act & Attendant Regulation (<i>medical emergency exceptions italicized and mens rea underlined for emphasis</i>)</p>	<p>Alabama Human Life Protection Act (<i>medical emergency exceptions italicized and mens rea underlined for emphasis</i>)</p>
<p>21 U.S.C. § 841 (2018). (a) <i>Except as authorized by this subchapter</i>, it shall be unlawful for any person <u>knowingly or intentionally</u>— (1) to manufacture, distribute, or dispense . . . a controlled substance</p>	<p>Ala. Code § 26-23H-4 (2023). (a) It shall be unlawful for any person to <u>intentionally</u> perform . . . an abortion <i>except as provided for by subsection (b)</i>. (b) An abortion shall be permitted if an attending physician licensed in Alabama determines that an abortion is <i>necessary in order to prevent a serious health risk to the unborn child's mother</i>.</p>
<p>21 C.F.R. § 1306.04(a) (2023). (a) A prescription for a controlled substance to be effective must be issued for a <i>legitimate medical purpose</i> by an individual practitioner acting <i>in the usual course of his professional practice</i>.</p>	<p>Ala. Code § 26-23H-3 (2023). (6) Serious Health Risk to the Unborn Child's Mother. In <u>reasonable medical judgment</u>, the child's mother has a condition that so complicates her medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function.</p>