WHEN PATIENTS ARE THEIR OWN DOCTORS: *ROE V. WADE* IN AN ERA OF SELF-MANAGED CARE

Yvonne Lindgren†

The Supreme Court in Roe v. Wade *framed the abortion right as the right to make an abortion decision in consultation with a "responsible physician." Under this framing, doctors were cast into the role of medical "gatekeepers" to mediate patient access to abortion. In the ensuing years, the doctor-patient relationship has become the site of restrictive abortion regulations in many states. This Article argues that* Roe*'s framing suffers from a foundational flaw: while the gatekeeper framing may have been appropriate in the* Roe *era when abortion was surgical and non-clinical abortions were potentially lethal, today, medication abortion—a two-drug non-surgical regimen that can safely and effectively terminate a pregnancy at home—renders the Court's gatekeeper framing obsolete and no longer reflects the technological or medical realities of abortion-related healthcare. This Article reasserts the constitutional right to abortion and argues that advances in medical technology call for a new framing for the right as one of direct access to abortion that is not dependent upon the provider-patient relationship. This framing is better suited to protect the breadth and depth of the abortion right because it reflects the new technological realities of the practice of abortion and the promise of abortion care outside of the medical gatekeeper model, which has been the focus of restrictive regulation and clinic harassment.*

It is a critical time to re-examine the gatekeeper framing of the abortion right considering the dramatic conservative shift in the Supreme Court that threatens Roe*, and in the midst of a*

† Associate Professor of Law, University of Missouri-Kansas City. J.S.D, LL.M., U.C. Berkeley School of Law; J.D., Hastings College of Law; B.A., U.C.L.A. For helpful suggestions and feedback I am grateful to Greer Donley, Tristin Green, Jill Hasday, Nancy Levit, Kristin Luker, Melissa Murray, Rachel Rebouché, Allen Rostron, the participants in the AALS Annual Meeting Law and Medicine Workshop, Seema Mohapatra, Elizabeth Pendo, Ruqaiijah Yearby, and Fazel Khan. Thank you to the Drake Law School Faculty Colloquium, the Annual Reproductive Ethics Conference of the Institute for Bioethics & Health Humanities, the Law & Society Annual Meeting, and the Annual Health Law Professors Conference of the American Society of Law, Medicine & Ethics for the opportunity to present and receive feedback on the Article. Tori Martin and the editorial staff at *Cornell Law Review* provided excellent editorial support.

pandemic, which—in a complete reversal of the Roe *period—renders in-person care by a provider potentially dangerous. In January, the Supreme Court's first abortion decision since President Trump's appointment of three justices,* FDA v. American College of Obstetricians & Gynecologists ("ACOG"), *doubled down on the medical gatekeeper model by reinstating an FDA requirement that medication abortion pills must be dispensed in person by a provider. Re-examining the historical, social, and technological assumptions that animate the current framing of the abortion right is vital to thinking of new ways to frame and expand abortion access. Today's online medical and pharmaceutical marketplaces reveal that the Court's confined vision of the abortion right was informed by the social and technological realities of its time—social and technological realities that no longer exist. If* Roe*'s cramped vision of the abortion right has run its course, as I argue here, then the movement to protect access to abortion must include direct consumer access to abortion. Empirical evidence reveals widespread use of self-managed medication abortion in the face of abortion restrictions. The shuttering of clinics as "non-essential services" during the COVID-19 pandemic and the unnecessary increased risk of clinic-based care for procedures that can be safely managed at home only amplify the need for direct-to-consumer access to abortion care. As state legislatures seek to make it easier to prosecute individuals suspected of terminating their own pregnancies, it is a crucial moment to reconsider the constitutional foundation of the abortion right and the right to self-managed care as a matter of criminal and reproductive justice and public health.*

INTRODUCTION

In January, the Supreme Court handed down its first abortion decision under the newly-constituted Court with three justices appointed by President Trump, most recently Amy Coney Barrett.[1] The decision in *FDA v. ACOG* reinstated a requirement that medication abortion pills—a non-surgical two-drug regimen for terminating pregnancy[2]—must be partially dispensed in person at a clinic.[3] A federal judge had suspended the Food and Drug Administration's ("FDA") in-person dispensing requirement for mifepristone during the COVID-19 pandemic because the in-person requirement unnecessarily subjected people seeking an abortion to a heightened risk of

---

1 *See, e.g.*, Sahil Kapur, Julie Tsirkin & Rebecca Shabad, *Senate Confirms Amy Coney Barrett, Heralding New Conservative Era for Supreme Court*, NBC NEWS (Oct. 26, 2020), https://www.nbcnews.com/politics/congress/amy-coney-barrett-set-be-confirmed-supreme-court-monday-n1244748 [https://perma.cc/SR4A-KUKN] (last updated Oct. 27, 2020) (describing the Senate confirmation of Amy Coney Barrett to the United States Supreme Court); Alisha Haridasani Gupta, *Justice Barrett Rises to Top of Increasingly Conservative Judiciary*, N.Y. TIMES (Oct. 27, 2020), https://www.nytimes.com/2020/10/27/us/justice-barrett-conservative-supreme-court.html [https://perma.cc/A242-6T5Y] (writing on Amy Coney Barrett's Supreme Court confirmation).

2 In the two-drug regimen that normally involves ingesting four pills, "[m]ifepristone . . . blocks progesterone, a hormone essential to the development of a pregnancy, and thereby prevents an existing pregnancy from progressing. Misoprostol, taken 24–48 hours after mifepristone, works to empty the uterus by causing cramping and bleeding, similar to an early miscarriage." *The Availability and Use of Medication Abortion*, KAISER FAM. FOUND. (Apr. 13, 2021), https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/ [https://perma.cc/GW86-5QFG]. By contrast, there are two types of surgical abortion—aspiration, and dilation and evacuation—which generally involve dilating the cervix and suctioning and/or scraping the uterine wall with a curette to expel the contents of the pregnancy. *Surgical Abortion*, HEALTHLINE, https://www.healthline.com/health/surgical-abortion#preparing [https://perma.cc/82K5-MJFJ] (last updated Dec. 6, 2018).

3 141 S.Ct. 578 (2021).

exposure to the virus to obtain a drug that could be safely delivered through the mail or through pharmacies.[4] The case signals how the new conservative majority on the Supreme Court may approach future abortion cases and the likelihood that Justice Barrett's confirmation raises the real possibility that *Roe v. Wade* will be overturned. The conservative shift in the federal courts generally and the Supreme Court specifically means that protecting the abortion right increasingly will take place at the state level[5] and at the federal administrative level—such as the FDA's recent decision to suspend the in-person dispensing requirement for mifepristone during the COVID-19 pandemic to allow medication abortion to be dispensed at pharmacies and through the mail, thereby neutralizing the Supreme Court's decision in *FDA v. ACOG*.[6] Last term the Supreme Court issued its decision in *June Medical Services L.L.C. v. Russo*,[7] with Chief Justice Roberts joining a 5-to-4 majority, which reaffirmed the holding of *Whole Woman's Health v. Hel-*

---

4 ACOG v. FDA, 472 F. Supp. 3d 183, 216, 218–19 (D. Md. 2020) (describing the in-person dispensing requirement as "medically unnecessary"). *See generally* Rachel Rebouché, *Abortion Opportunism*, 7 J.L. & BIOSCIENCES 1, 1–5 (2020) (examining some of the laws passed suspending abortion care in response to the COVID-19 pandemic and the implications of suspending constitutional rights as a health-emergency measure).

5 *See, e.g.*, Carrie N. Baker, *Barrett Hearings Inspire State Action to Protect Abortion Rights*, MS. MAG. (Oct. 26, 2020), https://msmagazine.com/2020/10/26/barrett-hearings-inspire-state-action-to-protect-abortion-rights/ [https://perma.cc/9Z8L-6D4M] (noting that the confirmation of Amy Coney Barrett has caused abortion rights activists to shift focus to state legislatures and Congress to protect the abortion right); Vanessa Romo, *Massachusetts Senate Overrides Veto, Passes Law Expanding Abortion Access*, NPR (Dec. 29, 2020), https://www.npr.org/2020/12/29/951259506/massachusetts-senate-overrides-veto-passes-law-expanding-abortion-access [https://perma.cc/J7J9-Y73Y] (describing state efforts in Massachusetts to enshrine abortion rights in state law and expand abortion access). In 2020, Massachusetts passed the ROE Abortion Act, an "Act to Remove Obstacles and Expand Abortion Access." *See* S.B. 1209, 191st S., 2nd Sess. (Mass. 2020).

6 In a letter dated April 12, 2021 to the ACOG, the acting commissioner of the FDA, Dr. Janet Woodcock, said that the agency would temporarily stop enforcement of the in-person dispensing requirement for the first drug, mifepristone, in the two-drug medication abortion regimen. The letter noted that "the overall findings from these studies do not appear to show increases in serious safety concerns . . . occurring with medical abortion as a result of modifying the in-person dispensing requirement during the COVID-19 pandemic." ACOG Action (@ACOGAction), TWITTER (Apr. 12, 2021, 9:27 PM) [hereinafter Woodcock Letter], https://twitter.com/ACOGAction/status/1381781110980501512/photo/1 [https://perma.cc/V5ED-F7ZK].

7 *See* 140 S. Ct. 2103, 2112–13 (2020); *see also June Medical Services LLC v. Russo*, SCOTUSBLOG, https://www.scotusblog.com/case-files/cases/june-medical-services-llc-v-russo/ [https://perma.cc/F6P3-GFY2] (last visited June 5, 2021).

lerstedt,[8] which struck down just four years earlier a nearly identical admitting privileges law that prohibited a doctor from performing abortions in the state unless the doctor had active admitting privileges at a local hospital within thirty miles of the doctor's clinic.[9] Whether or not *Roe* is overturned and *June Medical*'s apparent victory is short-lived,[10] the medical gatekeeper framing, upon which these cases rest and which has been central to abortion jurisprudence over the last forty-seven years, is no longer relevant to the social and technological realities of the practice of abortion care. Indeed, it is fitting that the Court's first abortion decision is a case involving medication abortion because, as I argue here, medication abortion represents a significant shift in the way abortion care is delivered, and as a result fundamentally challenges its constitutional framing.

The Supreme Court in *Roe v. Wade* framed the abortion right as the right to make an abortion decision in consultation with a "responsible physician."[11] Under this framing—what I term the "medical 'gatekeeper' model"—providers mediate ac-

---

8 136 S. Ct. 2292 (2016).

9 *See id.* at 2310, 2321; *June Med. Servs. L.L.C.*, 140 S. Ct. at 2112–13.

10 Chief Justice Roberts' concurrence in *June Medical* rejected the balancing test set forth in *Whole Woman's Health* that called upon courts to weigh both the benefits and burdens of an abortion restriction in the undue burden analysis. Instead, Justice Roberts retreated to the undue burden analysis of the *Casey* decision, which merely required courts to consider if a restriction placed a substantial obstacle in the path of a person seeking an abortion. *See June Med. Servs. L.L.C.*, 140 S. Ct. at 2135–36 (2020) (Roberts, C.J., concurring) (arguing that "[n]othing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts"). Many commentators have observed that the *June Med.* decision was not as much of a victory as many have suggested. *See, e.g.*, Melissa Murray, *Opinion: The Supreme Court's Abortion Decision Seems Pulled from the 'Casey' Playbook*, WASH. POST (June 29, 2020) [hereinafter Murray, *'Casey' Playbook*], https://www.washingtonpost.com/opinions/2020/06/29/problem-with-relying-precedent-protect-abortion-rights/ [https://perma.cc/9RP7-TZQC] (describing that Justice Roberts signed on to the majority opinion out of respect for stare decisis but critically rejected the reasoning of *Whole Woman's Health* that required courts to weigh whether an abortion law's purported benefits exceeded the burdens imposed and retreated to the *Casey* standard of whether the law places a "substantial obstacle" in the path of a woman seeking an abortion); Mary Ziegler, *OpEd: Why Abortion Rights Are Still at Risk*, L.A. TIMES (July 3, 2020), https://www.latimes.com/opinion/story/2020-07-03/june-medical-supreme-court-john-roberts-brett-kavanaugh-abortion-rights [https://perma.cc/H4LW-JKPT] (noting that Justice Roberts' decision was not based on a "newfound commitment" to the abortion right but simply his commitment to stare decisis). For a discussion of stare decisis in *June Medical*, see Melissa Murray, *The Supreme Court, 2019 Term—Comment: The Symbiosis of Abortion and Precedent*, 134 HARV. L. REV. 308, 319–27 (2020) [hereinafter Murray, *Symbiosis of Abortion*].

11 410 U.S. 113, 153 (1973).

cess to abortion and, in the ensuing years since the decision, the private doctor-patient relationship has become the site of restrictive abortion regulations in many states. Scholars have long criticized *Roe*'s accommodation of the medical model of abortion reform for subordinating pregnant people's constitutional rights to the judgment of their healthcare providers.[12] This Article brings a new analysis to bear on *Roe*'s medical model of the abortion right to argue that the gatekeeper framing suffers from an even more foundational flaw: while the gatekeeper framing may have been appropriate in the *Roe* era when abortion was surgical and non-clinical abortions were potentially lethal, today, medication abortion renders the Court's gatekeeper framing outdated and no longer reflects the technological or medical realities of abortion-related healthcare. This Article reasserts the constitutional right to abortion and argues that advances in medical technology call for a new framing of the right as one of direct access to abortion that is not dependent upon the provider-patient relationship. This

---

12 *See infra* notes 111–112 and accompanying text. Professor Reva B. Siegel has argued that the decision in *Roe v. Wade* straddled the women's rights and the medical models of abortion rights and gave only "confused expression" to women as constitutional-rights holders in the abortion context and gave greater protection to doctors' rights to make medical decisions than to women's rights to control reproduction. Reva B. Siegel, Roe's *Roots: The Women's Rights Claims That Engendered* Roe, 90 B.U. L. REV. 1875, 1897 (2010) [hereinafter Siegel, Roe's *Roots*]; *see also* Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 272–80 (1992) [hereinafter Siegel, *Reasoning from the Body*] (describing how *Roe* presented decisions about childbearing as a "private dilemma" between a patient and doctor). Nan Hunter has argued that the Court's decision in *Roe* can best be understood as the Court's attempt to delegate to physicians the juridical authority over the procreative questions presented by abortion. Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 194–97 (2006); *see also* LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES 45 (1990) (arguing that the medical model, which emphasized the role of doctors in the abortion decision, reinforced the traditional role of women as dependent and not in control of their destinies). *But see* Sylvia A. Law, *Abortion Compromise—Inevitable and Impossible*, 1992 U. ILL. L. REV. 921, 932–38 (1992) (offering a critique of Tribe's *The Clash of Absolutes*); Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L.Q. 183, 197–201 (1985) (describing commentary on Tribe's theories of *Roe*); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–200 (1992) ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician's medical judgment. The *Roe* decision might have been less of a storm center had it . . . homed in more precisely on the women's equality dimension of the issue . . . ." (footnotes omitted)); Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41, 42 (2008) (highlighting crucial language in the *Roe* decision that emphasized the central role of the physician in the abortion context).

framing is better suited to protect the breadth and depth of the abortion right because it reflects the new technological realities of the practice of abortion and the promise of abortion care outside of the medical gatekeeper model, which has been the focus of restrictive regulation and clinic harassment. The idealized doctor-patient relationship described by the *Roe* Court never reflected the realities of abortion access for people living in poverty, who are disproportionately of color, or who could not afford a private physician. The stranglehold of abortion restrictions in the ensuing years has only amplified the disparate lack of access to abortion for those who are most marginalized and vulnerable.[13]

Mounting evidence suggests that significant numbers of pregnant people[14]—as many as two hundred thousand in Texas alone[15]—have successfully terminated their pregnancies using various methods, including medication abortion pills procured online.[16] The evidence that increasing numbers of individuals are safely and effectively managing their abortions

---

13 *See e.g.*, Brief for Reproductive Justice Scholars as Amici Curiae Supporting Petitioners-Cross-Respondents at 7, June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020) (Nos. 18-1323, 18-1460) [hereinafter Bridges & Roberts RJ Scholars Brief] (describing the effect that restrictive abortion regulations have on marginalized populations in Louisiana).

14 I use the term "pregnant people" instead of "pregnant women" to acknowledge that trans men and other gender-non-conforming people may also seek abortion-related healthcare and may have even more difficulty accessing reproductive healthcare than cis-women seeking abortion. *See, e.g.*, Katha Pollitt, *Who Has Abortions?*, NATION (Mar. 13, 2015), https://www.thenation.com/article/archive/who-has-abortions/ [https://perma.cc/E8GD-9S3E] ("*Men* have abortions. 'We must acknowledge and come to terms with the implicit cissexism in assuming that only women have abortions . . . .'" (quoting feminist Lauren Rankin)). It has been noted that the term "pregnant people" is also reminiscent of the rhetorical sleight of hand in *Geduldig v. Aiello*, in which Justice Stewart famously rejected the argument that pregnancy discrimination is a form of gender discrimination because there are "pregnant women" and "nonpregnant persons" and women can belong to both categories. 417 U.S. 484, 496–97 n.20 (1974). The use of the term in *Geduldig* to undermine gender equality and in its present usage to denote inclusivity reveals the power of terminology to transform over time.

15 *See* D. GROSSMAN ET AL., TEX. POL'Y EVALUATION PROJECT RESEARCH BRIEF: KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS 1, 2 (2015) (finding that in the wake of Texas' passage of HB2, one of the most restrictive abortion laws in the country, there has been an increase in the use of self-induction abortion through medication, and estimating that between 100,000 and 240,000 women have attempted to end their own pregnancies); *see also* Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014), https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/ [https://perma.cc/E7P7-WJXP] (describing the rise of home-based medication abortion as a result of increased abortion provider regulations).

16 *See infra* notes 248–254 and accompanying text.

without the assistance of a provider calls into question the medical gatekeeper framing upon which abortion jurisprudence rests and which has been central to abortion cases over the last forty-eight years. The Court in *Roe* looked to then-current medical technology to craft the gatekeeper framing,[17] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*[18] revised *Roe*'s trimester framework in light of the new medical technology that rendered it unworkable.[19] Both holdings provide that courts should restructure the framing of the abortion right in light of current practices and technology without disturbing its underlying foundation. This Article compares the reality of modern abortion practice against the idealized doctor-patient relationship that anchored the *Roe* Court's medical gatekeeper framing, and animates the undue burden analysis to argue that the current framing of the abortion right is obsolete.

Self-managed abortion via the direct-to-consumer online pharmaceutical marketplace is a revolution in abortion care that was unimaginable at the time the *Roe* Court announced that the abortion right is "inherently, and primarily, a medical decision" to be made in consultation with a "responsible physician."[20] Critically, self-managed abortion falls outside of the narrow framing of the medical gatekeeper model of the abortion right. Indeed, self-managed abortion is tracking with larger trends in self-managed care, including direct-to-consumer blood testing, fecal testing, and DNA testing, self-managed gender-affirming hormone therapy,[21] and assisted reproductive

17 *See* Roe v. Wade, 410 U.S. 113, 144, 164–65 (1973).

18 505 U.S. 833 (1992) (plurality opinion).

19 *See* discussion *infra* subpart III.B.

20 *Roe*, 410 U.S. at 153, 166.

21 It is estimated that hormones used by TGNC people who take hormones outside of physician supervision ranges from twenty-nine percent to sixty-three percent in urban areas. *See, e.g.*, Nelson F. Sanchez, John P. Sanchez & Ann Danoff, *Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City*, 99 AM. J. PUB. HEALTH 713, 713–19 (2009), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2007.132035 [https://perma.cc/UAW6-89SD] (reporting that in their study of TGNC people in New York City, "[t]he prevalence of unsupervised hormone use reportedly ranges from 29% to 63% within urban groups of male-to-female transgender persons" (footnotes omitted)); Jessica Xavier et al., *Transgender Health Care Access in Virginia: A Qualitative Study*, 14 INT'L J. TRANSGENDERISM 3, 3, 10 (2013) (noting that "[f]aced with barriers to access, hormonal self-medication was common," and finding that many respondents in a survey of transgender and GNC people in Washington, D.C. have taken hormones that they acquired from friends or on the street); CATHY J. REBACK, PAUL A. SIMON, CATHLEEN C. BEMIS & BOBBY GATSON, THE LOS ANGELES TRANSGENDER HEALTH STUDY: COMMUNITY REPORT 17 (2001) (finding among respondents, 51% had obtained hormones off

technology such as ova and sperm shopping.[22] As a result, the ability of pregnant people to directly access safe and effective abortion medication online, completely outside of the doctor-patient relationship, upends the foundation upon which the current framing of abortion jurisprudence rests.

It is a critical time to re-examine the gatekeeper framing of the abortion right considering the significant conservative shift in the Supreme Court[23] that threatens *Roe*, and in the midst of a pandemic, which—in a complete reversal of the *Roe* period—renders in-person care by a provider potentially dangerous. This Article constructs a new way to frame and expand access to abortion by re-examining the historical, social, and technological assumptions that animate the current framing of the abortion right in contrast with the new technological realities of the online medical marketplace. The analysis forged in this Article reveals that the Court's confined vision of the abortion right was informed by the social and technological realities of its time—social and technological realities that no longer exist and should no longer guide the breadth and depth of the abortion right. If *Roe*'s cramped vision of the abortion right as one that requires a medical gatekeeper has run its course, as I argue here, then the movement to reassert the abortion right and protect access to abortion must include direct consumer access to self-managed abortion. Empirical evidence reveals widespread use of self-managed abortion in the face of abortion restrictions.[24] The shuttering of clinics as "non-essential services" during the COVID-19 pandemic, and the unnecessary

---

the streets); Stephanie L. Budge, *Psychotherapists as Gatekeepers: An Evidence-Based Case Study Highlighting the Role and Process of Letter Writing for Transgender Clients*, 52 PSYCHOTHERAPY 287, 288 (2015) (noting that as a result of barriers, many transgender individuals turn to the black market to obtain hormones); Kristen Clements-Nolle, Rani Marx, Robert Guzman & Mitchell Katz, *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention*, 91 AM. J. PUB. HEALTH 915, 918 (2001) (finding a number of respondents obtained hormones from non-medical sources).

22 *See, e.g.*, Meghana Keshavan, *These are the Key Players in the Home Health Testing Market*, MEDCITY NEWS (Jan. 20, 2016), https://medcitynews.com/2016/01/20-key-players-in-the-direct-to-consumer-lab-testing-market/ [https://perma.cc/6BH4-CNVT] (describing the rise in direct-to-consumer laboratory testing, including genetic testing, fertility analyses, blood testing, and cancer screenings).

23 *See, e.g.*, Kapur, *supra* note 1 (noting that "[s]ome legal experts say [the Supreme Court after Amy Coney Barrett's confirmation] will be the most conservative Supreme Court since before World War II").

24 *See, e.g.*, Grossman, *supra* note 15, at 4 (finding that in Texas, self-induced abortion appeared to be more common "among women who report[ed] barriers accessing reproductive health services").

increased risk of clinic-based care for procedures that can be safely managed at home but for regulations that require in-person dispensing by a clinic or provider, only amplifies the need for direct-to-consumer access to abortion care.[25] As state legislatures seek to make it easier to prosecute individuals suspected of terminating their own pregnancies,[26] it is a critical moment to reconsider the constitutional foundation of abortion and the right of self-managed care as a matter of criminal and reproductive justice and public health.

This Article proceeds in three parts: Part I examines the current legal framing of the abortion right as one in which a doctor acts as gatekeeper to access to abortion. It traces the history of early abortion regulation up to *Roe*, as well as the technological realities of abortion at the time. It draws out how central "current medical technology" of abortion care was to the *Roe* opinion's medical gatekeeper model as well as subsequent cases. It shows how abortion opponents seized upon the medical gatekeeper framing in *Roe* to restrict and regulate abortion through the doctor-patient relationship. In so doing, restrictive abortion legislation in many states has turned doctors into quasi-state actors in what had previously been the private doctor-patient relationship.

Part II examines the new social and technological realities of abortion care. Specifically, it argues that the social and technological landscape that informed *Roe*'s framing of the medical gatekeeper model no longer exists, and in fact never existed for those who lacked the social, political, or economic privilege to access a private doctor. Next, this Part examines how self-managed abortion is tracking with larger trends in the medical marketplace that has emerged in which patients act more like consumers as technology allows them to directly access healthcare through an online platform.

Part III explores the implications of replacing the outdated medical gatekeeper model of the abortion right to bring the

---

25 Sabrina Tavernise, *Texas and Ohio Include Abortion as Medical Procedures that Must Be Delayed*, N.Y. TIMES (Mar. 23, 2020), https://www.nytimes.com/2020/03/23/us/coronavirus-texas-ohio-abortion.html [https://perma.cc/AN5H-FY48]; Christina Cauterucci, *Abortion Care is Essential Health Care*, SLATE (Mar. 23, 2020), https://slate.com/technology/2020/03/coronavirus-abortion-ban-texas-ohio.html [https://perma.cc/4P7D-YVWT].

26 *See, e.g.*, Mark Joseph Stern, *Georgia Just Criminalized Abortion. Women Who Terminate Their Pregnancies Would Receive Life in Prison*, SLATE (May 7, 2019), https://slate.com/news-and-politics/2019/05/hb-481-georgia-law-criminalizes-abortion-subjects-women-to-life-in-prison.html [https://perma.cc/ZPS8-KZMU] (describing a new Georgia law that lacks previous exceptions from criminal penalties for people who self-abort).

right in line with the new technological realities in which abortion is practiced. First, it offers two constitutional foundations for the abortion right—framings foreclosed by the *Roe* Court's decision—as a right to care for one's health or the feminist vision of a right to abortion on demand. While this may be aspirational with the current make-up of the Court, it considers the broader legal landscape to re-assert the constitutional foundations of the abortion right while forging a new the way to frame the right in light of significant medical and social trends in abortion care and direct consumer access. Next, it examines how reframing the abortion right outside of the gatekeeper model would affect current restrictions on abortion access and on the criminalization of self-managed abortion for those individuals suspected of terminating their own pregnancies.

I
THE MEDICAL GATEKEEPER MODEL

In *Roe* the Supreme Court announced that the abortion right was, "inherently, and primarily, a medical decision" to be made in consultation with a "responsible physician."[27] In so doing, the Court articulated a right to abortion that was firmly embedded in the medical model that relied on doctors to negotiate pregnant people's access when exercising the right to abortion.[28] This section describes the historical context which gave rise to the *Roe* Court's framing of the abortion right in the medical gatekeeper model. It examines abortion jurisprudence to reveal how, over time, abortion jurisprudence has solidified the role of doctors acting as gatekeepers to abortion access, reaching a high-water mark in the undue burden analysis of *Casey*.[29]

---

27 Roe v. Wade, 410 U.S. 113, 153, 166 (1973).

28 *See, e.g.*, Mary Anne Wood & W. Cole Durham, Jr., *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U. L. REV. 783, 783–84 (describing *Roe*'s vision of an abortion decision resting with the patient and doctor); Appleton, *supra* note 12, at 199–200 (discussing the "medical counselor model" in which doctors actively participate in the woman's decision-making regarding abortion).

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

A. The History of the Medical Establishment in the Criminalization of Abortion

Historically, abortion was unregulated in the United States and was not a crime before quickening.[30] The movement to criminalize abortion began in the 1850s when "elite" or "regular" doctors began to call for restrictive abortion regulation in an effort to professionalize medicine and drive out competing "lay" healers, who were primarily women and people of color.[31] As doctors in the mid-nineteenth century began to be trained in newly-established medical schools, they sought to distinguish themselves from lay practitioners and healers.[32] Doctors used their movement to criminalize abortion as a maneuver to turn medicine from a domestic practice that took place in the home to a professional practice in the exclusive control of medically-trained doctors, who were primarily white, male, native-born, and from elite families.[33] To do so they sought to assert their superior moral and scientific knowledge by arguing that life began at conception and therefore abortion should be criminalized because it ended a human life.[34] Nineteenth-century physicians who lobbied state legislatures for laws criminalizing abortion argued that American women were committing a moral crime because of their ignorance about the science of embryonic life and doctors needed to come to bear on the issue in order to save American women from their own ignorance.[35] It was at this critical historical juncture that abortion was taken out of the domestic realm and professionalized into the medical realm and doctors were charged with determining when abortion would be medically "necessary" to protect the life or health of the pregnant person.[36]

---

30 Quickening is the period in which the pregnant person feels fetal movement. KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 14 (1984) (noting that at the opening of the nineteenth century, no laws governed early abortion in America).

31 *Id.* at 15–17. For an excellent discussion of the physician's crusade to professionalize the practice of medicine and criminalize abortion, see JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800–1900 147–71 (1978) (describing physicians' "aggressive campaign against abortion" in the mid-nineteenth century)

32 LUKER, *supra* note 30, at 17–18.

33 *Id.* at 27 (noting that "regular" physicians who tended to be wealthier and better educated sought to distinguish themselves both scientifically and socially from competing lay practitioners).

34 *Id.* at 20–21.

35 *Id.* at 21 (noting that indeed at the time American women did not consider early abortion to be morally wrong as reflected by the prevailing attitude since ancient history).

36 *Id.* at 32–33.

The call to criminalize abortion during this period was also fueled by fears of "race suicide" due to declining birth rates among white, Protestant, native-born married women between 1800 and 1900 that coincided with the dramatic rise in immigration at the turn of the century.[37] Reproduction among this group of women declined by half between 1800 and 1900, with the number of children born per married woman falling from 7.04 to 3.56.[38] Anxiety over the falling birthrates of white, upper-class women led one opponent of abortion to observe that abortion is

> one great cause and reason for so few native-born children of American parents . . . [and] one of the many reasons why we are fast losing our national characteristics, and slowly merging into those of our foreign population, who, according to the United States statistics of 1870, are rearing fifty per cent[ ] more children according to their number than Americans are doing.[39]

As historian James Mohr has documented, abortion came into public view in the 1840's because the practice of abortion changed from a procedure used by "desperate" single women to widespread use by white, married, Protestant, native-born middle- and upper-class women in order to control family size.[40] Laws criminalizing abortion were a response to falling birthrates for "good reproduction" and the desire to control women's fertility in service to the state in the reproduction of citizens as a bulwark to protect a white majority against the rising tide of immigration.[41]

The American Medical Association's lobbying efforts were successful. While at the opening of the nineteenth century

---

37 *See* ROSALIND POLLACK PETCHESKY, ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM 70–72 (rev. ed. 1990) (explaining that restrictions on fertility control such as contraception and criminal abortion laws were driven by white Anglo-Saxon fears of a mushrooming immigrant under-class alongside a declining birthrate of native-born white Protestant married women that caused fears of "race suicide"); Siegel, *Reasoning from the Body*, *supra* note 12, at 285, 297–300.

38 PETCHESKY, *supra* note 37, at 73.

39 Siegel, *Reasoning from the Body*, *supra* note 12, at 298 (citing James S. Whitmire, *Criminal Abortion*, 31 CHI. MED. J. 385, 392 (1874)).

40 MOHR, *supra* note 31, at 46, 86.

41 *See* PETCHESKY, *supra* note 37, at 78–79; Siegel, *Reasoning from the Body*, *supra* note 12, at 297–99; Melissa Murray, *Race-ing* Roe: *Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2036 & n.61–62 (2021) (describing that whites' fear of demographic changes taking place during the mid-1800s drove the campaign to criminalize abortion "as a means of deterring native-born white women from terminating pregnancies and allowing the white birth rate to be overwhelmed by immigrant and nonwhite births").

there were no laws in any state that prohibited abortion before quickening, by 1900 most states had laws on the books that prohibited abortion.[42] Critically, however, the laws reflected the interests of the medical professionals who pushed for them: rather than criminalizing abortion outright, the laws made it a crime for anyone but a *licensed physician* to perform an abortion and left wide discretion to doctors to determine when an abortion was "necessary" to preserve the life or health of the pregnant person.[43] In so doing, the physicians' lobby created a category of "justifiable" or "therapeutic" abortions and designated themselves as the sole custodians and arbiters of that decision.[44]

On the eve of *Roe*[45] and the companion case *Doe v. Bolton*[46] in 1973, abortion was firmly entrenched in the medical model, with the abortion decision dependent on a finding by a doctor, or often a medical review board, that an abortion was necessary to protect the life or health of the pregnant person.[47] Ironically, in the mid-1960s it was once again the medical profession that called for legislative reform of abortion, this time as a call to *liberalize* abortion.[48] Notably, physicians who called for reform of abortion laws—as opposed to their counterparts in the feminist movement who called for outright repeal of abortion laws[49]—wanted to keep the abortion decision exclusively in the hands of doctors and sought to reform abortion laws to give greater guidance to *doctors* when making the deci-

---

42 LUKER, *supra* note 30, at 14–15.

43 *Id.* at 32–33.

44 *Id.* (noting that only ten states had laws that specified that the physician must consult with another physician before performing an abortion; two states specifically stated that "regular" physicians must make the decision; Maryland stipulated that a "respectable" physician must make the decision).

45 Roe v. Wade, 410 U.S. 113 (1973).

46 410 U.S. 179 (1973).

47 The doctor-led medical abortion reform movement was comprised of doctors, lawyers, and public health officials who appealed to legislators to reform therapeutic abortion laws. The abortion reform movement sought to give doctors clearer guidelines and greater discretion in deciding when abortion was lawful. *See generally* LUKER, *supra* note 30, at 66–125 (describing abortion reform and the rise of the concept of a right to abortion); Siegel, Roe's *Roots*, *supra* note 12, at 1879–86 (noting the American Law Institute's efforts to liberalize abortion by providing for therapeutic abortions); LINDA GREENHOUSE & REVA B. SIEGEL, BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 3–5 (2010).

48 The "medical model" sought to reform abortion by giving doctors greater discretion in making the abortion decision. *See* LUKER, *supra* note 30, at 66, 72; Siegel, Roe's *Roots*, *supra* note 12, at 1879–80; Appleton, *supra* note 12, at 199–200.

49 *See* LUKER, *supra* note 30, at 93, 95; GREENHOUSE & SIEGEL, *supra* note 47, at 35–67; Siegel, Roe's *Roots*, *supra* note 12, at 1880–86.

sions about whether an abortion was necessary to protect the health or life of the pregnant person.[50] The definition of protecting "health" was broadly interpreted to include mental health, and thereby gave wide discretion to doctors in making the abortion decision on behalf of their patients.[51]

B. Technological Realities of Performing Abortions in the Time of *Roe*

Before non-surgical medication abortion was approved by the FDA in 2000,[52] abortions performed by doctors were solely surgical abortions, called "D&Cs" or dilation and curettage.[53] In the decades leading up to *Roe*, physicians used their medical expertise to determine which abortions were "medically necessary"; all others were by definition criminal.[54] However, between 1900 and 1960, as childbirth became safer and abortions became less necessary to preserve the life of the mother, a debate arose in the medical community about which abortions were medically indicated.[55] The therapeutic exception that placed the abortion decision exclusively in the realm of medical judgement gave rise to a wide range of views and practices on what it meant to preserve a mother's life. Doctors

---

50 The medical reform model sought to vest the discretion to decide when abortion was permissible solely in the hands of the physician, rather than giving pregnant women the right to abortion "on demand." American Medical Association Policy Statement, June 1970, "Resolution No. 44, Therapeutic Abortion," *in* GREENHOUSE & SIEGEL, *supra* note 47, at 26. Justice Harry A. Blackmun had a copy of this document in his file when he was writing his opinion in *Roe v. Wade*. *Id.* at 26.

51 *See* LUKER, *supra* note 30, at 46–47, 66 (noting that "[a]s 'preserving the life of the woman' in the physical sense of the word became a medical rarity, the continuum collapsed and the consensus broke down" and "health" was more broadly construed to include physical and mental health).

52 *See Questions and Answers on Mifeprex*, FOOD & DRUG ADMIN., https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex [https://perma.cc/7VN4-E3BK] (last updated Apr. 12, 2019).

53 The surgical procedure is one in which the provider dilates the cervix and scrapes the uterine lining with a spoon-shaped instrument called a curette. *Dilation and Curettage (D and C)*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/dilation-and-curettage-d-and-c [https://perma.cc/8Z2M-QC5T] (last visited June 5, 2021).

54 LUKER, *supra* note 30, at 43.

55 *Id.* at 40, 66 (noting that "[a]s 'preserving the life of the woman' in the physical sense of the word became a medical rarity, the continuum collapsed, and the consensus broke down. For the first time since the nineteenth century, medical technology—in this case, advances in obstetrical science—set the stage for abortion to reemerge as a political and moral issue"); MARY ZIEGLER, AFTER ROE: THE LOST HISTORY OF THE ABORTION DEBATE 6–7 (2015) (noting that as abortion became safer in the second half of the twentieth century, doctors were forced to find new justifications for the procedure).

who were strict constructionists interpreted the law as permitting abortion only to prevent the death of the woman. More liberal physicians interpreted the law more broadly, however, to mean preserving the *quality* of a woman's life—including economic and social considerations—as well as to preserve a woman's health, including her mental health.[56]

In the decades leading to *Roe*, an individual's access to legal abortion depended on their ability to find a doctor who interpreted the law more liberally. Data from the period between 1926 and 1960 bears this out, with abortion in the most liberal setting fifty-five times more likely than in more conservative settings.[57] In California, a study of twenty-six hospitals found that abortions were performed ranging from one therapeutic abortion for every 126 live births to no therapeutic abortions for every 7,615 live births.[58] As consensus among the medical community began to unravel, hospitals in the 1950s began to implement therapeutic abortion boards to review requests for abortion.[59] These boards generally consisted of internists, obstetrician-gynecologists, and psychiatrists who reviewed requests for abortion, with the result that abortion became less available in the hospital setting as review boards sought to act as a deterrent to abortion and approved only the most legally defensible requests for abortion.[60]

With doctors and medical review boards charged with the task of deciding which abortions were therapeutic, access to the procedure largely depended upon whether an individual had a relationship with a private physician. A public health official observed at the time that the difference between a "therapeutic" and illegal abortion "is $300 and knowing the right person."[61] As a result, women of color and women living in poverty had very limited access to legal abortion in comparison to wealthier white women.[62] For example, a study of abortion

---

56 LUKER, *supra* note 30, at 46–47.

57 *Id.* at 46.

58 *Id.* at 69.

59 *Id.* at 56.

60 *Id.* (noting that in one hospital, only one abortion was approved after the institution of the abortion review board and that some boards required sterilization as a precondition to approving the abortion request).

61 Mary Steichen Calderone, *Illegal Abortion as a Public Health Problem*, 50 AM. J. PUB. HEALTH 948, 949 (1960).

62 *See* Linda Greenhouse & Reva B. Siegel, *Before (and After)* Roe v. Wade*: New Questions About Backlash*, 120 YALE L.J. 2028, 2036 (2011) (explaining that the harms of illegal abortion were disproportionately experienced by the poor, while their wealthy and well-connected counterparts were able access "therapeutic" abortions by asking a psychiatrist to vouch for the impact of pregnancy on their mental health). A physician writing at the time described illegal abortion as

in New York's Sloane Hospital during the pre-*Roe* period from 1950 through 1955 revealed one abortion per thirty-seven births on the private wards, and one abortion per 141 births on the public or "charity" wards of the hospital.[63] All of the private patients but one were white, all of the public patients were Black, Asian, and white.[64] Once therapeutic abortion review committees were adopted between the 1940s and the 1960s, abortion access for women of color became even more rare, declining by sixty-five percent among "non-whites" and forty percent among "whites."[65] Of all therapeutic abortions performed in New York City in the 1960s, ninety percent were performed on white women.[66] The lack of access to therapeutic abortion during this period resulted in increased maternal mortality rate among women of color who were forced to turn to illegal abortion.[67] In the 1960s, half of all maternal deaths among black women were the result of illegal abortions.[68] Black women supported access to family planning, including abortion, because they were disproportionately dying and

---

a public health problem, describing the "inequity of application" of the medical procedure: "the woman with $300 who knows the right person and is successful in getting herself legally aborted on the private service of a voluntary hospital, in contrast to her poorer, less influential sister on the ward service of the same hospital or in a public hospital in the same city, a woman in exactly the same physical and mental state as the first one—whose application is turned down?" Calderone, *supra* note 61, at 951.

63 *See* Robert E. Hall, *Therapeutic Abortion, Sterilization, and Contraception*, 91 AM. J. OBSTETRICS & GYNECOLOGY 518, 518 (1965). Figures calculated by LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867–1973 205–06 n.42 (1997).

64 Hall, *supra* note 63, at 518.

65 REAGAN, *supra* note 63; *see* MELISSA MURRAY & KRISTIN LUKER, CASES ON REPRODUCTIVE RIGHTS AND JUSTICE 44–45 (2015).

66 ROBERT G. WEISBORD, GENOCIDE? BIRTH CONTROL AND THE BLACK AMERICAN 116 (1975). When Governor Nelson Rockefeller vetoed a law that sought to recriminalize abortion, he described the unequal access to hospital-based abortion, stating, "[t]he truth is that a safe abortion would remain the optional choice of the well-to-do woman, while the poor would again be seeking abortions at a grave risk to life in back-room abortion mills." Governor Nelson A. Rockefeller's Veto Message (May 13, 1972), *reprinted in* GREENHOUSE & SIEGEL, *supra* note 47, at 158, 160.

67 Between 1951 and 1962, while the death from therapeutic abortions rose from just over 25% of all maternal mortality, to a little over 42% while death rates of "non-white" pregnant women caused by abortion in this same period increased from approximately one-third to one-half, among Puerto Rican women from 44% to over 55%, and for white women from a little over 14% to just over 25%. *See* Edwin M. Gold, Carl L. Erhardt, Harold Jacobziner & Frieda G. Nelson, *Therapeutic Abortions in New York City: A 20-Year Review*, 55 AM. J. PUB. HEALTH 964, 965 (1965).

68 DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 101 (2d ed. 2017).

harmed by illegal abortion.[69] Congresswoman Shirley Chisholm, who served as honorary president of the National Abortion Rights Action League (NARAL), referenced the impact of illegal abortion on women of color as the reason for her support for abortion and for establishing family planning clinics in black communities, describing that "49 percent of the deaths of pregnant black women and 65 percent of those of Puerto Rican women . . . [are] due to criminal, amateur abortions."[70]

The necessity of having a private doctor-patient relationship to access abortion care resulted in racial and class inequality in access to abortion. Thus, abortion access was much more limited for people of color and people living in poverty who relied on public health systems for their healthcare.[71] Rather, until the 1860s, people of color and people living in poverty likely had greater access to abortion care when abortion was practiced in the home before it was medicalized and then criminalized in 1860s by the medical establishment. Before abortion was criminalized in the mid-nineteenth century, people seeking abortion who could not afford a private physician could turn to lay healers for traditional herbal methods of terminating a pregnancy or bringing on "blocked," "obstructed," or "'delayed' menstruation."[72] Indeed, in the years before criminalization, abortion providers regularly advertised in popular newspapers and magazines with wide circulation for ser-

---

69 *Id.*; Murray, *supra* note 41, at 2043–44 (describing black women as "especially vociferous in their desire for, and defense of, broader access to contraception and abortion" because the deleterious harms of criminal abortion fell disproportionately on black women).

70 SHIRLEY CHISHOLM, UNBOUGHT AND UNBOSSED 137 (2010) (first alteration in original).

71 *See* Brief for National Legal Program on Health Problems of the Poor, National Welfare Rights Organization, and American Public Health Association as Amici Curiae Supporting Jane Roe, Roe v. Wade, 410 U.S. 113 (1973), *reprinted in* GREENHOUSE & SIEGEL, *supra* note 47, at 269–73 (describing that because the poor rely primarily on public hospitals, poor and non-white women do not have equal access to abortion as their white counterparts with private physicians who can access "therapeutic" abortion, and as a result they suffer "greatly disproportionate numbers of deaths and crippling injuries as a result of being forced to seek criminal abortion"); REAGAN, *supra* note 63, at 173 (describing that after 1940, when therapeutic abortions began being performed in hospitals and illegal abortions were increasingly prosecuted, well-to-do women had greater access to abortion care than women living in poverty and women of color).

72 LUKER, *supra* note 30, at 18–19.

vices aimed at helping women to "bring on 'suppressed menses.'"[73]

Criminal or illegal abortions were commonplace in the decades before *Roe* for pregnant people who could not find a physician or medical review board willing to approve the abortion procedure. It is estimated that during the periods in the twentieth century that abortion was criminalized, between one-in-four and one-in-five pregnancies for women who had ever been married were terminated by abortion, most of them by illegal abortion.[74] The rate of abortion has remained relatively constant over time despite its illegality, with modern statistics of abortion rates substantially similar to those during the period that abortion was criminalized.[75] What is more, the data suggests that in the pre-*Roe* era, up to ninety percent of premarital pregnancies were terminated by abortion.[76] Self-induced abortion methods included herbal remedies, nonprescription preparations from pharmacies, and douching with noxious substances such as bleach and lye, as well as inserting instruments such as knitting needles and coat hangers into the vagina and uterus to induce miscarriage, often resulting in death or sterility.[77] Pregnant people with means were able to seek abortion abroad in countries where abortion was legal, like Japan, England, Puerto Rico, or Scandinavia.[78] It is estimated that death as the result of illegal abortion accounted for as high as one-third of all maternal deaths.[79] The incidence of

---

73 *Id.*; *see also Disgraceful Advertisements*, 15 BOS. MED. & SURGICAL J. 44, 265 (1844) (describing "shameless" advertising of abortifacients in newspapers in all of the "great Atlantic cities").

74 P. H. GEBHARD, W. B. POMEROY, C. E. MARTIN & C. V. CHRISTENSON, PREGNANCY, BIRTH, AND ABORTION 93–94 (1958); *see also* LUKER, *supra* note 30, at 49 (discussing the data on the incidence of abortion from various studies).

75 LUKER, *supra* note 30, at 19–20.

76 *Id.* at 49 (citing the Kinsey Report data and the findings of Gebhard et al.).

77 REAGAN, *supra* note 63, at 42–43, 208–09 (describing methods of self-inducing abortion, including inserting instruments from home such as coat hangers, knitting needles, and hair pins, drinking ergotrate and castor oil, douching with soap, lye, or bleach, and squatting in a basin of scalding hot water); *see also* Carrie N. Baker, *The History of Abortion Law in the United States*, OUR BODIES, OURSELVES (Sept. 14, 2020), (https://www.ourbodiesourselves.org/book-excerpts/health-article/u-s-abortion-history/ [https://perma.cc/MED9-TAVX] (describing that in the years before *Roe*, desperate women inserted knitting needles, coat hangers, and douched with lye or swallowed strong drugs or chemicals).

78 GREENHOUSE & SIEGEL, *supra* note 47, at 8 (describing the Society for Humane Abortion's detailed step-by-step procedure for obtaining an abortion in Japan, from how to purchase airline tickets, to the number of yen needed for the taxi ride from the airport to the abortion clinic).

79 LUKER, *supra* note 30, at 73–74 (citing State of California, State Assembly Interim Committee on Criminal Procedure, *Abortion Hearing AB 2614* (Dec.

death from illegal abortion was higher for people living in poverty seeking abortion than for wealthier people.[80]

Thus, at the time *Roe* was decided, terminating a pregnancy required surgery which necessarily required a cooperative physician or medical panel, and illegal abortions were dangerous and potentially lethal. While an emerging feminist movement was beginning to mobilize for abortion on demand based on an equality argument, medical organizations were, once again, the predominant voices in the call for abortion reform.[81] In the mid-1960s the American Law Institute's 1962 draft of the Model Penal Code called for reforming criminal abortion laws by legalizing therapeutic abortion.[82] The American Medical Association's policy statement, adopted at the 1970 annual meeting, called for abortion reform that left the abortion decision to the "sound medical judgment" of providers, describing that "abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians."[83] The *Roe* decision reflects the medical reform model and was informed by the way that abortion was practiced at the time of the decision. However, on the eve of *Roe*, the medical gatekeeper model of abortion access was already a fallacy for all but the most privileged individuals. People of color, people living in poverty, and people in rural areas without access to private physicians and hospitals had much less access to abortion under the therapeutic model.[84] The next section will examine the feminist framing of abortion on demand, followed by section D that describes how the *Roe* Court diluted the feminist model by drawing upon the thera-

---

17–18, 1962) (testimony of Theodore Montgomery, M.D. State Department of Public Health, at 72-74)).

80 LUKER, *supra* note 30, at 74. In response to concern over maternal mortality at the hands of illegal abortion providers, organizations ranging from religious clergy groups to feminist organizations began organizing underground referral services providing lists of safe illegal abortion providers to pregnant people seeking to terminate their pregnancies. *Letter to the Society for Humane Abortion*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 7. The Clergymen's Consultation Service on Abortion was a nationwide abortion referral service founded in 1967 by ministers and rabbis who referred as many as 150,000 pregnant people a year to safe and affordable abortion providers. *Id.* at 29.

81 *See* Siegel, Roe's *Roots*, *supra* note 12, at 1879–83.

82 *See American Law Institute Abortion Policy, 1962*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 24.

83 *American Medical Association Policy Statements, 1967 and 1970*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 25–29.

84 *See* GREENHOUSE & SIEGEL, *supra* note 47, at 22.

peutic model of abortion access to identify an integral role for physicians in an individual's access to abortion.

C. Feminist Framing of Abortion on Demand

In the years leading up to *Roe* there were two competing strands of litigation that challenged criminal abortion laws. Doctors' organizations sought reform of criminal abortion laws and turned to the courts seeking greater clarity about when therapeutic abortions were justified and giving doctors greater discretion when making the decision that an abortion was lawful.[85] This "medical model" identified abortion as a medical decision to be made in consultation with a doctor.[86] By contrast, feminists called for an outright *repeal* of criminal abortion laws based on arguments that abortion is a right of bodily autonomy that should rest with the pregnant person alone and identified the right as more appropriately sourced in Equal Protection than privacy.[87] While early cases challenging criminal abortion laws were brought on behalf of physicians per-

---

85 *See* LUKER, *supra* note 30, at 66–125; Siegel, Roe*'s Roots*, *supra* note 12, at 1879–86; Appleton, *supra* note 12, at 197–201.

86 *See, e.g.*, People v. Belous, 458 P.2d 194, 206 (Cal. 1969) (challenging California abortion laws as infringing the constitutional rights of doctors); United States v. Vuitch, 402 U.S. 62 (1971); Doe v. Bolton, 410 U.S. 179, 193 (1973) (arguing that both a woman's privacy right and "the physician's right to practice his profession" could be violated by abortion restrictions); Singleton v. Wulff, 428 U.S. 106, 106–108 (1976) (holding that two doctors had standing to challenge a Missouri law that denied Medicaid benefits for abortions not deemed medically necessary, holding that patients' and physicians' interests were one and the same). *See* Siegel, Roe*'s Roots*, *supra* note 12, at 1884; Appleton, *supra* note 12, at 203.

87 *See, e.g.* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW, 1353–1359 (2d ed. 1988) (arguing that *Roe*'s framing of the right to abortion "in terms of the woman's right to privacy . . . . is something of a misnomer [because] what is truly implicated in the decision whether to abort or to give birth is not privacy, but autonomy" (footnote omitted)); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 962 (1984) (arguing that abortion restrictions contribute to unconstitutional gender-based discrimination); Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 824 (2007) (describing the role of the Equal Protection Clause in amicus briefs in *Roe*); Cass R. Sunstein, *Neutrality in Constitutional Law (With Special Reference to Pornography, Abortion, and Surrogacy)*, 92 COLUM. L. REV. 1, 31–44 (1992) (suggesting that, from an equal protection standpoint, the problem with abortion restrictions is that they are intertwined with the role of women as second-class citizens); Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1308–24 (1991) ("Grounding a sex equality approach to reproductive control requires situating pregnancy in the legal and social context of sex inequality . . . ."); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. REV. 375, 375 (1985) (agreeing with commentary that the Supreme Court in *Roe* should have adverted specifically to sex equality).

forming abortions, *Hall v. Lefkowitz* was the first to challenge a criminal abortion statute based on the right of women to access abortion.[88] The case, along with other early cases and accompanying amicus briefs filed in support, argued that abortion was a woman's right based on equal protection of the law and the right of bodily autonomy rather than a right sourced in privacy.[89] However, in the contentious battle over the Equal Rights Amendment, abortion rights advocates changed tack and began to distance abortion litigation from equality claims in response to strong counter-mobilization in opposition to the ERA.[90]

Feminists explicitly challenged the medical gatekeeper framing that vested doctors the discretion to make decisions about abortion[91] and argued that the abortion decision should rest solely with the pregnant person.[92] The feminist movement called instead for abortion "on demand" to explicitly challenge the medical model of "therapeutic" abortion.[93] Feminists ar-

---

88 305 F. Supp. 1030 (S.D.N.Y. 1969). *See* Nancy Stearns, Roe v. Wade*: Our Struggle Continues*, 4 BERKELEY WOMEN'S L.J. 1, 2 (1988) (observing that the case was the first to consider women's rights in being denied abortions rather than doctors' rights to perform abortions); Reva B. Siegel, *Constitutional Culture, Social Movement Conflict and the Constitutional Change: The Case of the De Facto ERA*, 94 CALIF. L. REV. 1323, 1395–96 (2006) (describing the early abortion litigation animated by women's equality and autonomy claims in abortion litigation).

89 *See* Abele v. Markle, 342 F. Supp. 800, 801 (D. Conn. 1972) (holding that Connecticut's criminal abortion ban violated the constitutional rights of *women seeking abortion* and finding that the statute "trespasse[d] unjustifiably on the personal privacy and liberty of its female citizenry"), *vacated*, 410 U.S. 951 (1973); *see* Siegel, *supra* note 88, at 1395–96; Brief for Human Rights for Women, Inc. as Amicus Curiae at 11–12, United States v. Vuitch, 402 U.S. 62 (1971) (No. 84) (arguing that the criminal abortion statute at issue denies women equal protection under the Fifth Amendment to pursue education and employment, and to decide their future and under the Thirteenth Amendment based on the demands of pregnancy, childbirth, and rearing of children); Brief for the Joint Washington Office for Social Concern et al. as Amici Curiae at 10–11, *Vuitch*, 402 U.S. 62 (No. 84) (arguing the abortion statute violates women's right of equal protection); Brief for New Women Lawyers et al. as Amicus Curiae at 24, 32, Roe v. Wade, 410 U.S. 113 (1973) (No. 70–18) (arguing that Texas' and Georgia's restrictive abortion laws violate equal protection and prevent women from fully functioning in society "in a manner that will enable them to participate as equals with men").

90 *See* Siegel, *supra* note 88, at 1396–97 (noting that Schlafly effectively mobilized opposition to the ERA by arguing that the Amendment would usher in same-sex marriage and abortion rights. In response, abortion rights advocates explicitly distanced their claims from equality claims, engaging in "self-censorship" in an effort to simultaneously defend the ERA and abortion rights).

91 LINDA GORDON, THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA 295 (2002); Siegel, Roe's *Roots*, *supra* note 12, at 1880.

92 *See* LUKER, *supra* note 30, at 92–100; GREENHOUSE & SIEGEL, *supra* note 47, at 39; Siegel, Roe's *Roots*, *supra* note 12, at 1880–86.

93 *See* PETCHESKY, *supra* note 37, at 126–27; *Flyer Announcing Women's March and Listing Demands*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 44. It is

gued that women should be able to access abortions as they did any other medical procedure without having to justify their choice to committees of doctors.[94] As Betty Friedan argued in 1969,

> There is only one voice that needs to be heard on the question of the final decision as to whether a woman will or will not bear a child, and that is the voice of the woman herself. . . . [In the medical model w]omen are the passive objects that somehow must be regulated . . . . What right has any man to say to any woman: you must bear this child?[95]

By the end of the 1960s, feminist organizations such as the National Organization for Women identified abortion as integral to women's equal citizenship, describing abortion as "a basic and valuable human civil right."[96] The feminist framing of abortion on demand stood in opposition to the gatekeeper model that required a learned intermediary to access abortion.

---

important to note that this framing morphed into the "right to choose" narrative of the mainstream abortion rights movement that was problematic in that it distilled the right of abortion to a right of decision-making that reinforced neoliberal conceptions of constitutional rights that failed to acknowledge that systems and structures of oppression deny individuals and communities meaningful access to "choice" in reproduction. This inclusive and intersectional analysis of reproduction within the context of systemic oppression of marginalized communities is captured by the reproductive justice movement. *See generally* LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 47 (2017) (describing that women of color activists "pointed out that the concept of choice masks the different economic, political, and environmental contexts in which women live their reproductive lives"); JAEL SILLIMAN, MARLENE GERBER FRIED, LORETTA ROSS & ELENA R. GUTIÉRREZ, UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE 127 (2004) (noting the sterilization abuse among Native women); ASIAN COMMUNITIES FOR REPRODUCTIVE JUSTICE, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE, https://forwardtogether.org/tools/a-new-vision/ [https://perma.cc/ALD8-8DM6] (last visited Nov. 28, 2021) (discussing the three main frameworks that deal with addressing reproductive oppression); *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice [https://perma.cc/P9FW-BUXV] (last visited May 5, 2021); SISTERSONG WOMEN OF COLOR REPRODUCTIVE HEALTH COLLECTIVE, REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051 [https://perma.cc/T7TN-MWMB] (last visited Sept. 11, 2021) (arguing that reproductive justice is a human right). The reproductive justice movement draws upon the work of Kimberlé W. Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race, and Social Control*, 59 UCLA L. REV. 1418, 1449 (2012) ("The interplay between structures and identities are key elements in understanding the ways that . . . women [of color] are situated within and affected by the various systems of social control.").

94 *See* GREENHOUSE & SIEGEL, *supra* note 47, at 44.

95 Betty Friedan, *Abortion: A Woman's Civil Right*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 39.

96 *Id.*

D. *Roe v. Wade*: The "Responsible Physician" as Gatekeeper

In the decisions in *Roe* and its companion case *Bolton*, the Supreme Court held unconstitutional criminal abortion law and also rejected the medical model of abortion reform.[97] Articulating the right of abortion in *Roe,* the Court combined elements of both the feminist and the medical model of abortion. On the one hand, the Court announced that the right of privacy was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy" and recognized the importance of women's right to control their reproduction with respect to distressful life, psychological harm, and harm to women's mental and physical health if the right is denied.[98] However, the Court noted that the right is not absolute and did not encompass a right to abortion on demand.[99] Rather, the Court's decision "vindicates *the right of the physician* to administer medical treatment *according to his professional judgment* up to the points where important state interests provide compelling justifications for intervention."[100] While recognizing the State's interest in protecting health and maternal life, the *Roe* Court stated that, "neither interest justified broad limitations on the reasons for which *a physician and his pregnant patient might decide* that she should have an abortion in the early stages of pregnancy."[101] And again, "prior to this 'compelling' point, *the attending physician, in consultation with his patient*, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."[102] Thus, the *Roe* Court both identified a constitutional right of abortion *and* asserted that, "the abortion decision in all its aspects is inherently, and primarily, a medical decision"[103] to be made in consultation with a "responsible physician."[104]

---

97 In *Doe v. Bolton*, 410 U.S. 179 (1973), the Court rejected the medical model of abortion reform by striking down a Georgia abortion statute that was modeled on proposed model language of the American Law Institute (ALI). The statute required two physicians to certify that an abortion was necessary to protect the mental or physical health of the women or to prevent the risk of birth defects, or for pregnancies that result from rape or incest. *Id.* at 205–06.

98 Roe v. Wade, 410 U.S. 113, 153 (1973).

99 *Id.* at 154.

100 *Id.* at 165–66 (emphasis added); *see also* Elizabeth Reilly, *The "Jurisprudence of Doubt": How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative* Liberty, 14 J.L. & POL. 757, 774–77 (1998) (describing *Roe*'s vision of the physician as "the decider, the actor, even the rights-holder").

101 *Roe*, 410 U.S. at 156 (emphasis added).

102 *Id.* at 163 (emphasis added).

103 *Id.* at 166.

104 *Id.* at 153.

> In *Bolton*,[105] decided the same day as *Roe*, the Court described the role of doctors in the abortion decision: "the conscientious physician . . . concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients . . . . The good physician . . . will have sympathy and understanding for the pregnant patient."[106] In the succeeding years, the Court reaffirmed the role of the "trusted physician" in the abortion right. For example, three years later, in *Planned Parenthood of Central Missouri v. Danforth*,[107] the Court set forth the role of the physician as central to the abortion decision: "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."[108] In *City of Akron v. Akron Center for Reproductive Health*,[109] the Court described that, "because abortion is a medical procedure . . . the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment.' . . . The physician's exercise of this medical judgment encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion."[110]

Each of these cases describes a framework of the abortion right reliant upon a doctor acting as a gatekeeper to ensure that the abortion decision is appropriate.

The *Roe* Court's accommodation of the medical model of abortion reform was widely criticized for subordinating women's constitutional rights to the judgment of their healthcare providers.[111] Professor Reva Siegel has argued that the deci-

---

105 Doe v. Bolton, 410 U.S. 179 (1973).

106 *Id.* at 196–97.

107 428 U.S. 52 (1976).

108 *Id.* at 61 (quoting *Roe*, 410 U.S. at 164) (summarizing the *Roe* decision by stating, "[t]he participation by the attending physician in the abortion decision, and his responsibility in that decision, thus, were emphasized").

109 462 U.S. 416 (1983), *overruled by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992). The Supreme Court held unconstitutional several provisions of an Akron, Ohio ordinance requiring performance of all post-first-trimester abortions in a hospital, parental consent, informed consent, a twenty-four-hour waiting period, and the disposal of fetal remains. *See id.* at 419, 422–26.

110 *Id.* at 427 (citing *Doe*, 410 U.S. at 192 (other citations omitted)).

111 Nan Hunter has argued that the Court's decision in *Roe* can best be understood as the Court's attempt to delegate to physicians the juridical authority over the procreative questions presented by abortion. *See* Hunter, *supra* note 12, at 194–97; *see also* Appleton, *supra* note 12, at 199–200; Ginsburg, *supra* note 12, at 1199–200 ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician's medical judgment. The *Roe* decision might have been less of a storm center had it . . . homed in more precisely on the women's equality dimension of the issue . . . ." (footnotes omitted)); Greenhouse, *supra* note 12, at 42; TRIBE, *supra* note 12, at 45 (arguing

sion in *Roe* straddled women's rights and the medical models of abortion rights, gave only "confused expression" to women as constitutional rights holders in the abortion decision, and gave greater protection to doctors' rights to make medical decisions than to women's rights to control their reproduction.[112] Specifically, the decision in *Roe* to identify doctors as central to the abortion right foreclosed the feminist framing of abortion on demand—as a "right to choose"—that was gaining traction at the time of the decision.[113] The framing of the abortion right as a medical decision between pregnant patients and their doctors established the role of doctors as gatekeepers in accessing the constitutional right of abortion. In so doing, the opinion identified doctors as the mechanism for mediating pregnant people's rights to access care necessary to exercise the constitutional right of bodily autonomy.[114] Scholars have argued that the Court's decision was intended to place in the hands of doctors the moral question raised by abortion. As such, doctors are placed in the role of expressing public morality in private decision-making in the abortion context, with providers serving as the mediator between private choices and public concerns.[115] Thus, medical judgment shields politically divisive moral choices and serves as the benign face of state regulation designed to deny access to care that is central to core constitu-

---

that the medical model, which emphasized the role of doctors in the abortion decision, reinforced the traditional role of women as dependent and not in control of their destinies). *But see* Law, *supra* note 12, at 937–38 (offering a critique of Tribe's *The Clash of Absolutes*).

112 *See* Siegel, Roe's *Roots*, *supra* note 12, at 1897; *see e.g.*, Siegel, *Reasoning from the Body*, *supra* note 12, at 273–79 (describing how the *Roe* Court suggested that "states should defer to private decisions respecting abortion because they reflect the expertise of a medical professional, not because the community owes any particular deference to women's decisions about whether to assume the obligations of motherhood" (footnotes omitted)).

113 *See* Jimmye Kimmey, *Right to Choose Memorandum*, *in* GREENHOUSE & SIEGEL, *supra* note 47, at 33–34.

114 *See* Wood & Durham, *supra* note 28, at 783–84; Appleton, *supra* note 12, at 199–200 (discussing the "medical counselor" model in which doctors actively participate in the woman's decision-making regarding abortion).

115 *See, e.g.*, M. Gregg Bloche, *The "Gag Rule" Revisited: Physicians as Abortion Gatekeepers*, 20 L. MED. & HEALTH CARE 392, 397 (1992) (describing the "moral choice" physicians are increasingly forced to make in the abortion context); Louis Michael Seidman, *Public Principle and Private Choice: The Uneasy Case for a Boundary Maintenance Theory of Constitutional Law*, 96 YALE L.J. 1006, 1011–12 (1987) (describing the law as mediating between enclaves of private choice and contrary assertions of public morality and thereby protecting certain spheres of private choice from public visibility); Cass R. Sunstein, *Legal Interference with Private Preferences*, 53 U. CHI. L. REV. 1129, 1131 (1986) (noting that in the doctor's role of expressing public morality, the law shields certain spheres of private choice from public visibility).

tional rights without the political cost of outright repeal of the abortion right through the courts.[116] Professor Nan Hunter has described that the *Roe* Court's decision to place doctors in the role of mediating women's decision-making was an attempt to delegate to physicians the juridical authority over the procreative questions presented by abortion.[117]

The next section examines the critical leap the Court made in *Casey*[118] that transformed doctors from trusted advisors to gatekeepers. It begins by examining how abortion opponents seized upon restricting abortion at the site of doctors' sentinel role rather than seeking to overturn *Roe* outright. Next, it considers how the *Casey* decision's undue burden analysis enabled states to revise the role of doctors and turn them into quasi-state actors required to read informed consent scripts and perform forced ultrasounds on pregnant people seeking an abortion.

E. Restrictions that Target the Doctor-Patient Relationship

History has revealed the extent to which the *Roe* Court's decision to establish doctors as gatekeepers to the abortion right left abortion vulnerable to restricting the right at the site of the doctor-patient relationship. The *Roe v. Wade*[119] decision has been consistently challenged over the last forty-eight years by a well-organized minority opposed to abortion rights.[120] In

---

116 Doctors play a similar role in the context of care that is closely tied to constitutional rights of bodily autonomy that engage significant moral and ethical questions. Bloche, *supra* note 116, at 396 (arguing that medical necessity analysis to overcome the "gag rule" in *Rust v. Sullivan* serves as a shield for private choice about abortion).

117 Hunter, *supra* note 12, at 194–97 (arguing that the Court's decision in *Roe v. Wade* can be understood as the Court's attempt to delegate to physicians the juridical authority over the procreative questions presented by abortion). At the time the case was decided, most doctors, including obstetricians, were men, so the medical gatekeeper was a gendered construct that reinforced the role of male gatekeepers in women's lives more generally, from husbands to fathers and now physicians.

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

119 410 U.S. 113 (1973).

120 A recent Gallup Poll found that the largest segment of people in the U.S. say that abortion should be legal under certain circumstances, which "is broadly similar to what Gallup has found in four decades of measurement." Lydia Saad, *U.S. Abortion Attitudes Stable; No Consensus on Legality*, GALLUP: SOC. & POL'Y ISSUES (June 9, 2017), http://www.gallup.com/poll/211901/abortion-attitudes-stable-no-consensus-legality.aspx?g_source=ABORTION&g_medium=Topic&g_campaign=tiles [https://perma.cc/CC56-9Y47] (finding that the largest segment of Americans favor the middle position that abortion should be "legal only under certain circumstances" as "broadly similar to what Gallup has found in four decades of measurement"); *see also Public Opinion on Abortion: Views on*

1985, after a series of unsuccessful challenges to *Roe*, then-Assistant Solicitor General Samuel Alito drafted a memorandum ("Alito Memo") that outlined a strategy to effectively repeal *Roe* by chipping away at abortion access through state-level restrictions that target the doctor-patient relationship.[121] Realizing that it was unlikely that *Roe* could be overturned due to the then-current makeup of the Court, the Memo offers a piecemeal strategy designed to achieve the ends sought without having to overturn the decision outright: "There may be an opportunity to nudge the Court toward . . . greater recognition of the states' interest in protecting the unborn through pregnancy, or to dispel in part the mystical faith in the attending physician that supports *Roe* and the subsequent cases. I find this approach preferable to a frontal assault on *Roe v. Wade*."[122] The Alito Memo reveals a strategy to shift focus from court challenges to state-level legislation to limit abortion rights by regulating providers and leveraging the doctor-patient relationship to achieve political rather than healthcare ends.[123]

State-level regulations to restrict abortion access came before the Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[124] The *Casey* decision upheld all of the provisions of the Pennsylvania Abortion Control Act with the exception of the spousal consent provision, including man-

---

Abortion, 1995–2019, PEW RSCH. CTR. (Aug. 29, 2019), http://www.pewforum.org/fact-sheet/public-opinion-on-abortion/ [https://perma.cc/X8H5-RWJQ] (finding public support for legal abortion remains as high as it has been in two decades of polling, setting support at 61%); Samantha Luks & Michael Salamone, *Abortion, in* PUBLIC OPINION AND CONSTITUTIONAL CONTROVERSY 80, 101 (Nathaniel Persily, Jack Citrin, and Patrick J. Egan eds., 2008) (finding that public opinion has remained fairly stable in support of the abortion right).

121 The memo outlined a strategy to erode the abortion right through state regulations that restrict access to abortion. He relied on a series of cases that offered the opportunity to focus action at the state level, including *American Coll. of Obstetrics & Gynecology v. Thornburgh*, 737 F.2d 283 (3d Cir. 1984), *Diamond v. Charles*, 749 F.2d 452 (7th Cir. 1984), and *City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416 (1983), *overruled by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992). *See* MELISSA MURRAY & KRISTIN LUKER, CASES ON REPRODUCTIVE RIGHTS AND JUSTICE 663 (2015).

122 Memorandum from Samuel Alito, Assistant to the Solic. Gen., to Charles Fried, Solic. Gen. (May 30, 1985) [hereinafter Alito Memorandum] (excerpted in MURRAY & LUKER, *supra* note 121, at 663–64.) The memo describes a strategy to dispel "the mystical faith in the attending physician," and in recent years, anti-abortion activists have begun to challenge whether providers have standing to sue on behalf of their patients. *See id.;* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2117–18 (2020) (arguing that the State had waived its argument that physicians lack standing to bring the case on behalf of their patients because the State raised the argument for the first time on cross-appeal).

123 *See* Alito Memorandum, *supra* note 122.

124 505 U.S. 833 (1992) (plurality opinion).

dated 24-hour waiting periods and informed consent dialogues that required doctors to read state-mandated scripts.[125] Most importantly, the *Casey* decision downgraded the standard of judicial review for abortion regulations from what was arguably strict scrutiny to the lower undue burden standard.[126] The case held that a state may express its interest in potential life by regulating abortion, so long as those regulations do not pose an "undue burden" on a pregnant person's ability to seek an abortion before viability.[127]

The *Casey* decision encapsulates the extent to which the abortion right has become bifurcated between the rightsholder and their doctor-gatekeeper.[128] The *Casey* opinion briefly addressed the significance of the constitutional right of abortion before turning to the regulation of the doctor-patient relationship in the Pennsylvania Abortion Control Act.[129] Describing the issue at stake in the abortion right, the opinion states:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.[130]

---

125 The Court upheld all of the provisions of the Pennsylvania Abortion Control Act with the exception of the spousal consent provision. *Id.* at 895. In addition, the case upheld parental consent requirements for minors seeking abortion and new clinic reporting requirements. *Id.* at 899–901.

126 *See* MURRAY & LUKER, *supra* note 121, at 775–76 (describing that the undue burden standard replaced the earlier strict scrutiny standard and was originally proposed by Justice O'Connor in her dissent in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)).

127 *See Casey*, 505 U.S. at 874, 879. The undue burden standard was defined as "a state regulation [that] has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877. While a state may seek to ensure that a woman's choice is informed and protect the health and safety of a woman, a state may not prohibit a woman from making the ultimate decision to undergo an abortion. *Id.* at 878–79.

128 *See also*, Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385, 387–88 (2013) (describing that the Court's evolving abortion analysis increasingly identifies pregnant people who seek abortion as "rights holders" rather than as medical consumers and has thereby severed the right to *decide* to terminate a pregnancy from access to healthcare necessary to exercise the abortion decision).

129 *Casey*, 505 U.S. at 844 (citing 18 Pa. Cons. Stat. §§ 3203–3220 (1990)). Note that the fifth provision, spousal consent for married women seeking an abortion, was struck down by the *Casey* court. *Id.* at 895.

130 *Id.* at 851.

The Court's description of the right at stake gestures toward the connection between pregnant people's ability to control their reproduction and equal protection, noting that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[131] The Court notes that this is where the analysis begins—with the description of the abortion right—but does not end.[132] Here, the *Casey* Court recalibrates the state's interest in regulating doctors as gatekeepers in accessing abortion; the state may put in place abortion restrictions designed to express the state's "profound respect for the life of the unborn"[133] even if the regulations do not further a health interest.[134] Courts will strike only state regulations that pose an undue burden—one that "has the purpose or effect of placing a substantial obstacle in the path" of a pregnant person "seeking an abortion of a nonviable fetus."[135] The *Casey* Court describes that the doctor-patient relationship is only "derivative of the woman's position" and specifically separates the right of abortion from the framework for regulating abortion access at the site of the doctor-patient relationship.[136] While *Roe* and subsequent cases conceptualized the doctor-patient relationship as integral to the abortion right, the *Casey* Court cleaved the connection between the right to make the abortion decision and the doctor-patient relationship, making them two distinct concerns worthy of independent evaluation. This framing opened the possibility of what had always lay dormant: the ability of the state to restrict abortion by leveraging the role of the doctor-gatekeeper. Under the undue burden analysis, once the physician was isolated from the abortion rightsholder, their role could be manipulated to achieve state ends without affecting the *decisional* right, which the Court identified was distinct and separate from healthcare access.

In the wake of *Casey,* states have passed an unprecedented number of abortion regulations aimed at restricting access by imposing onerous requirements to access clinic-based care. Indeed, the five-year period from 2010–2015 accounts for

---

131 *Id.* at 856 (citing PETCHESKY, *supra* note 37, at 109, 133 n.7).

132 *Id.* at 852.

133 *Id.* at 877.

134 *Id.* at 886.

135 *Id.* at 877.

136 *Id.* at 884 (noting that the doctor-patient relationship is only "derivative of the woman's position" and "does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy").

more than one-quarter of all abortion restrictions passed since the Supreme Court's *Roe v. Wade*[137] decision in 1973.[138] More abortion restrictions were enacted in the three years from 2011–2013 than in the entire previous decade.[139] As the Alito Memo presaged, many of the restrictions target the provider-patient relationship in an attempt to "dispel . . . the mystical faith in the attending physician that supports *Roe* and the subsequent cases."[140] By targeting the doctor-patient relationship, abortion opponents have increasingly turned doctors into quasi-state actors whose role is to carry out and enforce the state's pro-life message through the doctor-patient relationship, even where those messages do not comport with the doctor's own beliefs, science, or the best healthcare outcomes for their patients. These laws have been facilitated by the undue burden analysis announced in *Casey* that allows the state to insert a pro-life message into the doctor-patient relationship even where the activity does not further healthcare outcomes but merely expresses the state's interest in fetal life.

A significant way that states have sought to restrict access through doctors' gatekeeper roles is through imposing onerous informed consent requirements. To date, eighteen states have enacted abortion-related informed consent legislation, five of the states require doctors to inform people seeking an abortion of the link between abortion and cancer, thirteen states demand fetal pain disclosures, and eight states require providing information about long-term mental health effects of abortion.[141] In many states with these types of informed consent requirements, physicians have sought to comply with its terms by reading the consent provisions aloud to patients, thus be-

---

137 410 U.S. 113 (1973).

138 As of 2016, states had enacted 1,074 abortion restrictions; 288 or twenty-seven percent of these laws were enacted after 2010. This marks the most precipitous rise in anti-abortion legislation in any five-year period since *Roe. Last Five Years Account for More Than One-Quarter of All Abortion Restrictions Enacted Since* Roe, GUTTMACHER INST. (Jan. 13, 2016), https://www.guttmacher.org/article/2016/01/last-five-years-account-more-one-quarter-all-abortion-restrictions-enacted-roe [https://perma.cc/GL5Z-LTN7].

139 Two hundred and five abortion restrictions were enacted from 2011–2013, while just 189 were enacted during the period 2001–2010. *More State Abortion Restrictions Were Enacted in 2011–2013 Than in the Entire Previous Decade*, GUTTMACHER INST. (Jan. 2, 2014), https://www.guttmacher.org/article/2014/01/more-state-abortion-restrictions-were-enacted-2011-2013-entire-previous-decade [https://perma.cc/C47D-5E2N].

140 Alito Memorandum, *supra* note 122.

141 *An Overview of Abortion Laws*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/overview-abortion-laws [https://perma.cc/XSG9-ZU3N] (last updated Apr. 1, 2021).

coming a "script" that physicians must read. Doctors must read these scripts even when it does not accurately comport with their views and even where the information contained in the script is known to be scientifically or medically inaccurate.[142] Requiring providers to read scripts not only raises significant First Amendment concerns,[143] but it also degrades the provider-patient relationship by requiring doctors to become the mouthpiece of the State[144] and to provide their patients with information about abortion that is not supported by scientific research.[145] By requiring physicians to deliver misinformation, the state forces providers to violate their obligation to their patients to obtain informed consent and erodes trust between patients and their physicians.[146]

Another way states have restricted abortion access by targeting providers' role as gatekeepers is by imposing mandatory and clinically unnecessary ultrasounds.[147] For example, Oklahoma requires that a medical provider must perform an ultrasound before performing any abortion procedure and must "[d]isplay the ultrasound images so that the pregnant

---

142 *See* MURRAY & LUKER, *supra* note 121, at 806; Zita Lazzarini, *South Dakota's Abortion Script—Threatening the Physician-Patient Relationship,* 359 NEW ENG. J. MED. 2189, 2191 (2008) ("By requiring physicians to deliver such misinformation and discouraging them from providing alternative accurate information, the [South Dakota] statute forces physicians to violate their obligation to solicit truly informed consent . . . ."); Maya Manian, *Perverting Informed Consent: The South Dakota Court Decision,* REWIRE NEWS GRP. (Aug. 1, 2012), https://rewirenewsgroup.com/article/2012/08/01/perverting-informed-consent-south-dakota/ [https://perma.cc/7HND-5WC3] (noting that informed consent laws like South Dakota's "exploit informed consent doctrine to further goals antithetical to the notion of autonomy that these laws pretend to promote").

143 *See* Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech,* 2007 U. ILL. L. REV. 939, 989 (2007) ("The First Amendment . . . is not primarily concerned to protect the autonomy of those trying to decide whether to seek an abortion, but instead to preserve the integrity of physician-patient communications as a channel for the dissemination of expert knowledge."); David Orentlicher, *Abortion and Compelled Physician Speech*, 43 J.L. MED. & ETHICS 9, 9–10 (2015) (discussing the conflicting legal principles of the First Amendment and the duty to obtain informed consent that arise in informed consent mandates in the context of abortion).

144 The underlying value that animates informed consent is the legal recognition of the medical patient's right of autonomous decision-making. Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking,* 1979 WIS. L. REV. 413, 420 (1979) (describing that the purpose of requiring patient consent to treatment is to preserve and protect his "physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous, self-determining human being").

145 *See* Lazzarini, *supra* note 142, at 2191.

146 *See id.*; Manian, *supra* note 142.

147 *See* Manian, *supra* note 142.

woman may view them" and provide a description of what the ultrasound image depicts.[148] These ultrasounds are fundamentally inconsistent with the doctrine of informed consent, which provides that doctors must give patients objective and neutral information so that patients can make autonomous decisions about their medical treatment.[149] Mandatory ultrasounds also significantly increase the cost of the abortion procedure.[150] Finally, requiring that a patient undergo an unwanted and medically unnecessary ultrasound at the legislature's behest intrudes upon the doctor-patient relationship[151] and mandates that doctors violate a patient's right to refuse medical treatment.[152]

States have sought to regulate the provider-patient relationship and to restrict abortion through waiting periods, some

---

148 OKLA. STAT. tit. 63, § 1-738.3d (2004), *declared unconstitutional by* Nova Health Sys. v. Pruitt, 2012 OK 103, 292 P.3d 28.

149 *See* Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law,* 76 GEO. WASH. L. REV. 1599, 1602–03 (2008) (stating that informed consent doctrine "emphasiz[es] the individual's right to control what happens to her body and to be protected from unwanted physical intrusions"); Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent,* 10 GUTTMACHER POL'Y REV. 6, 7 (2007) (stating that the "fundamental goal of the entire informed consent process" is "personal well-being and individual autonomy"); Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making,* 16 DUKE J. GENDER L. & POL'Y 223, 226 (2009) ("Informed consent law serves primarily to respect patient self-determination and autonomy."); Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide,* 39 HASTINGS CTR. REP. 21, 21 (2009) ("Informed consent . . . is grounded in the principle of respect for persons, which affirms an individual's consequent right to autonomous decision-making."); Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice,* 56 UCLA L. REV. 351, 397–403 (2008) (arguing that abortion restrictions "undermine[ ] the law's traditional meaning of informed consent"). *But see* Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat,* 21 CORNELL J.L. & PUB. POL'Y 1, 18–28 (2011) (arguing that the doctrine of informed consent is a socially constructed doctrine that has always reflected value judgments of both society and doctors.).

150 *See* Jen Russo, *Mandated Ultrasound Prior to Abortion*, 14 AM. MEDICAL ASS'N J. ETHICS 240, 231 (2014) (citing *Requirements for Ultrasound*, GUTTMACHER INST. (Nov. 1, 2021), https://www.guttmacher.org/state-policy/explore/requirements-ultrasound [https://perma.cc/W6AX-YH3Q]).

151 *See Requirements for Ultrasound*, GUTTMACHER INST. (Mar. 1, 2019), https://www.guttmacher.org/state-policy/explore/requirements-ultrasound [https://perma.cc/6HJA-6PZG]. Twenty-six states regulate the provision of an ultrasound before an abortion may be performed. *Id.* Of these, four require the physician to show and describe the image. *Id.* Eight others require the physician to offer the pregnant person the opportunity to view the image. *Id.*

152 Manian, *supra* note 142 ("[M]andatory ultrasounds impose a medical procedure in violation of a patient's right to refuse treatment protected by informed consent law.").

as high as 72 hours.[153] Funding restrictions in the federal Hyde Amendment, which prohibits the use of federal funds to be used to pay for abortions,[154] and similar state-level funding restrictions[155] have severely limited access to abortion for people living in poverty and those who rely on public health programs, such as those who serve in the military.[156] Finally, a new wave of so-called "heartbeat" bills prohibit abortion as soon as a fetal heartbeat can be detected, which happens at about six weeks into pregnancy, often before many people realize they are pregnant.[157]

The Trump administration expanded "conscience rules" to protect healthcare workers who oppose abortion, sterilization, physician assisted dying, and other medical procedures on religious or moral grounds.[158] The rule established guidelines for punishing healthcare institutions with a loss of federal funding for failure to respect workers' rights who assert religious or

---

153 *See Abortion Waiting Period Requirements*, LAWATLAS: THE POLICY SURVEILLANCE PROGRAM (Dec. 1, 2018), http://lawatlas.org/datasets/abortion-waiting-period-requirements [https://perma.cc/7D3P-9FT6] (last updated Mar. 1, 2021) (documenting state abortion waiting period laws, which generally require a waiting period between 24 and 72 hours).

154 Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434. Various versions of this appropriations rider have been passed by Congress every year since 1976. *See* Maggie Astor, *What is the Hyde Amendment? A Look at Its Impact as Biden Reverses His Stance*, N.Y. TIMES (June 7, 2019), https://www.nytimes.com/2019/06/07/us/politics/what-is-the-hyde-amendment.html [https://perma.cc/XGU5-7H52].

155 *See* Beal v. Doe, 432 U.S. 438, 440, 447 (1977) (upholding limits on state funding for non-therapeutic abortions); Maher v. Roe, 432 U.S. 464, 466, 474 (1977) (upholding prohibitions on state funding for non-medically necessary abortions); Poelker v. Doe, 432 U.S. 519, 519–521 (1977) (upholding a city's refusal to provide publicly financed hospital services for non-therapeutic abortions); Harris v. McRae, 448 U.S. 297, 326 (1980) (upholding the Hyde Amendment's restriction on the use of federal funds for medically necessary abortions under Medicaid program).

156 *See* Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting* Harris v. McRae, 21 WM. & MARY J. WOMEN & L. 5, 13 (2014) (describing the effect of *McRae* on abortions funded by Medicaid).

157 Sarah Mervosh, *Georgia Is Latest State to Pass Fetal Heartbeat Bill as Part of Growing Trend*, N.Y. TIMES (Mar. 30, 2019), https://www.nytimes.com/2019/03/30/us/georgia-fetal-heartbeat-abortion-law.html [https://perma.cc/JW4P-EJSN] (describing the growing momentum for these bills, including recent versions signed into law in Mississippi and Kentucky, and similar bills expected to follow in Florida, Missouri, Ohio, Tennessee, and Texas). Fetal heartbeat bills in Iowa, Kentucky, and North Dakota have been halted in the courts. *Id.*

158 *See* Margot Sanger-Katz, *Trump Administration Strengthens 'Conscience Rule' for Health Care Workers*, N.Y. TIMES (May 2, 2019), https://www.nytimes.com/2019/05/02/upshot/conscience-rule-trump-religious-exemption-health-care.html [https://perma.cc/D4BB-JRUP].

moral objections to providing care.[159] Finally, the Trump administration reintroduced the "domestic gag rule," since rescinded by President Biden in his first two weeks in office, which prohibited providers who receive federal funding from counseling patients about abortion, even when an abortion is medically indicated in a provider's medical judgment.[160]

States have also passed laws to restrict abortion that do not restrict the abortion services themselves but regulate facilities and the doctors who perform abortions, known as TRAP laws (Targeted Regulations of Abortion Providers).[161] TRAP laws in various states have imposed burdensome record-keeping and reporting requirements, and have required that doctors who perform abortions have admitting privileges at local hospitals, a virtual impossibility in states hostile to abortion. TRAP laws also include regulations that impose building requirements for physical facilities that provide abortion—such as the width of hallways and equipment—that are not required of other ambulatory surgical centers.[162] These onerous TRAP

---

159 *See* DEP'T OF HEALTH & HUMAN SERVS., FACTSHEET: FINAL CONSCIENCE REGULATION (May 2, 2019), https://www.hhs.gov/sites/default/files/final-conscience-rule-factsheet.pdf [https://perma.cc/KP9U-HRWJ].

160 *See* Pam Belluck, *Trump Administration Blocks Funds for Planned Parenthood and Others Over Abortion Referrals*, N.Y. TIMES (Feb. 22, 2019), https://www.nytimes.com/2019/02/22/health/trump-defunds-planned-parenthood.html [https://perma.cc/RP5W-8BWD]. In his first two weeks in office, President Biden rescinded the global gag rule, the so-called "Mexico City Policy." Steve Benen, *Why Biden Reversing the Anti-Abortion "Gag Rule" Matters*, MSNBC (Jan. 29, 2021), https://www.msnbc.com/rachel-maddow-show/why-biden-reversing-anti-abortion-gag-rule-matters-n1256157 [https://perma.cc/3UVP-F96Z]. While the global gag rule can be rescinded by executive order, the domestic gag rule requires a regulatory process that is currently underway. *Id.*

161 *See Targeted Regulation of Abortion Providers*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers [https://perma.cc/CJL2-EJ5R] (last updated Mar. 1, 2021) (describing regulations specific to abortion providers in various states). "Abortion exceptionalism" is a term that has been used to describe the tendency of legislatures and courts to subject abortion to uniquely burdensome rules that are not imposed on other healthcare providers who perform procedures with a greater risk of injury and death to patients than the abortion procedure. Ian Vanderwalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 3 (2012).

162 *See Targeted Regulation of Abortion Providers (TRAP)*, CTR. REPROD. RTS. (Aug. 28, 2015), https://reproductiverights.org/targeted-regulation-of-abortion-providers-trap/ [https://perma.cc/B82F-4QB3] (describing burdens imposed by TRAP laws); Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2314–15 (2016) (describing burdens imposed by Texas's TRAP law). In *Whole Women's Health*, the Court found that health care claims asserted in the Texas law were called into question when the state did not similarly regulate more dangerous procedures such as colonoscopy, liposuction, and childbirth. 136 S. Ct. at 2315. Indeed, in her concurrence, Justice Ginsburg stated that, "[g]iven those realities, it is beyond rational belief that [the Texas law] . . . could genuinely protect the

laws have effectively achieved their intended goal of reducing the number of abortion providers and increasing both cost and distance to reach providers.[163]

TRAP laws came before the Supreme Court in 2015 in *Whole Woman's Health v. Hellerstedt*.[164] In that case, the Court considered a Texas law, H.B. 2, that required abortion providers to secure admitting privileges at nearby hospitals and required that abortion clinics meet the requirements of ambulatory surgical centers.[165] In *Whole Woman's Health*, the Court clarified the undue burden standard by requiring that a state offer an evidentiary basis to substantiate its claim that abortion restrictions protected women's health.[166] Under the new analysis, the courts' role is to interrogate the veracity of healthcare claims underlying abortion restrictions. Next, the courts must balance the purported health benefits of an abortion regulation against the burdens placed upon women's access to abortion-related healthcare.[167] The Court found a "virtual absence of any health benefit"[168] from the Texas law and detailed the law's detrimental effect on pregnant people's access to abortion-related healthcare.[169] The decision in *Whole*

---

health of women, and certain that the law 'would simply make it more difficult for them to obtain abortions.'" *Id.* at 2321 (quoting Planned Parenthood of Wis. v. Schimel, 806 F.3d 908, 910 (7th Cir. 2015)). As one court has described, "first trimester abortions are less likely to result in complications than many other surgical procedures that are routinely performed in doctor's offices." Tenn. Dep't of Health v. Boyle, No. M2001-01738-COA-R3-CV, 2002 WL 31840685, at *7 (Tenn. Ct. App. Dec. 19, 2002).

163 *See* K.K. Rebecca Lai & Jugal K. Patel, *For Millions of American Women, Abortion Access is Out of Reach*, N.Y. TIMES (May 31, 2019), https://www.nytimes.com/interactive/2019/05/31/us/abortion-clinics-map.html [https://perma.cc/ZCN8-6ZML] (stating that more than 11 million women live more than an hour's drive from an abortion facility); Rachel K. Jones, Elizabeth Witwer, & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER INST., https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017 [https://perma.cc/F6RE-E2ST] (last updated Sept. 2009) (stating that "[i]n 2017, 89% of U.S. counties did not have a clinic facility that provided abortion care").

164 136 S. Ct. 2292 (2016).

165 *See id.* at 2310, 2314 (describing the admitting privileges and ambulatory surgical center requirements).

166 *Id.* at 2310.

167 *Id.* at 2309 (stating that "[t]he rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer").

168 *Id.* at 2313.

169 *See id.* at 2312–13. *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103 (2020) involved a nearly identical admitting privileges law, this time out of Louisiana, and came just three years after *Whole Woman's Health*, but with two new Trump-appointed members on the Court. Nonetheless, the Court found that Louisiana law unconstitutional. *June Med. Servs.*, 140 S. Ct. at 2113.

Woman's Health reasserts that patients and patient access to services are a central concern when reviewing restrictive abortion legislation under the undue burden analysis.[170] The Court noted that Texas' restrictive abortion regulation H.B. 2, which required doctor to have admitting privileges and abortion clinics to meet the rigorous standards of ambulatory surgical centers, had shuttered most of the state's abortion clinics, and as a result, "[p]atients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered."[171] As the *June Medical Services* case—which came on the heels of *Whole Woman's Health* just three years earlier—reveals, the TRAP strategy has resulted in an ongoing barrage of cases that seek to erode the abortion right at the point of access to clinic-based medical care rather than to overturn *Roe* outright. The *June Medical* decision also calls into question whether the balancing approach in *Whole Women's Health* and its renewed focus on patients in the undue burden analysis will hold.[172] Chief Justice Roberts' concurrence in *June Medical* rejected the balancing test set forth in *Whole Woman's Health* and retreated to the undue burden analysis of the *Casey* decision, which merely required courts to consider whether a restriction placed a substantial obstacle in the path of a person seeking an abortion.[173]

An unprecedented number of abortion restrictions regulate abortion at the point of access and have significantly degraded the quality of the provider-patient relationship. These laws reduce the trust and confidence central to the doctor-patient

---

170 *See also* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA 35–36 (2017) (describing that in the case "the Court gave a textured account of how women in Texas experience the consequences of abortion regulation").

171 *Whole Woman's Health*, 136 S. Ct. at 2318.

172 *June Med. Servs.*, 140 S. Ct. at 2133 (Roberts, C.J., concurring). Many commentators have observed that the *June Medical* decision was not as much a victory as many have suggested. *See, e.g.*, Murray, *'Casey' Playbook*, *supra* note 10 (describing that Justice Roberts signed on to the majority out of respect for *stare decisis* but critically rejected the reasoning of *Whole Woman's Health* that required courts to weigh whether an abortion law's purported benefits exceeded the burdens imposed and retreated to the *Casey* standard of whether the law places a "substantial obstacle" in the path of a woman seeking an abortion); Ziegler, *supra* note 10 (noting that Justice Roberts' decision was not based on a "newfound commitment" to the abortion right but simply his commitment to *stare decisis*). For a discussion of stare decisis in *June Medical*, see Murray, *supra* note 10, at 319–27.

173 *See June Med. Servs.*, 140 S. Ct. at 2135–36 (Roberts, C.J., concurring) (arguing that "[n]othing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts").

relationship as doctors are turned from trusted consultants to vehicles of state regulation. What is more, the Court's language suggests that it has come to view doctors, once trusted advisors in *Roe,* as trying to trick unsuspecting women.[174] Thus, legislatures and the courts alike have cleaved the doctor-patient relationship. They have put in place obstacles to abortion-related healthcare access, set doctors in opposition to patients, and made doctors the state's mouthpiece in scripts and mandatory ultrasounds.

F. Medication Abortion: Eliminating the Need for Doctors

In 2000, the FDA approved the use of medication abortion, a non-surgical two-drug protocol—mifepristone and misoprostol—for safely and effectively terminating pregnancy up to eleven weeks gestation.[175] Because this method does not involve surgery, a pregnant person may end a pregnancy at home using medication abortion under two circumstances: within the clinical context facilitated by a provider or outside of the clinical context by self-inducing abortion.[176] The two-drug medication abortion regimen is used by hundreds of thousands of women in the United States.[177] The FDA protocol requires

---

174 For example, in marked contrast to earlier case law that viewed physicians as trusted advisors in the abortion relationship, the Court suggested in *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) that providers might intentionally seek to withhold information about the details of the abortion procedure from their female patients. The Court then wrote that "[i]t is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form." *Id.* at 159–60.

175 *Mifeprex (Mifepristone) Information*, FDA [hereinafter *Mifeprex Information*], https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information [https://perma.cc/X5UZ-ZZKK] (last visited Mar. 25, 2021). Since FDA approval, medication abortion has been used by almost two million women in the United States to end early pregnancies, about 200,000 a year. Linda Greenhouse, *The Next Abortion Case is Here,* N.Y. TIMES (Sept. 4, 2013), https://opinionator.blogs.nytimes.com/2013/09/04/the-next-abortion-case-is-here/ [https://perma.cc/86PU-KPKL].

176 Medication abortion involves the use of medication rather than surgery to induce an abortion. Self-managed abortion is discussed in Section III.

177 Medication abortion accounted for 39% of all abortions in the U.S. in 2017. Jones, Witwer, & Jerman, *supra* note 163. The number of medication abortions performed in nonhospital facilities also increased by 25% from 2014 to 2017. *Id.* While protecting direct access to medication abortion will protect people seeking the procedure in the first trimester, it is important to note that it is not a panacea because it still leaves later term abortions unprotected. While approximately 92% of abortions are within the first thirteen weeks gestation, *CDCs Abortion Surveillance System FAQs*, CDC, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm [https://perma.cc/SF33-P8JN] (last visited May 2, 2021), later term abortions are necessary healthcare. The need for later term abortions often re-

that the first medication, mifepristone, be dispensed in-person at a clinic[178] but does not indicate where either of the two drugs must be ingested. In most of the world, self-administration has become the standard of care.[179] Telemedicine—virtual consultation with a physician by video—has been an effective way to provide abortion-related healthcare to pregnant people in rural areas.[180] When telemedicine is used in a clinical setting, a doctor talks with patients on-screen, reviews test results, and then the doctor dispenses the dosage of the pills by remotely opening a drawer containing the pills.[181] The pills are dispensed in the clinic, and the patient takes the first pill, mifepristone, with the doctor watching over video and the second pill, misoprostol, at home.[182] A current study underway by Gynuity Health Projects under an Investigational New Drug Approval study examines the effectiveness of providing abortion medication by mail using telemedicine, thereby entirely foregoing the need for a clinic visit.[183] The first set of results published three years after the start of their clinical trial concluded that in-home administration of medication abortion obtained through the mail was as safe and effective and as acceptable to pregnant people as clinic administration.[184] Similarly, a study of the effectiveness and acceptability of medication abortion with both drugs dispensed by a pharmacy rather

---

sults from delays due to barriers to accessing the procedure, including raising the necessary funds to pay for an abortion, and from the discovery of fetal anomaly or maternal health concerns later in the pregnancy. Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 PERSPS. ON SEXUAL & REPROD. HEALTH 210, 214 (2013) (describing that later term abortions were frequently due to logistical delays such as difficulty finding a provider or raising necessary funds for the procedure or travel costs).

178 A certified healthcare provider must dispense mifepristone under the FDA's Risk Evaluation and Mitigation Strategy. *See Mifeprex Information*, *supra* note 175.

179 Mitchell D. Creinin & Kristina Gemzell Danielsson, *Medical Abortion in Early Pregnancy*, *in* MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCY: COMPREHENSIVE ABORTION CARE 111, 119 (Maureen Paul et al. eds., 2009).

180 *See* Emily Bazelon, *The Dawn of the Post-Clinic Abortion,* N.Y. TIMES (Aug. 28, 2014), https://www.nytimes.com/2014/08/31/magazine/the-dawn-of-the-post-clinic-abortion.html [https://perma.cc/2DBT-LSE4].

181 *Id.*

182 *Id.*

183 After consulting with an abortion provider by videoconference, the patient is sent the necessary abortion medication by mail. *See* TELABORTION, http://telabortion.org/ [https://perma.cc/MML2-7B7N] (last visited Mar. 9, 2021).

184 *See* Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 CONTRACEPTION 173, 176 (2019); Greer Donley, *Early Abortion Exceptionalism* (U. Pitt. Law Sch., Working Paper No. 2021-09, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3795414 [https://perma.cc/F5UU-QH5Y] (forthcoming in Vol. 107 of the *Cornell Law Review*).

than in-person dispensing protocol found that pharmacy dispensing of both pills, mifepristone and misoprostol, to be safe, effective, and acceptable to patients.[185]

Medication abortion is successful in about 95 percent of cases.[186] The FDA has found that mifepristone "has been increasingly used as its efficacy and safety have become well-established by both research and experience, and serious complications have proven to be extremely rare."[187] The American College of Obstetricians and Gynecologists ("ACOG") has determined that pregnant people can "safely and effectively" use telemedicine to have medication abortion at home.[188] An analysis of pooled data from nine studies conducted by WHO found home-based medication abortions to be as effective as those administered in clinics, noting that "past research has established that home-based medication abortions may have several advantages over clinic-based protocols, including allowing for greater privacy and lessening the burden on both women and service providers by reducing the number of clinic visits."[189]

Despite the proven safety and efficacy of at-home administration of the two-drug regimen of medication abortion under a doctor's supervision, abortion opponents have sought to restrict medication abortion through telemedicine by requiring that a patient be physically present at a clinic or healthcare facility when taking medication abortion. Republican senators introduced a bill in 2020 to ban abortion by telemedicine[190]

---

185 Daniel Grossman, et al., *Medication Abortion with Pharmacist Dispensing of Mifepristone*, 137 OBSTETRICS & GYNECOLOGY 613, 613–21 (2021) .

186 Christian Fiala & Kristina Gemzell-Danielsson, *Review of Medical Abortion Using Mifepristone in Combination with a Prostaglandin Analogue,* 74 CONTRACEPTION 66, 77 (2006).

187 CTR. FOR DRUG EVALUATION AND RSCH., MEDICAL REVIEW OF MIFEPRISTONE/MIFEPREX 12 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf [https://perma.cc/K3UB-HELK].

188 Committee on Practice Bulletins—Gynecology and Society and Family Planning, *Medication Abortion Up to 70 Days of Gestation*, 136 OBSTETRICS & GYNECOLOGY e31, e35 (2020) [hereinafter *Practice Bulletin*].

189 H. Ball, *Medication Abortion May Be Equally Safe Whether Done at Home or Clinic,* 37 INT'L PERSPS. ON SEXUAL & REPROD. HEALTH 160, 160–61 (2011); Thoai D. Ngo, Min Hae Park, Haleema Shakur & Caroline Free, *Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: A Systematic Review*, 89 BULL. WORLD HEALTH ORG. 360, 360–70 (2011). In light of its safety and efficacy, some researchers are calling for misoprostol alone to be available over-the-counter and have suggested calling it "Plan C" in reference to the morning-after pill, RU486, that is sold under the name "Plan B." Francine Coeytaux & Victoria Nichols, *Plan C: The Safe Strategy for a Missed Period When You Don't Want to Be Pregnant,* REWIRE NEWS GRP. (Feb. 7, 2014), https://rewirenewsgroup.com/article/2014/02/07/plan-c-safe-strategy-missed-period-dont-want-pregnant [https://perma.cc/BQW2-BCZ9].

190 Teleabortion Prevention Act of 2020, S. 3252, 116th Cong. (2020).

and nineteen states have passed laws effectively banning abortion by telemedicine by requiring that the two-drug regimen for medication abortion be taken while *physically* present on site at a clinic,[191] despite the fact that guidelines by the Food and Drug Administration (FDA)[192] do not require that *either* of the pills be ingested in-person at a clinic or provider's office.[193] In states with an in-person doctor requirement, a pregnant person may have to travel long distances to visit a clinic, and attend in-person counseling or undergo enforced ultrasound examinations that necessitate multiple trips to the clinic.[194]

The FDA has suspended the in-person dispensing requirement during the COVID-19 pandemic,[195] however state laws in the nineteen states that require in-person dispensing will remain in effect and the in-person dispensing requirement for mifepristone will come back into effect at the end of the pandemic unless there is further FDA action to remove the REMS for mifepristone.[196] These in-person requirements—for both dispensing and ingesting medication abortion—pose unnecessary risk to both patients and providers during the global COVID-19 pandemic, and those risks fall disproportionately upon communities of color.[197] Justice Sotomayor's dissent in *FDA v. ACOG* describes that "more than half of women who have abortions are women of color, and COVID-19's mortality rate is three times higher for Black and Hispanic individuals than non-Hispanic White individuals. On top of that, three-quarters of abortion patients have low incomes, making them more likely to rely on public transportation to get to a clinic to pick up their medication."[198] Long travel distances to clinics with limited operating hours during the pandemic increases

---

191 *Medication Abortion*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/medication-abortion [https://perma.cc/WT82-2RWP] (last updated May 1, 2021).

192 The new FDA guidelines require that the first drug, mifepristone, be "dispensed" by a doctor but does not require that the pills be ingested in the presence of a doctor. Because the guidelines do not require that either drug, mifepristone or misoprostol, be taken in the presence of a doctor, they can be taken at home. *See Mifeprex Information*, *supra* note 175.

193 *See Practice Bulletin*, *supra* note 188, at e35.

194 *Id.*; Creinin & Gemzell Danielsson, *supra* note 179, at 114.

195 Pam Belluck, *F.D.A. Will Allow Abortion Pills by Mail During the Pandemic*, N.Y. TIMES (Apr. 13, 2021), https://www.nytimes.com/2021/04/13/health/covid-abortion-pills-mailed.html [https://perma.cc/242E-9CGZ].

196 *See* Donley, *supra* note 184 (noting that even if the mifepristone REMS is released under the Biden administration, in-person dispensing would still be required by state law in the nineteen states that require in-person dispensing by a physician).

197 141 S. Ct. 578, 582 (2021) (Sotomayor, J., dissenting).

198 *Id.*

the risk of exposure to the virus not only for the patients seeking abortions, but also for their families because, as Justice Sotomayor points out, "minority and low-income populations are more likely to live in intergenerational housing, so patients risk infecting not just themselves, but also elderly parents and grandparents."[199]

Abortion opponents have seized upon the medical gatekeeper model to both make it more difficult to access clinic-based care and at the same time unnecessarily require patients to be physically present in clinics. Against this backdrop, the next section describes the cultural and technological shifts that have transformed the landscape of healthcare generally and abortion specifically to render the gatekeeper model obsolete. In the face of barriers to access, significant numbers of people are turning to self-managed abortion with medication abortion pills procured online. Self-managed abortion reveals the degree to which the antiquated gatekeeper model has been rendered obsolete in the face of technology not contemplated at the time of the *Roe* decision.[200]

II
THE RISE OF SELF-MANAGED CARE AND THE FALLACY OF THE GATEKEEPER MODEL

The Supreme Court's gatekeeper model, first laid out in *Roe* and entrenched in both abortion jurisprudence and state law over the last forty-eight years, no longer comports with the realities of abortion practice and indeed never reflected the lived experiences of individuals living in poverty, who are disproportionately of color, and frequently lack access to adequate healthcare generally, and abortion care specifically. This section considers the antiquated gatekeeper model in light of the revolution in patient autonomy ushered in by the Patient's Bill of Rights and the rise of empowered patient consumers in the direct-to-consumer medical marketplace. Finally, the section examines self-managed abortion, that is, abortion that takes place outside of the clinical setting through medication procured online directly by consumers without the assistance of a

199 *Id.*

200 While the Court may not have contemplated self-managed care in *Roe*, to be sure, pregnant people have been self-managing abortion throughout history. There are historical accounts of home abortion dating back at least two thousand years. LUKER, *supra* note 30, at 11–12. In colonial America and the early days of the republic, people seeking to terminate a pregnancy or "bring[] on 'delayed menses'" turned to herbalists, midwives, and "Indian doctors" for herbal remedies. MURRAY & LUKER, *supra* note 121, at 627–28.

physician. It describes the evidence that significant numbers of pregnant people are turning to self-managed abortion, especially when faced with barriers to access to clinic-based abortion.

A. Longstanding Holes in the Gatekeeper Model

The *Roe* Court's idealized description of a doctor who counseled his passive and trusting patient on the abortion decision was never an accurate depiction of abortion for any but the most privileged patients who were able to access a private physician and who delegated decision-making authority to that doctor. As the statistics described earlier reveal, people living in poverty and people of color giving birth in the public maternity wards were unable to access abortion and people of color and living in poverty were disproportionately dying of illegal abortion due to their lack of access to clinic-based abortion.[201] What is more, the idealized medical gatekeeper was also not a reality in abortion care in the period even *after Roe.* In the years after *Roe,* abortion rights activists worked quickly to establish stand-alone abortion clinics as the cheapest and most effective strategy to rapidly expand abortion access.[202] Abortion-related medical care moved from general medical practice and became isolated in stand-alone clinics.[203] After 1973 the medical profession failed to make a concerted effort to train doctors to do abortions and to encourage doctors to integrate

---

201 *See supra* text accompanying notes 62–79.

202 *See, e.g.*, Rachel K. Jones, Mia R. S. Zolna, Stanley K. Henshaw, & Lawrence B. Finer, *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSPS. ON SEXUAL & REPROD. HEALTH 6, 14 (2008) (noting that for many freestanding clinics, the "larger the caseload, the less charged for the procedure"); Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSPS. ON SEXUAL & REPROD. HEALTH 16, 18 (2003) (finding that by 2001, the mean charge for an abortion at ten weeks since a woman's last menstrual period at an abortion clinic was $364 compared to $426 at a non-specialized clinic and $632 at a physician's office); Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 FAM. PLANNING PERSPS. 246, 249 (1991) (finding that large facilities achieve "economies of scale" by providing a *large* number of abortions).

203 *See* Emily Bazelon, *The New Abortion Providers*, N.Y. TIMES (July 14, 2010), https://www.nytimes.com/2010/07/18/magazine/18abortion-t.html [https://perma.cc/GM3K-H74S]; Elisabeth Rosenthal, *Finances and Fear Spurring Hospitals to Drop Abortions*, N.Y. TIMES (Feb. 20, 1995), https://www.nytimes.com/1995/02/20/nyregion/finances-and-fear-spurring-hospitals-to-drop-abortions.html [https://perma.cc/3E8Y-BPYU] (stating in 1995 that "almost all of New York City's full-service hospitals have backed out of the abortion business, driven away in part by economics and in part by fear" and reporting that, by 1988, only sixteen percent of abortions in New York were performed in hospitals and, by 1993, only nine percent).

abortion into ordinary practice.[204] As a result, over the last forty-eight years abortion training has been steadily disappearing from residency programs that produce new doctors and abortion care has been almost exclusively performed in stand-alone clinics.[205] In 1973 hospitals made up eighty percent of the country's abortion facilities and by 1996 ninety percent of the abortions in the U.S. were performed at clinics.[206]

Because abortion clinics are isolated from ordinary healthcare practice, most people who terminate their pregnancies do so at stand-alone clinics and necessarily do not have an existing doctor-patient relationship like the one described by the *Roe* Court. As Professor Nan Hunter has argued, once abortion opponents realized that doctors could not be trusted to impose conservative mores and that the privacy of the doctor-patient relationship was a space in which women and doctors could make decisions that resisted traditional norms, abortion opponents sought to reinsert the state into the doctor-patient relationship.[207] As a result, abortion opponents have taken aim at stand-alone clinics, describing them as "abortion mills" and seeking to undermine the legitimacy of abortion providers.[208]

In the intervening years since the *Roe* decision, abortion restrictions have had a disproportionate impact on the poorest and most vulnerable, who are disproportionately people of color.[209] Lack of health insurance coverage for abortion-related healthcare and lack of resources to pay out of pocket for clinic-based care means that people living in poverty have less access to abortion. Waiting periods require people seeking abortion to make two trips to clinics, which is a greater challenge to low-income and hourly workers who have less flexibility in their work schedules and must take time off from work. Long travel to reach a provider, especially when combined with

---

204 *Id.* *See* Bazelon, *supra* note 203 ("The American Medical Association did not maintain standards of care for the procedure . . . . Being a pro-choice doctor came to mean referring your patients to a clinic rather than doing abortions in your own office.").

205 *Id.* ("In 1995, the number of OB-GYN residencies offering abortion training fell to a low of 12 percent.").

206 *Id.*

207 Hunter, *supra* note 12, at 196.

208 KARISSA HAUGEBERG, WOMEN AGAINST ABORTION: INSIDE THE LARGEST MORAL REFORM MOVEMENT OF THE TWENTIETH CENTURY 78, 138 (2017) (describing anti-abortion protesters using the term "abortion mill"); SANGER, *supra* note 170, at 36 (describing that the "pro-life movement has long characterized abortion clinics as 'mills' that run women through for profit alone").

209 *See* Bridges & Roberts RJ Scholars Brief, *supra* note 12, at 9–11 (arguing that a Louisiana admitting privileges law disproportionately burdens "a vulnerable group of marginalized women—black women").

waiting periods, means that people seeking abortion must stay overnight, arrange work schedules, and arrange for childcare if they are already parenting. People living in rural areas are even more likely to have to travel long distances to reach providers, as ninety-seven percent of rural counties do not have a single abortion provider.[210] Pregnant people with compromised immigration status face greater obstacles to accessing abortion care because their ability to travel long distances to obtain reproductive healthcare is limited by the threat of apprehension, detention, and deportation, which severely restricts their travel and movement.[211] It is often these very barriers to access to providers, the proliferation of regulation of abortion at the site of access, and significant harassment at abortion clinics that have driven people to turn to self-managed care.[212]

The "responsible physician" central to the *Roe* Court's vision of the abortion right has not only become obsolete, but in many states has become an obstacle to abortion access, especially for those who are most vulnerable and marginalized. As described earlier, anti-abortion tactics have focused on the doctor-patient relationship—from requiring that a patient be physically present at a clinic or provider's office when dispensing abortion medication, to forced ultrasounds, waiting periods, consent scripts, and TRAP laws. These laws reveal that the anti-abortion strategy reflected in the Alito Memo has re-

---

210 Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSPS. ON SEXUAL & REPROD. HEALTH 41, 46, 49 (2011); Johnathan M. Bearak, Kristen Lagasse Burke, & Rachel K. Jones, *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis* 2 LANCET PUB. HEALTH e493, e493 (2017) (noting that "those who live in rural areas typically travel greater distances than those who live in urban areas" with median travel distance of 100 miles to have an abortion), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5943037/ [https://perma.cc/N7EU-STPS].

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

212 *See, e.g.*, GROSSMAN ET AL., *supra* note 15, at 4 (finding that in Texas, self-induced abortion appeared to be more common "among women who report[ed] barriers accessing reproductive health services"); Brief for National Asian Pacific American Women's Forum and Center on Reproductive Rights and Justice at the University of California, Berkeley, School of Law et al. as Amicus Curiae at 10–19, 22–28, Patel v. State, 60 N.E.3d 1041 (Ind. Ct. App. 2016) (No. 71A04-1504-CR-166) [hereinafter Patel Amicus Brief] (describing the "myriad" of legal restrictions and practical barriers that may drive a pregnant person toward self-managed abortion, including travel distance, waiting periods, and cost of clinic based care).

duced the role of the responsible physician in many states from a trusted adviser to an unwilling anti-abortion mouthpiece of the state. While the anti-abortion strategy that targets the doctor-patient relationship has played out, however, technology has given rise to a fundamental change in self-managed care and direct-to-consumer healthcare access that upends the strategy and calls for a new framing of the abortion right.

B. Patients as Consumers in the Direct-to-Consumer Medical Marketplace

Over the last fifty years patients have been transformed from passive recipients of doctors' orders to actively engaged consumers who manage and direct their own healthcare.[213] The transformation grew out of the "rights revolution" era of the 1970's and led to the Patient's Bill of Rights in 1973 that required doctors give patients complete and accurate information so that patients may make their own healthcare decisions in order to give informed consent.[214] During this period, the patients' rights movement overlapped with the feminist movement's call for greater agency for women in healthcare decisions and the critique of women's treatment at the hands of the patriarchal medical establishment.[215] Indeed, one of the first patients' rights successes was the battle for direct-to-patient labeling of prescription birth control pills and estrogen replacement therapy.[216]

Researchers and policymakers such as the Food and Drug Administration (FDA) have embraced the potential of increased consumer autonomy and self-managed care in order to enhance patient autonomy, increase quality, and decrease the cost of healthcare.[217] Researchers and policymakers have sug-

---

213 Lewis A. Grossman, *FDA and the Rise of the Empowered Consumer*, 66 ADMIN. L. REV. 627, 630–31 (2014) (describing the transformation of passive and trusting consumers in the 1960s into active engaged and informed consumers of 2014 who work to shape FDA policy).

214 *Id.* at 637–38.

215 *Id.* at 638–39; SANDRA MORGEN, INTO OUR OWN HANDS: THE WOMEN'S HEALTH MOVEMENT IN THE UNITED STATES, 1969–1990 3–4 (2002) (describing the women's health movement as "wrest[ing] back some control" of women's health from "condescending, paternalistic, judgmental, and non-informative" doctors); CAROL S. WEISMAN, WOMEN'S HEALTH CARE: ACTIVIST TRADITIONS AND INSTITUTIONAL CHANGE 37–38 (1998); Amy Sue Bix, *Engendering Alternatives: Women's Health Care Choices and Feminist Medical Rebellions*, *in* THE POLITICS OF HEALING: HISTORIES OF ALTERNATIVE MEDICINE IN THE TWENTIETH-CENTURY NORTH AMERICA 153, 156–62 (Robert D. Johnston ed., 2004).

216 Grossman, *supra* note 213, at 639, 652–53.

217 *See, e.g.*, Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?* 35 AM. J. L. MED. 7 (2009); John E. Calfee, Clifford

gested that self-managed health interventions delivered through online platforms can effectively address issues of rising costs,[218] increasing demand, an aging population, and chronic illness.[219] Proponents of participatory or direct-to-consumer medicine argue that the new model increases patient autonomy while also reducing costs to both individuals and the healthcare system as a whole.[220] In response, Medicare and FDA policy have shifted to meet the expansion of patient autonomy and healthcare self-management. For example, Medicare is now taking steps to make it easier for people to do their own kidney dialysis at home. Not only does at-home use save money, but federal Medicare authorities as well as doctors recognize that patients do better when they are active participants in their own care while at the same time improving patient's experience and lowering medical costs.[221] In approving direct-

---

Winston & Randolph Stempski, *Direct-to-Consumer Advertising and the Demand for Cholesterol-Reducing Drugs*, 45 J.L. & ECON. 673, 673–75 (2002) (describing the FDA's 1997 policy change to allow direct-to-consumer prescription drug advertising, describing that the change enhanced consumer education about health conditions and their treatments. In addition, the FDA accelerated the pace of switching prescription drugs to over-the-counter to recognition of "the greater role that consumers were taking in their healthcare decision").

218 More of the U.S. gross domestic product (GDP) goes to health care (16%) than in any comparable country but without any indication that the healthcare delivered is better by any measure and healthcare costs are rising faster than inflation. Schneider & Hall, *supra* note 217, at 8.

219 Harald Schmidt, *Chronic Disease Prevention and Health Promotion*, *in* PUBLIC HEALTH ETHICS: CASES SPANNING THE GLOBE 137, 137 (Drue H. Barrett et. al. eds., 2016) (reporting that treatment of chronic disease accounts for an estimated three quarters of U.S. health care spending); *see, e.g.*, Mary A.M. Rogers, Kelsey Lemmen, Rachel Kramer, Jason Mann & Vineet Chopra, *Internet-Delivered Health Interventions That Work: Systematic Review of Meta-Analyses and Evaluation of Website Availability,* 19 J. MED. INTERNET RSCH. e90 (2017) (noting that because of easy access and low cost, internet-delivered therapies are a good alternative to improving health in the face of rising cost and demand); Catherine M. Sharkey, *Direct-to-Consumer Genetic Testing: The FDA's Dual Role as Safety and Health Information Regulator,* 68 DEPAUL L. REV. 343, 363–64 (2019) (citing MICHAEL J. SAKS & STEPHAN LANDSMAN, CLOSING DEATH'S DOOR: LEGAL INNOVATIONS TO STEM THE EPIDEMIC OF HEALTHCARE HARM 240–43 (2021)) (observing that the medical establishment's resistance to providing medical information directly to consumers may be driven by a desire to preserve its own authority and revenue streams and may result in inefficiency and expense).

220 Sharkey, *supra* note 219, at 364 ("Proponents of the libertarian model tout its potential to promote preventative and individualized medicine, while simultaneously reducing costs to individuals and the health care system."); Rogers, Lemmen, Kramer, Mann, & Chopra, *supra* note 219, at 19 ("Therapies that are Internet-based offer an attractive option for certain types of conditions due to easy access and low cost.").

221 Eric Whitney, *Feds Say More People Should Try Dialysis at Home*, NPR NEWS (Oct. 4, 2016), http://www.npr.org/sections/health-shots/2016/10/04/492932675/feds-say-more-people-should-try-dialysis-at-home) [https://perma.cc/2B7F-PXSN].

to-consumer (DTC) genetic testing the FDA noted "that consumers are increasingly interested in genetic information to help make decisions about their health care."[222] In more recent years, the transformation has been furthered by drug manufacturers directly advertising to consumers[223] and shifts in FDA policies requiring patient labeling in drugs.[224] Consumer activism has also shaped FDA policy by accelerating the movement of drugs from prescription to over-the-counter (OTC) availability, which has been described as a "tidal shift of authority away from the medical profession and toward the consumer."[225] The movement of drugs to OTC availability, especially drugs such as the emergency contraception drug Plan B, has come in response to what the FDA has described as "a growing desire of consumers to have greater control over their health care" and the "self-care movement."[226]

In the new healthcare marketplace, individuals seeking health care exercise greater autonomy and look and act more like consumers than patients.[227] While early struggles were geared toward labeling of prescription drug information for consumers, technology has accelerated the ability of patient-consumers to directly access healthcare information and personal healthcare data and thereby assess their own health conditions and address potential problems.[228] A Pew survey published in 2013 found that thirty-five percent of U.S. adults reported using the internet at one time or another to try to diagnose a medical condition.[229] In recent years technology

---

222 Sharkey, *supra* note 219, at 357 (citing Press Release, U.S. Food and Drug Admin., FDA Authorizes First Direct-to-Consumer Test for Detecting Genetic Variants That May Be Associated with Medication Metabolism (Oct. 31, 2018)).

223 While never expressly prohibited by FDA regulations, the practice did not start until the mid-1980s, after comments by FDA Commissioner Arthur Hull Hayes Jr. to the Pharmaceutical Advertising Council in which he predicted "exponential growth" in DTC advertising of drugs. *See* Wayne L. Pines, *A History and Perspective on Direct-to-Consumer Promotion,* 54 FOOD & DRUG L.J. 489, 492–93 (1999). The practice surged again in 1997 when FDA issued draft guidance allowing television advertising of prescription drugs for the first time. *Id.* at 496–98.

224 *See* Grossman, *supra* note 213, at 651, 656–57.

225 *Id.* at 662?63.

226 *Id.* at 665 (internal quotation marks omitted).

227 *Id.* at 627 (stating that the "FDA's role as a paternalistic gatekeeper" has diminished and that "today's consumers of food and drugs have far greater freedom to make unmediated choices among a wider variety of products"); Nancy Tomes, *Patients or Health-Care Consumers? Why the History of Contested Terms Matters*, *in* HISTORY AND HEALTH POLICY IN THE UNITED STATES: PUTTING THE PAST BACK IN 83, 101 (Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns eds., 2006).

228 *See* Sharkey, *supra* note 219, at 365 n.86.

229 SUSANNAH FOX & MAEVE DUGGAN, PEW RSCH. CTR., HEALTH ONLINE 2013 2 (Jan 15, 2013), http//www.pewinternet.org/~/media//Files/Reports/

has accelerated the shift towards greater patient autonomy and self-managed healthcare by increasing the availability of direct-to-consumer healthcare devices and digital and mobile health products. The electrocardiogram (ECG) software application on the Apple Watch can detect atrial fibrillation and other arrhythmias.[230] The transformation of patients into autonomous consumers capable of caring for their own health is also reflected in the availability of OTC diagnostic devices, including home testing for blood pressure, cholesterol, blood glucose levels, and HIV.[231] Individuals seeking assisted reproductive technology (ART) can shop for and purchase sperm and ova directly in the online marketplace.[232] Individuals can now directly order fecal and blood testing online without a doctor acting as intermediary to write an order. Similarly, while genetic testing had been the sole purview of doctors for the last fifty years, the rise of DTC genetic testing such as 23andMe have allowed individuals to by-pass doctors to obtain genetic testing directly in the marketplace.[233] Consumers have used these DTC tests for a wide range of uses, from discovering ancestry, to screening for diseases like cancer, to diagnosis and screening for drug responses.[234] Thus, healthcare trends and technology such as direct to consumer medical devices, testing, Web solutions, and mobile apps have increased patient autonomy and self-management of one's own healthcare outside of doctors acting in the role of medical intermediaries.

PIP_HealthOnline.pdf. [https://perma.cc/2L8T-XL3H]. The rise of WebMD, launched in 1998, exemplifies the importance of the internet. Within ten years of its launch, WebMD had forty million unique visitors each month. Grossman, *supra* note 213, at 639?40. It is worth noting that even before the internet, the increase in healthcare information directed to consumers began in 1970s and 80s with publications such as *The Pill Book* and the *American Medical Association Family Medical Guide*. *Id.* at 639–40. The latter was published "with the stated goal of 'creat[ing] an effective partnership with your doctor.'" *Id.* at 640 (citing the Random House publisher description of the *AMA Family Medical Guide* (1987)).

230 Nathan Cortez, *Digital Health and Regulatory Experimentation at the FDA*, 21 YALE J. L. & TECH. 4, 9 (2019). The FDA now applies post- rather than pre-market scrutiny to such devices in order to allow new and emerging technology to reach the market without being bogged down in regulatory quagmire. *See id.* at 6.

231 Grossman, *supra* note 213, at 665 n.214.

232 *See* Maya Sabatello, *Regulating Gamete Donation in the U.S.: Ethical, Legal and Societal Implications*, 4 LAWS 352, 354 (2015) (noting that the U.S. is unique among all other nations in that ART is a private commercial activity that is almost entirely unregulated but rather is driven by consumer demand).

233 *See* Sharkey, *supra* note 219, at 349–58 (discussing 23andMe).

234 *See id.* at 346 n.6. In March of 2018 the FDA authorized the first DTC cancer health risk test for breast cancer, although the Acting Director cautioned that the test should not be used as a substitute for seeing a doctor. *Id.* at 356–57.

While it is clear that patients in the traditional clinical context are acting more like consumers to directly manage their own healthcare through online technology, significant evidence has revealed that individuals are obtaining medication directly online *outside* of the clinical context to self-manage a range of healthcare issues, including gender-affirming hormone therapy and abortion. In response to barriers facing transgender and gender nonconforming (TGNC) people[235] who seek transition-related care, many transgender individuals are turning to self-managed hormone therapy.[236] Recent studies indicate that TGNC people are obtaining hormones from nontraditional sources such as friends, street vendors, online, and through pharmacies without a prescribing physician.[237] These studies indicate that "unsupervised hormone use reportedly ranges from [twenty-nine percent] to [sixty-three percent] within urban groups of male-to-female" TGNC people.[238] These studies report that the reasons for turning to self-managed hormone use include lack of insurance, cost of accessing health care, stigma, and difficulty finding sensitive and compassionate medical care providers.[239]

C. Self-Managed Medication Abortion

As described earlier, doctors and medical providers widely use the two-drug medication abortion regimen of misoprostol and mifepristone in the clinical context when providing abor-

---

235 Transgender and gender nonconforming people are individuals whose gender identity does not align with their biological sex at birth. While the term "transgender and gender nonconforming" is widely used, it is important to recognize that some TGNC people do not prefer these terms. *See* American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* 70 AM. PSYCH. 832, 835 (2015) (recognizing that "[a] nonbinary understanding of gender is fundamental to the provision of affirmative care for TGNC people" and stating that "[p]sychologists are encouraged to adapt or modify their understanding of gender, broadening the range of variation viewed as healthy and normative"); *Transgender Care and Treatment Guidelines: Terminology and Definitions*, UCSF TRANSGENDER CARE (June 17, 2016), http://transhealth.ucsf.edu/trans?page=Guidelines-terminology [https://perma.cc/4T8Q-CYVQ] (providing definitions of commonly encountered terms).

236 *See, e.g.*, Sanchez, Sanchez & Danoff, *supra* note 21, at 713 ("The prevalence of unsupervised hormone use reportedly ranges from 29% to 63% within urban groups of male-to-female transgender persons . . . ."); Xavier et al., *supra* note 21, at 12 ("Faced with many barriers to health care access, participants reported self-medication with transgender hormones to increase their passing ability and thus gain social acceptance."); Budge, *supra* note 21, at 288 (noting that as a result of barriers, many transgender individuals turn to the black market to obtain hormones.).

237 Sanchez, Sanchez & Danoff, *supra* note 21, at 713.

238 *Id.*

239 *Id.*

tion care up to eleven weeks gestation.[240] However, when pregnant people end their own pregnancies using medication without medical supervision, they generally take misoprostol alone because the FDA has required that mifepristone only be provided in-person by a clinic or provider, thereby preventing distribution through pharmacies and the mail.[241] Gynuity Health Projects has developed a sample protocol for no-test medical abortion, and the WHO recognizes the use of misoprostol alone for first-trimester abortion and abortions that occur after twelve to fourteen weeks of gestational age.[242] This single-medication method can safely induce an abortion and is between seventy-eight to eighty-seven percent effective depending on dosage and ingestion.[243] Much research has pointed to the safety and efficacy of the single-drug regimen for medication abortion using misoprostol.[244]

WHO examined the safety of self-administered medication abortion using misoprostol alone, as opposed to the two-drug regimen that requires a doctor visit, and recommended the use of misoprostol alone in those settings where mifepristone is not

---

240 *See* text accompanying *supra* notes 175–185.

241 *See Mifeprex Information*, *supra* note 175.

242 *See* E.G. Raymond et al., *Medical Abortion, A Sample Protocol for Increasing Access During A Pandemic and Beyond*, 101 CONTRACEPTION 361, 362, 364 (2020); WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 31–32 (2d ed. 2012).

243 *See* Elizabeth G. Raymond, Margo S. Harrison & Mark A. Weaver, *Efficacy of Misoprostol Alone for First-Trimester Medical Abortion: A Systematic Review*, 133 OBSTETRICS & GYNECOLOGY 137, 137–47 (2019) (describing that the results of a systematic review of research finds that the overall the effectiveness of misoprostol alone was 78% but that higher doses and sublingual or vaginal delivery increased the efficacy of the single-drug regimen to eighty-seven percent); *see also* N.L. Moreno-Ruiz, L. Borgatta, S. Yanow, N Kapp, E.R. Wiebe & B. Winikoff, *Alternatives to Mifepristone for Early Medical Abortion*, 96 INT'L J. GYNECOLOGY & OBSTETRICS 212 (2007) (systemic review of research finds the efficacy of misoprostol alone in terminating pregnancy ranged from eighty-four percent to ninety-six percent).

244 GYNUITY HEALTH PROJECTS & REPROD. HEALTH TECH., INSTRUCTIONS FOR USE: ABORTION INDUCTION WITH MISOPROSTOL IN PREGNANCY THROUGH 9 WEEKS LMP (July 28, 2003), https://www.rhsupplies.org/uploads/tx_rhscpublications/Gynuity_Instructions%20for%20use%20-%20Abortion%20induction%20with%20misoprostol_2004.pdf [https://perma.cc/CR2W-LVH8] ("Use of misoprostol for pregnancy termination of gestations through 9 weeks LMP has a success rate of 85–90%."); N. L. Moreno-Ruiz et. al., *supra* note 243, at 217 (2007) ("Self-induced abortion with misoprostol, because of its simplicity and quick results, is an option for women without other alternatives."); Helena von Hertzen et al., *Efficacy of Two Intervals and Two Routes of Administration of Misoprostol for Termination of Early Pregnancy: A Randomized Controlled Equivalence Trial*, 396 LANCET 1938, 1945 (2007) (stating that "misoprostol has proved to be safe and well tolerated").

available.[245] The WHO safe abortion guidelines provide that misoprostol can be used alone to safely end a pregnancy through twelve weeks after the first day of the last menstrual period.[246]

Medication abortion—that is, abortion without the need for surgery—was a technology not contemplated by the Supreme Court at the time that *Roe* was decided and eliminates the need for a medical gatekeeper to serve as an intermediary because it involves dispensing pills rather than performing surgery. There is evidence that large numbers of individuals turn to self-managed abortion in the face of the obstacles to accessing clinic-based care.[247] Researchers recently found that significant numbers of pregnant people from immigrant communities are self-managing abortions through traditional herbal methods or by obtaining medication from one of the border *mercados* or at a pharmacy across the border in Mexico where

---

245 R.J. Gomperts, K. Jelinska, S. Davies, K. Gemzell-Danielsson & G. Kleiverda., *Using Telemedicine for Termination of Pregnancy with Mifepristone and Misoprostol in Settings Where There is No Access to Safe Services*, 115 BJOG 1171, 1173 (2008). Misoprostol is readily available over the counter elsewhere in the world and is commonly used to induce abortion outside of clinical settings. *Id.* Indeed, in an effort to reduce the number of deaths due to illegal abortions throughout much of Latin America, Africa, Asia and the Persian Gulf, WHO recently put mifepristone and misoprostol on its Essential Medicines List. *Id.* at 1171.

246 Ferid A. Abubeker, Antonella Lavelanet, Maria I. Rodriguez & Caron Kim, *Medical Termination for Pregnancy in Early First Trimester (•63 Days) Using Combination of Mifepristone and Misoprostol or Misoprostol Alone: A Systematic Review*, 20 BMC WOMEN'S HEALTH 142 (July 2020); Bela Ganatra et al., *From Concept to Measurement: Operationalizing WHO's Definition of Unsafe Abortion*, 92 BULL WORLD HEALTH ORG. 155, 155 (2014).

247 Research reveals that especially among immigrant communities along the U.S. southern border, individuals seeking to terminate their own pregnancies continue to employ traditional herbal and alternative techniques for inducing abortion, but the majority turn to medication abortion to self-manage abortion. *See* Rachel K. Jones, *How Commonly Do US Abortion Patients Report Attempts to Self-Induce?*, 204 AM. J. OBSTETRICS & GYNECOLOGY 23.e1, 23.e1–23.e3 (2011) (describing a 2008 national survey of abortion patients that revealed that about 1.4% attempted to terminate their own pregnancies using a method other than medication abortion); ADVANCING NEW STANDARDS IN REPROD. HEALTH, GYNUITY HEALTH PROJECTS & IBIS REPROD. HEALTH, A ROADMAP FOR RESEARCH ON SELF-MANAGED ABORTION IN THE UNITED STATES 2 (2018) [hereinafter A ROADMAP], https://ibisreproductivehealth.org/sites/default/files/files/publications/US%20research%20roadmap%20self%20managed%20abortion.pdf [https://perma.cc/4T4H-RRH2]. There are historical accounts of abortion dating back at least two thousand years. In Colonial America and the early days of the Republic, people seeking to terminate a pregnancy or "bring[ ] on 'delayed menses'" turned to herbalists, midwives, and "Indian doctors" for herbal remedies. *See* MURRAY & LUKER, *supra* note 121, at 627–28.

misoprostol is sold over the counter without a prescription.[248] The study found that in 2013 after the Texas legislature passed the controversial state law HB 2, which was the subject of the *Whole Women's Health* case, that shuttered thirty of the state's forty-eight abortion clinics, somewhere between 100,000 and 240,000 women of reproductive age living in Texas tried to end their pregnancies entirely on their own, without any medical assistance.[249] Self-managed care allows individuals without access to clinic-based care to end their pregnancy safely, at low cost, in the comfort of their homes, and without the threat of clinic protesters and, for those with compromised immigration status, without fear of detention by immigration enforcement.[250] In 2015 there were more than 700,000 Google searches using terms related to self-induced abortion in the United States.[251] A 2014 national survey of abortion patients revealed that about 1.3% of them had attempted to terminate a pregnancy on their own using misoprostol, with another 0.9% using a method other than medication abortion.[252] In each of these studies, individuals reported various reasons for turning to self-managed abortion care, including difficulty obtaining reproductive health services, inability to afford the cost of clinic-based care, wanting to avoid clinic-based care, not knowing that abortion was legal and that they could access clinic-based care, and preference for self-managed care as more natural and easier.[253]

---

248 *See* GROSSMAN ET. AL., *supra* note 15, at 3 (finding that in the wake of Texas' passage of HB2, one of the most restrictive abortion laws in the country, there has been an increase in the use of self-induction abortion through medication). The study in Texas estimates that between 100,000 and 240,000 women have attempted to end their own pregnancies. *Id.* at 2. *See also* Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014), (discussing the growing use of restrictions on abortions as the reason for women to take matters into their own hands), https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/ [https://perma.cc/VZ5N-EVDY].

249 *See* GROSSMAN ET. AL., *supra* note 15, at 1–2.

250 *See* Yvonne Lindgren, *The Doctor Requirement:* Griswold, *Privacy, and At-Home Reproductive Care,* 32 CONST. COMMENT. 341, 360–61 (2017).

251 Seth Stephens-Davidowitz, *The Return of the D.I.Y. Abortion,* N.Y. TIMES (Mar. 5, 2016), https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html [https://perma.cc/DW67-VNN2].

252 A ROADMAP, *supra* note 247; *see also* Jones, *supra* note 247, at 23.e3 (revealing via a 2008 survey that about 1.2% of women had attempted to terminate a pregnancy on their own using misoprostol, with another 1.4% using a method other than medication abortion); Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States,* 18 REPROD. HEALTH MATTERS 136, 136–46 (2010) (exploring women's motivations for self-induced abortions).

253 *See* Grossman et al., *supra* note 252, at 140–42.

The technology that has given rise to direct-to-consumer access to abortion care follows larger trends in direct-to-consumer healthcare and self-managed care in healthcare. The next section considers alternative constitutional foundations beyond the cramped gatekeeper model that better reflect the new realities in abortion care and better protect the abortion right.

III
IMPLICATIONS FOR THE ABORTION RIGHT BEYOND THE GATEKEEPER

In 2019 a coalition of six medical organizations representing 560,000 frontline physicians issued a letter calling for an end to state legislators inserting politics into the practice and delivery of evidence-based medicine.[254] In the open letter, the authors argued that "[t]he insertion of politics between patients and their physicians undermines the foundation of trust this relationship is built on and inhibits the delivery of safe, timely, and comprehensive care."[255] This section describes ways to reenvision and challenge the gatekeeper model: First, it examines alternative constitutional foundations that were necessarily foreclosed by the *Roe* Court's decision to pursue the medical gatekeeper framing of the abortion right. It investigates what is left of the Supreme Court's abortion holdings in the absence of the medical gatekeeper framing. Next, the section considers federal and state-level approaches to protecting abortion access by expanding direct-to-consumer access to medication abortion through the mail and pharmacies and expanding who can dispense medication abortion. Finally, this section reveals the high cost of the gatekeeper framework in the prosecutions of individuals suspected of terminating their pregnancies, a hazard that falls disproportionately on poor and marginalized individuals and communities. The section concludes that doing away with the medical gatekeeper framework is necessary as a question of criminal and reproductive justice as well as public health.

---

254 The letter was issued by the American Academy of Family Physicians representing 560,000 physicians across organizations including the American Academy of Pediatrics, the ACOG, and the American College of Physicians. *Frontline Physicians Call on Politicians to End Political Interference in the Delivery of Evidence Based Medicine*, AM. ACAD. FAM. PHYSICIANS (May 15, 2019) [hereinafter *Frontline Physicians Letter*], https://www.aafp.org/news/media-center/more-statements/physicians-call-on-politicians-to-end-political-interference-in-the-delivery-of-evidence-based-medicine.html [https://perma.cc/4VC7-6FV3].

255 *Id.*

A. Constitutional Bases

In the years leading up to *Roe*, there were competing visions of the abortion right that were specifically foreclosed by the Court's decision to frame the right as a decision between pregnant people and their doctors acting as gatekeepers. Feminists strongly opposed the medical reform model that sought to grant doctors greater discretion when making the abortion decision in consultation with their patients.[256] Rather than reform, feminists worked for outright repeal of criminal abortion laws and called for abortion on demand that would do away with providers as "moral gatekeepers" to abortion access.[257] Feminists argued that abortion on demand was a necessary part of their agenda because abortion allowed women exclusive control over their reproduction and allowed them to shape their destinies.[258] Indeed, the Court in *Roe* explicitly distanced its ruling from the feminist model of abortion on demand, concluding that the right of privacy does not include "an unlimited right to do with one's body as one pleases."[259]

While the *Roe* decision framed the abortion right as a right of privacy related to marriage, family, and childrearing, Justice Douglas' concurring opinion argued that abortion was a right of health, describing the medical privacy right as "the right to care for one's health and person and to seek out a physician of one's own choice."[260] His concurrence argued that the term "liberty" in the Fourteenth Amendment included the right to seek healthcare free from bodily restraint and without compulsion by the state.[261] Identifying abortion as a right of healthcare is a more appropriate framing for medication abortion and the larger revolution in consumer-directed healthcare that has emerged over the last nearly fifty years. *Roe*'s right of privacy related to marriage, family, and childrearing suggests the privacy of *relationships*, in *Roe*, the doctor-patient relationship.

---

256 *See* PETCHESKY, *supra* note 37, at 125–27; GREENHOUSE & SIEGEL, *supra* note 47, at 40 (describing the National Association for the Repeal of Abortion Laws (NARAL) Policy Statement as one example of the new premise of feminist activism in support of repealing abortion laws rather than simply reforming them which "emphasiz[ed] the rights of women rather than those of doctors"). *See generally* LUKER, *supra* note 30, at 32–33 (discussing nineteenth century state laws that gave doctors unlimited discretion as to when an abortion was warranted).

257 PETCHESKY, *supra* note 37, at 126.

258 *Id.* at 125–26.

259 Roe v. Wade, 410 U.S. 113, 153 (1973).

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

261 *Id.* at 213 (Douglas, J., concurring) (describing "the freedom to care for one's health and person, freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf").

By contrast, a right of healthcare—variously identified as a "right to care for one's health,"[262] to seek a doctor of one's choosing and to refuse and seek medical care—more accurately describes the right of individuals to act autonomously without a doctor acting as an intermediary. Health care delivery generally, and abortion care specifically, has shifted away from the clinic and into the home. The transition to home-based healthcare has been spurred by the COVID-19 pandemic and technological innovations such as telehealth, wearable sensors, and direct-to-consumer testing and monitoring devices.

Justice Blackmun's concurring opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*[263] similarly identified abortion as a right of reproductive choice related to medical decisions, stating, "[j]ust as the Due Process Clause protects the deeply personal decision of the individual to *refuse* medical treatment, it also must protect the deeply personal decision to *obtain* medical treatment, including a woman's decision to terminate a pregnancy."[264] This characterization of the abortion right highlights that the ability to make healthcare decisions, including the right to access abortion-related healthcare, is an integral aspect of liberty. The autonomy of medical decision-making has been recognized in the right to refuse medical treatment in *Cruzan v. Director, Missouri Department of Health*.[265] While the courts have not yet extended the *Cruzan* holding to include the constitutional right to *access* medication,[266] the federal government and thirty-eight states have adopted "right to try" laws that allow terminally ill people to access experimental drugs that the FDA has not yet approved as a matter of state law.[267] Prohibitions on the use of self-managed abortion infringe on the liberty and autonomy of re-

---

262 *Id.* at 219 (Douglas, J., concurring).

263 505 U.S. 833 (1992) (plurality opinion).

264 *Id.* at 927 n.3 (Blackmun, J. concurring) (emphasis in the original).

265 497 U.S. 261, 278 (1990) (upholding the right of an individual to withdraw lifesaving hydration and feeding equipment after catastrophic brain injury left her in a permanent vegetative state).

266 *See* Abigail All. for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 713 (D.C. Cir. 2007) (en banc) (holding that patients do not have a right to access potentially life-saving experimental treatments).

267 *Right to Try Act*, FDA, https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/right-try [https://perma.cc/95TQ-78EF] (last visited Dec. 6, 2021); *see* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 255–56 (8th ed. 2018) (noting that that thirty-eight states have adopted "right to try" laws that permit individuals who are terminally ill to experiment with unproved treatments); Emily Hogan, Note, *"Right to Try" Legislation and Its Implications for the FDA Drug Approval Process*, 50 WASH. U. J.L. &

productive decision-making that the Court has recognized at the core of the Fourteenth Amendment.[268]

The technology of self-managed abortion care, along with evidence that it is being accessed by tens of thousands of people each year, reveals that the constitutional architecture that undergirds the abortion right needs to accommodate this new technology and changing practice.[269] The medical gatekeeper model merely reflects a historic compromise between competing models, feminists, and medical organizations, but it is not critical to the foundation of abortion jurisprudence. The abortion right must reflect the new reality of a medical landscape in which safe and effective self-managed abortion care is available and readily accessible. Self-managed care of any type—from abortion to self-managed dentistry and bone-setting—falls within an individual's right to manage their health and make autonomous medical decisions.

B. Challenging Medical Restrictions with a New Direct-Access Model

It is a critical time to reassert the constitutional right of abortion, reframed as a right to directly access abortion-related healthcare. Self-managed abortion has laid bare what has been inherently problematic from the beginning: The *Roe* Court centered doctors and healthcare regulations as integral to the abortion right. This approach was arguably legitimate in a medical landscape in which abortions were necessarily surgical, and non-medical abortions were often lethal. However, the medical gatekeeper framing is onerous when abortion technology and widespread practice allows pregnant people to access safe and effective non-surgical self-managed abortions. It is time to once again reframe the abortion right in response to

---

POL'Y 171, 189 (2016) (tracing the history of the laws); RIGHT TO TRY, https://righttotry.org [https://perma.cc/NQ9E-C6L6] (last visited Aug. 30, 2021).

268 *See, e.g.*, Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) (stating that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.").

269 Indeed, the dichotomy of safe legal abortion and its antithesis of dangerous back-alley "coat hanger" abortions has given way. As one recent activist suggested, "[i]magine if those old coat hanger pins warning against unsafe abortion were replaced by pins with pills on them to show that we have access to this [safe] medic[ation]?" Cari Sietstra, *Opinion: Alabama's Terrible Law Doesn't Have to Be the Future of Abortion*, N.Y. TIMES (May 11, 2019), https://www.nytimes.com/2019/05/11/opinion/abortion-pregnancy-misoprostol.html [https://perma.cc/A5S6-3HMT].

changing technology to better protect the right and access to abortion-related healthcare. As this section will describe, this is not the first time that the Court has reasserted the "central right recognized by *Roe*" while at the same time that it has adjusted the Court's analysis to respond to changing medical technology.[270] This section highlights the extent to which then-current medical practice informed the *Roe* Court's framing of the abortion right and concludes that the time has come for current medical technology to inform the framing of the abortion right as a right that includes self-managed care.

The *Roe* Court looked to "modern [medical] techniques" to reject opponents' arguments that criminal abortion laws were necessary to protect women's health.[271] The Court relied heavily on the work of Cyril Means whose research had argued that nineteenth-century abortion laws had been driven by a desire to protect women from the dangers of surgical abortion.[272] His report, drafted at the request of Governor Nelson Rockefeller, had unearthed evidence that when the advent of surgical abortion using instruments had replaced more traditional herbal abortifacients, abortions became more lethal and the high mortality rate from abortions had driven the states to pass criminal abortion laws across the nation in the mid-1800's.[273] In examining the historical record of why criminal abortion laws were passed, the *Roe* Court described that "[w]hen most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman. This was particularly true prior to the development of antisepsis."[274] The Court then goes on to explain that until the development of antibiotics in the 1940's "standard modern techniques such as dilation and curettage were not nearly so safe as they are today."[275] Relying on medical data, the Court concludes that unlike earlier periods in

---

270 *Casey*, 505 U.S. at 878–79 (1992) (describing that "[o]ur adoption of the undue burden analysis does not disturb the central holding of *Roe v. Wade*, and we reaffirm that holding").

271 Roe v. Wade, 410 U.S. 113, 149 (1973).

272 MURRAY & LUKER, *supra* note 65, at 661 n.6 (describing that the *Roe* Court relied heavily on the work of Professor Cyril Means' research that the history of abortion regulation was ushered in to protect women's health).

273 *Id.* Note that his historical account has since been challenged by historians who have discussed that the campaign to criminalize abortion was driven by a professionalization campaign by doctors and racist fears of declining white middle class birthrates. Siegel, *Reasoning from the Body*, *supra* note 12, at 283–87 (describing the doctor's professionalization campaign and fears over declining white middle-class birthrates that drove the movement to criminalize abortion in the 1860's).

274 *Roe*, 410 U.S. at 148–49 (footnote omitted).

275 *Id.* at 149.

which abortion "placed [a woman's] life in serious jeopardy," the safety of modern medical techniques for performing abortion made it is safe, and in fact safer than, rates for normal childbirth.[276] The changing medical technology of abortion was central to the Court's concluding that the relative safety of abortion means that the State's interest in protecting women from a harmful procedure had "largely disappeared."[277]

Many commentators have suggested that *Roe*'s prominent medical framing and trimester framework were influenced by Justice Blackmun's experience as in-house counsel for a hospital.[278] The opinion references the state's interests in protecting women's health "*in the light of present medical knowledge*," placing the point at the end of the first trimester based on "*the now-established medical fact*" that until the end of the first trimester abortion is safer with respect to maternal mortality than normal childbirth.[279] The safety of abortion relative to childbirth was central to the Court's conclusion that in the first trimester a physician may decide with his patient to terminate a pregnancy free of state interference.[280] The Court rejected the suggestion that "the woman's right is absolute," but rather, states may impose reasonable regulations in the first trimester to protect maternal health, including qualifications of those who will be performing abortions, licensure of doctors, and the licensing of facilities in which abortions are performed.[281]

The decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*[282] offers further support that changes in abortion technology should prompt revision of the abortion right's constitutional framework. In the case, the Court reaffirmed the central holding of *Roe* while discarding the trimester framework and lowering the standard of review from what was arguably strict scrutiny to the lower and more vague undue burden standard.[283] The *Casey* decision parses the constitutional core claim of the abortion right from its more ancillary framework. There the Court revised the framework—most notably *Roe*'s trimester framework—because "time has overtaken

---

276 *Id.*
277 *Id.*
278 *See, e.g.*, LINDA GREENHOUSE, BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN'S SUPREME COURT JOURNEY 72–74, 90–92 (2005) (discussing how Justice Blackmun's "ties to [the] Mayo [Clinic] and to the medical profession generally" likely influenced his views on abortion).
279 *Roe*, 410 U.S. at 163 (emphasis added).
280 *Id.* at 163.
281 *Id.* at 153, 163.
282 505 U.S. 833 (1992) (plurality opinion).
283 *Id.* at 833–834.

some of *Roe*'s factual assumptions: advances in maternal health care allow for abortions safe to the mother later in pregnancy than was true in 1973."[284] Critically, the *Casey* decision offers a roadmap to retain the core constitutional abortion right sourced in liberty, autonomy, and gesturing toward Equal Protection[285] while restructuring the framework vis-a-vis the medical model *because of updates in medical practice and technology*. In short, the Court parses the *Roe* decision between its central holding that individuals possess the right to decide whether to bear or beget a child free from compulsion by the state and merely restructures the framework through which to analyze the right, the contested framework of the medical gatekeeper.

The technology of abortion has been transformed in the years since the *Roe* and *Casey* Courts crafted the abortion right guided by then-current medical facts related to maternal mortality risks inherent in the surgical procedure. As described above, most first-trimester clinical abortions involve non-surgical medication abortion.[286] While mifepristone's REMS requires in-person dispensing at a healthcare facility, the REMS does not require that it be dispensed in-person in the physical presence of a doctor, and yet state laws in at least nineteen states have required in-person dispensing by a doctor which effectively prohibit abortion by telemedicine.[287] Justice Sotomayor's dissent in *FDA v. ACOG* homed in on this aspect of the disconnect between medication abortion and the imposition of onerous in-person dispensing requirements, describing that the Government has recognized that in-person healthcare during the pandemic poses a risk, and yet, "[w]omen must still go to a clinic in person to pick up their mifepristone prescriptions, even though physicians may provide all counseling virtually, women may ingest the drug unsupervised at home, and any complications will occur long after the patient has left the clinic."[288] She concludes by observing that "[t]his country's

---

284 *Id.* at 860.

285 *Id.* at 851–52; 856 (citing PETCHESKY, *supra* note 37, at 109, 133 n. 7).

286 *See supra* notes 175–185 and accompanying text; Adam Liptak, *Supreme Court Revives Abortion-Pill Restriction*, N.Y. TIMES (Jan. 12, 2021), https://www.nytimes.com/2021/01/12/us/supreme-court-abortion-pill.html [https://perma.cc/KA6Y-SG7H] (noting that about sixty percent of abortions performed in the first ten weeks use medication abortion rather than surgery).

287 *Medication Abortion*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/medication-abortion [https://perma.cc/Y7PF-8K2C] (last updated Aug. 1, 2021).

288 FDA v. ACOG, 141 S. Ct. 578, 580 (2021) (Sotomayor, J., dissenting). Justice Sotomayor also addressed this issue during her questioning at oral argu-

laws have long singled out abortions for more onerous treatment than other medical procedures that carry similar or greater risks."[289]

The medical gatekeeper is obsolete in the context of medication abortion and has been transformed from the *Roe* and *Casey* Courts' preoccupation with protecting pregnant people's health to an obstacle for accessing care, a political pawn decried by the frontline doctors in their open letter to lawmakers.[290]

There are many parallels between the current crisis in abortion care and the crisis in abortion care in the years leading up to *Roe.* In the pre-*Roe* period, criminal abortion laws lead pregnant people to seek abortion outside of the care of a doctor, and evidence of high maternal mortality rates from illegal abortion, unequal access to abortion for people who lacked resources, and doctors' fear of criminal prosecution resulted in widespread calls for repeal and reform of criminal abortion laws from organizations as varied as medical organizations, religious groups, lawmakers, and feminists.[291] High mortality and morbidity rates from illegal abortions lead religious clergy and feminist organizations such as the Clergy Consultation Service and the Jane Collective to set up underground counseling and referral services to safe abortion providers.[292] One such underground network, the Jane Collective, a referral ser-

---

ments in *Whole Woman's Health v. Hellerstedt*, noting that while a doctor could prescribe the medication to be taken at home, under the Texas law, even "when [a patient] could take it at home . . . now she has to travel 200 miles or pay for a hotel to get . . . two days of treatment." Transcript of Oral Argument at 20, Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (No. 15-274).

289 FDA v. ACOG, 141 S. Ct. at 585 (Sotomayor, J., dissenting) (citing Linda Greenhouse & Reva B. Siegel, Casey *and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 Yale L.J. 1428, 1430 (2016)).

290 *See Frontline Physicians Letter*, *supra* note 254 (describing that "[t]he insertion of politics between patients and their physicians . . . inhibits the delivery of safe, timely, and comprehensive care").

291 Evangelical Christians, including the Southern Baptist Convention, were in support of legalization of abortion. Indeed, the Southern Baptist Convention passed a resolution in the years before *Roe* calling on members to work for abortion's legalization and leaders praised the *Roe* decision. During this period, many religious leaders made pro-choice arguments on explicitly religious and moral grounds. R. MARIE GRIFFITH, MORAL COMBAT: HOW SEX DIVIDED AMERICAN CHRISTIANS & FRACTURED AMERICAN POLITICS 202 (2017); ROBERT WUTHNOW, RED STATE RELIGION: FAITH AND POLITICS IN AMERICA'S HEARTLAND 273 (2012) (noting that between 1966 and 1972 most of the denominations affiliated with the National Council of Churches adopted statement in support of abortion).

292 *See* PETCHESKY, *supra* note 37, at 128–29; GRIFFITH, *supra* note 291, at 203, 216–22, 238–39 (describing several religious organizations that worked tirelessly for legalization of abortion, most notably the Catholics for Free Choice and the Clergy Consultation Service that assisted women with procuring safe abortions in

vice for people seeking a safe illegal abortion, got its name because the individuals who used their referral service were told to tell the provider that "Jane" sent them.[293] The Jane Collective eventually trained women in the organization to provide abortion, providing 11,000 safe abortions in the years before *Roe*.[294] In 1971, feminist activists Lorraine Rothman developed the menstrual extraction machine designed for personal use as a way of accessing early-stage abortion without the help of a medical provider.[295]

Like in the pre-*Roe* era, underground organizations are springing up to get medication abortion into the hands of pregnant people outside of the channels of the medical establishment, people are being prosecuted for accessing self-managed abortion, and doctors' best practices for treating patients safely are being thwarted by outdated constraints handed down by courts and legislatures rather than by physicians themselves. In 2018, an international organization, Aid Access, began offering U.S. women access to medication abortion pills through the mail after an online consultation with a doctor.[296] The program is designed to reach people who are unable to access clinic-based abortion because of domestic violence or because they live in areas without an abortion provider, such as rural areas and states with few abortion providers.[297] The pregnant

---

the years before *Roe* by referring them to abortion providers before abortion's legalization).

293 *See* Nellie Gilles, Sarah Kramer & Joe Richman, *Before 'Roe v. Wade,' The Women of 'Jane' Provided Abortions For The Women Of Chicago*, NPR (Jan. 19, 2018), https://www.npr.org/2018/01/19/578620266/before-roe-v-wade-the-women-of-jane-provided-abortions-for-the-women-of-chicago [https://perma.cc/9Y7E-EGKG].

294 *Id.*; PETCHESKY, *supra* note 37, at 128.

295 *See* Coeytaux & Nichols, *supra* note 189; Elaine Woo, *Lorraine Rothman, 75; Feminist Clinic's Co-Founder Helped Demystify Gynecology*, L.A. TIMES (Oct. 3, 2007), https://www.latimes.com/archives/la-xpm-2007-oct-03-me-rothman3-story.html [https://perma.cc/5J8V-WV9Z]. *See generally Medicine: Unofficial Abortion*, TIME MAG. (Sept. 11, 1972), http://content.time.com/time/subscriber/article/0,33009,906342,00.html [https://perma.cc/Q4LN-KMGC] (describing the technique of menstrual extraction as a way of terminating a suspected pregnancy before it has been confirmed and "[t]herefore an abortion in fact is not an abortion officially").

296 Sarah McCammon, *European Doctor Who Prescribes Abortion Pills to U.S. Women Online Sues FDA*, NPR (Sept. 9, 2020), https://www.npr.org/2019/09/09/758871490/european-doctor-who-prescribes-abortion-pills-to-u-s-women-online-sues-fda?t=1638886119585 [https://perma.cc/J54B-LXLQ]; *Who Are We*, AIDACCESS, https://aidaccess.org/en/page/561 [https://perma.cc/AV57-LKMK] (last visited Dec. 7, 2021).

297 *FDA vs Aid Access*, AIDACCESS (Apr. 2019), https://aidaccess.org/en/page/200797/fda-vs-aid-access [https://perma.cc/3E49-AMEU] (last visited Dec. 7, 2021). On September 9, 2019, the organization and its leader, Dr. Re-

person consults online with a doctor and, if the medication abortion protocol is appropriate, the two-drug regimen is sent through the mail via an international pharmacy in India.[298] The organization has defied a warning letter issued by the FDA to Aid Access on March 8, 2019 that its actions violated the Food, Drug & Cosmetic Act.[299] An advocacy organization has established a legal helpline for people seeking information about self-managed abortion and legal advice for those facing possible criminal prosecution for managing their abortion or assisting others to self-managed abortion.[300] The organization Plan C researches and holds informational meetings about the ways that people are accessing medication pills online, has put out a report card that ranks the online pharmacies offering abortion pills online, and is laying the groundwork for over-the-counter access to abortion pills.[301] Currently, the group is recruiting doctors to offer medication abortion pills through the mail based on a broad interpretation of the REMS "dispensing" language for mifepristone.[302] And there is anecdotal evidence that collectives in hubs across the country are procuring and dispensing medication abortion to individuals seeking to self-

becca Gomperts, sued the FDA for seizing between two and ten doses of medication abortion pills that had been prescribed to U.S. women and for blocking payment by patients. The case is currently on appeal after the court sided with the FDA. *See* McCammon, *supra* note 296.

298 McCammon, *supra* note 296. During its first year in operation in 2018, the organization received of over 11,000 requests from people in the U.S. requesting medication abortion drugs, and the organization filled 2,500 of those requests. The following year Aid Access filled a third of the 21,000 requests from the U.S. Donley, *supra* note 184, at 30.

299 *Warning Letter to Aid Access*, FDA (Mar. 8, 2019), https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019 [https://perma.cc/TF54-AX66] (last updated Mar. 12, 2019); *Legal Complaint Against the FDA*, AID ACCESS, https://aidaccess.org/en/page/302089/legal-complaint-against-the-fda [https://perma.cc/2CJX-AVL8] (last visited Aug. 30, 2021).

300 REPRO LEGAL HELPLINE, http://www.reprolegalhelpline.org/ [https://perma.cc/22AM-6YMT] (last visited Aug. 30, 2021).

301 *See About Us*, PLAN C [hereinafter PLAN C], https://www.plancpills.org/about [https://perma.cc/A54X-3YD2] (last visited Aug. 30, 2021); *see also* Patrick Adams, *Spreading Plan C to End Pregnancy,* N.Y. TIMES (Apr. 27, 2017), https://www.nytimes.com/2017/04/27/opinion/spreading-plan-c-to-end-pregnancy.html [https://perma.cc/82NU-HFAB] (describing the campaign by Francine Coeytaux and others to increase awareness that pills can be used safely to terminate a pregnancy); Coeytaux & Nichols, *supra* note 189 (describing that in Bangladesh, "menstrual regulation" pills are widely available despite strict criminal abortion laws).

302 Patrick Adams, *Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill*, N.Y. TIMES (May 12, 2020), https://www.nytimes.com/2020/05/12/opinion/covid-abortion-pill.html [https://perma.cc/WXA3-44BL].

manage their abortions through an underground network.[303] Researchers, advocates, and activists have also sought to reframe the issue of self-managed abortion and to introduce the concept of "missed-period pills" or medication designed to "bring on 'delayed' menstruation," which creates an interstitial space in which a pregnancy has not been confirmed, but a menstrual cycle is delayed, in the same rhetorical sleight-of-hand that was used in the 1800's to openly advertise abortifacients in widely-circulated magazines at a time when abortion was illegal.[304] Finally, researchers have called for over-the-counter availability of abortion medication—what they have dubbed "Plan C"—in light of the safety and efficacy of the two-drug regimen for self-administration.[305] As in the years before *Roe*, restricted access to abortion has resulted in a groundswell of self-help networks designed to increase direct access to abortion outside of the clinical context.

The crisis in abortion care in the mid-1960's lead to liberalizing abortion laws at the state level in places like California and eventually lead to *Roe v. Wade*.[306] Commentators have

---

303 *See, e.g.*, Deb Gordon, *Harsh Legal Restrictions on Abortion Spur A Movement for DIY Care*, CTR. FOR HEALTH JOURNALISM (Sept. 29, 2021), https://centerforhealthjournalism.org/2021/09/22/harsh-legal-restrictions-abortion-spur-movement-diy-care [https://perma.cc/66WH-R6BH] (describing an underground effort to help women self-manage abortion in states with restrictive abortion laws); Nina Liss-Schultz, *Inside the Top-Secret Abortion Underground*, MOTHER JONES, https://www.motherjones.com/crime-justice/2018/02/inside-the-top-secret-abortion-underground/ [https://perma.cc/DC7W-RRDK] (last visited Dec. 15,2021) (describing a growing underground movement of people helping women terminate pregnancies without a doctor.). The nonprofit Women Help Women recently launched Self-Managed Abortion; Safe & Supported ("SASS") to provide information and train women to spread information about self-managed abortion. *See About SAAS, a Project of Women Help Women*, SASS: SELF-MANAGED ABORTION; SAFE & SUPPORTED, https://abortionpillinfo.org/en/about-sass [https://perma.cc/96WE-NNTM] (last visited Dec. 15, 2021).

304 *See* Patrick Adams, *Why Some Women Might Want 'Missed-Period Pills'*, N.Y. TIMES (Dec. 3, 2020)), https://www.nytimes.com/2020/12/03/opinion/pregnancy-missed-period-pills.html [https://perma.cc/NBD5-JGHE] ((describing the results of a recent study that found that of people surveyed, forty percent expressed interest in a missed period pill that would allow them to terminate a suspected pregnancy by restoring their menstrual cycle without ever confirming pregnancy); LUKER, *supra* note 30, at 18–19.

305 Coeytaux & Nichols, *supra* note 189 (noting that misoprostol is widely available in most countries to end pregnancies and calling for over-the-counter distribution which they dubbed "Plan C"); Adams, *supra* note 301 (describing the campaign by Francine Coeytaux and others to increase awareness of abortion pills).

306 *See* LUKER, *supra* note 30, at 66–76. The Beilenson bill, also known as the Therapeutic Abortion Act, was an abortion reform bill introduced in the California legislature by Anthony Beilenson. *See id.* at 70–72. On the eve of the *Roe* decision, sixteen states had already liberalized and reformed their abortion laws. *See id.* at 126–27.

documented that the Supreme Court's decision in *Roe* did not catalyze social change, but rather, the decision came in the wake of decades of opposing movements working through courts and state legislatures to advance their legal goals.[307] Abortion access has arguably reached such a point that the Supreme Court should be urged to revise its outdated abortion framework. In the meantime, as in the pre-*Roe* period, the work will have to be done at the state level. Unfortunately, like during the pre-*Roe* period, in states with restrictive abortion laws, abortion access will be readily available solely to those with means to travel and have private insurance to access it.

At least two courts have asserted the right of individuals to access abortion directly without a medical gatekeeper based on the undue burden analysis because of the lack of purported healthcare benefits associated with requiring that pregnant people be in a doctor's *physical* presence to end their pregnancies. The Ninth Circuit in *McCormack v. Herzog*[308] held that an Idaho provision that required that all second-trimester abortions be performed in a hospital violated the rights of women who wished to obtain pre-viability abortions from a physician prescribing FDA-approved medication abortions.[309] Jeanne McCormack chose to end her pregnancy using misoprostol that she obtained online because there were no licensed abortion providers in southeastern Idaho where she lived, and the nearest abortion clinic in Salt Lake City would cost between four hundred and two thousand dollars.[310] She obtained the pills online for two hundred dollars and successfully ended her pregnancy at home.[311] Similarly, the Iowa Supreme Court in *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine* struck down a regulation banning the use of telemedicine for medication abortion.[312] The case involved a program set up by Planned Parenthood in Iowa in

---

307 *See, e.g.* Greenhouse & Siegel, *supra* note 62, at 272 (challenging the claim that backlash to the *Roe* decision catalyzed opposition to abortion and noting that at the time of the decision a majority of Americans supported reforming criminal abortion laws); ZIEGLER, *supra* note 55, at 6–9 (describing the landscape of feminist, environmental, Catholic, and pro-life organizations efforts to advance their goals); *see also* GERALD N. ROSENBERG, THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE? 182–85 (2d ed. 2008) (describing that the tide of legislation and public opinion had already turned in favor of the abortion right at the time of the Court's decision).

308 788 F. 3d 1017, 1018 (2015).

309 *Id.* at 1030–33.

310 *Id.* at 1022 n.3.

311 *Id.* at 1022.

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

2008 that used videoconferencing to provide abortion medications to more than 6,500 pregnant people in rural clinics.[313] In 2010, the Iowa Medical Board conducted a study of the program and found that the telemedicine program was safe and met the prevailing standard of care.[314] Despite these findings, the Iowa Right to Life organization put pressure on Governor Terry Brandstad, who then replaced the board. The new board voted to halt telemedicine for abortions in Iowa.[315] The court struck down the regulation banning the use of telemedicine, arguing that the imposition posed an undue burden on access to abortion without sufficient evidence that it protected pregnant people's health.

Critically, these cases relied on an undue burden analysis which necessarily required that the restriction did not have the purpose or effect of placing a substantial obstacle in the path of a person seeking an abortion. The undue burden standard has resulted in endless litigation and as states attempt to test the limits of the vague standard, testing the outer limits of waiting periods, driving distances, and informed consent scripts, to name only a few. Indeed, the undue burden analysis has so significantly narrowed the courts' inquiry in cases that challenge abortion restrictions that the nature of the right at stake—the right of bodily autonomy, of an individual to seek out medical care, and to make healthcare decisions—has languished. Replacing the medical gatekeeper model with a right to directly access and self-manage abortion will dispense with the undue burden analysis, which will no longer define the depth and breadth of the abortion right.

The undue burden analysis that supports and enables the medical gatekeeper has limited the depth and breadth of the constitutional analysis of the abortion right. As Professor Cait-

---

313 *See* Eric Wicklund, *Abortion-by-Telemedicine Pilot Launches in 4 States*, MHEALTH INTELLIGENCE (Apr. 1, 2016), https://mhealthintelligence.com/news/abortion-by-telemedicine-pilot-launches-in-4-states [https://perma.cc/P8F3-VWP7]; Bazelon, *supra* note 180; *see also* Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 CONTRACEPTION 173, 174 (2019) (discussing the TelAbortion model, which allows abortion providers to communicate via video with patients).

314 Daniel Grossman, Kate Grindlay, Todd Buchacker, Kathleen Lane, & Kelley Blanchard, *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 OBSTETRICS & GYNECOLOGY 296, 302–03 (2011) (hereinafter Grossman, *Telemedicine*) (finding that abortion via telemedicine was safe and effective with comparable clinical outcomes to face-to-face provision of medication abortion and a very high patient satisfaction rate); Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Through Telemedicine Compared with In Person*, 130 OBSTETRICS & GYNECOLOGY 778, 781 (2017).

315 Bazelon, *supra* note 180.

lin Borgman has described, attempts to challenge abortion restrictions on other constitutional bases, such as bodily integrity, equal protection, and the right against compelled speech, are routinely subsumed by the undue burden analysis.[316] In *Planned Parenthood Southeastern Ohio Region v. DeWine,*[317] the Sixth Circuit downgraded the plaintiff's bodily integrity claims, which normally would have been subject to strict scrutiny standard, using the lower undue burden analysis.[318] The suit was a challenge to an Ohio law that required doctors to adhere to labeling requirements for mifepristone when dispensing medication for abortion. The challengers wanted to dispense lower dosages of mifepristone "off-label" in accordance with significant research that lower doses of mifepristone in the two-drug medication abortion regimen were equally effective and less expensive to administer.[319] Critically, the court, while addressing the bodily intrusion claim, recognized that "individuals possess a constitutional right to be free from forcible physical intrusions of their bodies against their will, absent a compelling state interest."[320] The court also found that the strict scrutiny standard does not apply when bodily intrusion involves abortion which must be analyzed using the lower undue burden standard.[321]

Recognizing a right to directly access abortion would uncover the range of constitutional rights at stake in abortion restrictions currently masked behind the undue burden analysis. These include the right of bodily integrity, equal protection, and freedom from compelled speech.[322] The right to directly access abortion without the forced intervention of a doctor falls within the right of pregnant people's decisional autonomy to make choices about the care they will receive. Restrictions on access to medication abortion for self-managed care are more than regulations about how abortion-related healthcare is delivered; rather, decisions over medical care are at the heart of decisional autonomy. As Justice Blackmun described in his concurring opinion in *Planned Parenthood of*

316 *See* Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1055–56 (2014) (describing that challenges to abortion restrictions based on claims of bodily autonomy, equal protection, and the right against compelled speech, are subsumed or displaced by the undue burden analysis).

317 696 F.3d 490 (6th Cir. 2012).

318 Borgmann, *supra* note 316, at 1056–57.

319 *Id.* at 1057 (citing *DeWine*, 696 F.3d at 495).

320 *Id.* at 1057–58 (quoting *DeWine*, 696 F.3d at 506).

321 *Id.*

322 *See id.* at 1055–56.

Southeastern Pennsylvania v. Casey,[323] the Due Process Clause must include protection of an individual's decision to both obtain and refuse medical treatment, including the abortion decision.[324] Similarly, Justice Douglas' view that abortion was a right of health that included the right to seek medical care could form a foundation for recognizing a right of direct access to abortion.[325] The compelled intervention of a doctor in abortion infringes on the liberty and autonomy of reproductive decision-making that is at the core of the Fourteenth Amendment.[326]

Significant evidence reveals that large numbers of individuals are safely and effectively terminating their pregnancies outside of the care of a medical provider using pills procured online. The *Roe* Court looked to current medical practice of the early 1970's and with a keen consideration of health risks to establish the gatekeeper model. The *Casey* Court revised the abortion right's framework based on medical advances that left *Roe*'s trimester framework "unworkable." The time has come once again for the abortion right to be revised in light of current medical technology to recalibrate the state's interest in imposing a medical gatekeeper nominally designed to protect maternal health. While in the *Roe* period, abortions were surgical and arguably required a doctor to protect patient's health, there is extensive research and compelling empirical evidence that neither doctors nor facilities fulfill the function integral to the *Roe* Court's description of the abortion right. The fallacy of the medical gatekeeper has been brought into sharp relief during the global COVID-19 pandemic. The next section considers ways to enhance access to medication abortion at the state and federal levels.

C. Enhancing Direct Access at the State and Federal Levels

With the conservative shift in the Supreme Court, increasing access to medication abortion will have to take place at the federal level through legislation like the Women's Health Pro-

---

323 505 U.S. 833 (1992) (plurality opinion).

324 *Id.* at 927 n.3 (Blackmun, J., concurring).

325 *See* Roe v. Wade, 410 U.S. 113, 219–20 (1973) (Douglas, J., concurring).

326 *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) (stating that, "our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education . . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.").

tection Act and by changing FDA labeling to remove the in-person dispensing requirement for mifepristone with the ultimate goal of medication abortion available over-the-counter, what advocates have dubbed "Plan C."[327] At the state-level, increasing access to medication abortion will be propelled by making the pills more readily available and expanding the types of providers who can dispense the two-drug regimen.

The Women's Health Protection Act is a federal bill introduced in 2019 that would protect abortion access by prohibiting state and local governments from imposing medically unnecessary restrictions.[328] The Act creates a statutory right for health care providers to deliver abortion care and the right of their patients to receive care free from medically unnecessary restrictions, including medically inaccurate informed consent "scripts," medically-unnecessary in-person visits, waiting periods, forced ultrasounds and other unnecessary tests, restrictions on prescribing medication abortion in early pregnancy, and pre-viability bans that are unconstitutional. The bill currently has 217 co-sponsors in the House and forty-three in the Senate.

Expanding access to mifepristone, the second drug in the two-drug medication abortion regimen, to allow its provision through the mail, through pharmacies, and ultimately, over the counter, would go a long way toward loosening the hold of the medical gatekeeper model on abortion access. Currently, the FDA labeling of mifepristone requires that it be dispensed by a certified provider at a healthcare facility which necessarily prohibits its distribution through the mail, via telemedicine, and through pharmacies. The Biden Administration has suspended the mifepristone REMS in-person dispensing requirement during the COVID-19 pandemic thereby allowing distribution through the mail and pharmacies during the pandemic.[329] The selection of a new FDA commissioner could permanently release mifepristone's in-person REMS and allow distribution through the mail and by pharmacies even after the

---

327 *See* PLAN C, *supra* note 301; Adams, *supra* note 301 (describing the campaign by Francine Coeytaux and others to increase awareness of abortion pills); Coeytaux & Nichols, *supra* note 189.

328 *See* Women's Health Protection Act of 2019, S. 1645, 116th Cong. (2019).

329 Belluck, *supra* note 195 (describing that the Biden administration has suspended the in-person dispensing requirement for mifepristone during the COVID-19 pandemic); Woodcock Letter, *supra* note 6 (stating that the agency would temporarily stop enforcement of the in-person dispensing requirement for the first drug, mifepristone, in the two-drug medication abortion regimen. during the COVID-19 pandemic).

pandemic has ended.[330] In early February, the House Committee on Oversight and Reform submitted a letter calling on the FDA to lift the in-person requirement for medication abortion.[331] Changing the labeling of mifepristone will greatly enhance access to medication abortion both inside and outside of the doctor-patient relationship.[332] Despite its proven safety and efficacy, mifepristone is subject to a special designation by the FDA as needing a REMS, which requires that the drug only be provided to a patient by a certified provider at a healthcare facility.[333] The REMS designation thereby not only makes it very difficult to administer mifepristone—and with it, the two-drug medication abortion regimen—via telemedicine, but also prohibits the drug from being obtained by retail or mail-order pharmacies. The certified provider requirement and implicit bans on the use of telemedicine for abortion have become a critical issue during the pandemic because it prohibits safe at-home medication abortion under a doctor's supervision and requires that patients and providers alike risk their health by coming in-person to a clinic. As a result, lawmakers, health-

---

330 *See* Rachel Rebouché, *The Supreme Court Doesn't Hold All the Power When It Comes to Abortion Rights. Here Are 2 Things the Biden Administration Can Do to Extend Access*, TIME MAG. (Dec. 22, 2020), https://time.com/5922555/medication-abortion-joe-biden/ [https://perma.cc/77F3-GPG9]; Carrie N. Baker, *SCOTUS Blocks Access to Abortion Pill by Mail During Pandemic. Advocates Look to Biden Administration to Reverse Trump Policy*, MS. MAG. (Jan. 13, 2021), https://msmagazine.com/2021/01/13/supreme-court-abortion-pill-trump-biden/ [https://perma.cc/8MQE-PLWM]; *see also* Phillip A. Sharp, Ellen V. Sigal & Sherry Lansing, *The Right Leader for the FDA in a Time of Crisis*, L.A. TIMES (Feb. 4, 2021), https://www.latimes.com/opinion/story/2021-02-04/food-drug-administration-janet-woodcock-biden?_amp=true [https://perma.cc/HY5Z-YYAA] (arguing that much is at stake with a selection of an FDA leader).

331 Letter from Carolyn B. Maloney et al., Comm. on Oversight and Reform, to Dr. Janet Woodcock, Acting Comm'r, FDA (Feb. 9, 2021), https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2021-02-09.CBM%20Pressley%20et%20al.%2C%20to%20Woodcock-FDA%20re%20Mifepristone%20REMS.pdf [https://perma.cc/HP23-KQKT]; *see also* Jessie Hellmann, *Democrats Urge Biden FDA to Drop In-Person Rule for Abortion Pill*, THE HILL (Feb. 9, 2021), https://thehill.com/policy/healthcare/538013-dems-urge-biden-fda-to-drop-in-person-rule-for-abortion-pill [https://perma.cc/AE75-D9EY] (stating that House Democrats pressed the FDA to lift the restriction on mifepristone).

332 In 2018, Canada got rid of the mifepristone restrictions that required in-person distribution by a physician and instead now regulates it similarly to other prescription drugs. *See* Melissa Grant, *The Case for Making the Abortion Pill More Accessible*, REWIRE NEWS GRP. (Nov. 17, 2017), https://rewirenewsgroup.com/article/2017/11/17/case-making-abortion-pill-accessible/ [https://perma.cc/8448-M5AG].

333 The REMS designation requires that a patient be handed the mifepristone at a clinic, medical office, or hospital under the supervision of a healthcare provider and that the healthcare provider must be registered with the drug manufacturer. *See Mifeprex Information*, *supra* note 175.

care researchers, abortion providers, and advocates have called on the FDA to change the REMS requirement for mifepristone.

The ACOG has also called upon the FDA to remove the REMS for mifepristone, arguing that the mifepristone REMS are "outdated and substantially limit access to . . . safe, effective medication."[334] The American Medical Association and the American Academy of Family Physicians have also called upon the FDA to remove the REMS for mifepristone.[335] As these physician organizations point out, mifepristone has been singled out in being subjected to the burdensome REMS designation when it is four times safer than Viagra and fourteen times safer than childbirth.[336] Indeed, the FDA itself has acknowledged that the "safety profile of Mifepristone is well-characterized and its risks well-understood after more than 15 years of marketing. Serious adverse events are rare and the safety profile of Mifepristone has not substantially changed."[337] Dr. Daniel Grossman, a researcher, and professor of gynecology at the University of California, San Francisco, tweeted that, "[d]uring the pandemic, it would be possible to provide medication abortion through 11 weeks of pregnancy without an in-person visit [and] by mailing pills to a patient."[338] Medication abortion with pills provided by mail would reduce the risk of transmission to both patients and providers and could be accomplished without the need for personal protective equip-

---

334 *Position Statement: Improving Access to Mifepristone for Reproductive Health Indications*, ACOG, https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/improving-access-to-mifepristone-for-reproductive-health-indications [https://perma.cc/AH2Q-ASYD] (last visited Dec. 10, 2021).

335 Letter From Michael L. Munger, Bd. Chair, Am. Acad. Fam. Physicians, to Norman Sharpless, Acting Comm'r, FDA (June 20, 2019), https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-FDA-MifepristoneREMS-062019.pdf [https://perma.cc/HCH2-PVL8] (noting that "the current drug label creates an unnecessary health care barrier for women who need it the most"); *Mifepristone*, AMA: POLICY FINDER (2018), https://policysearch.ama-assn.org/policyfinder/detail/mifepristone?uri=%2FAMADoc%2FHOD.xml-H-100.948.xml [https://perma.cc/G42X-9CLK].

336 Letter from Xavier Becerra, Cal. Att'y Gen., et al., to Alex M. Azar II, Sec'y, U.S. Dep't of Health & Human Servs., & Stephen Hahn, Comm'r, FDA 3 (Mar. 30, 2020), https://www.oag.ca.gov/system/files/attachments/press-docs/AG%20Letter%20HHS%20Medication%20Abortion%202020.pdf [https://perma.cc/Z6NM-SLVU].

337 *Id.* at 3.

338 Dr. Daniel Grossman (@DrDGrossman), TWITTER (Mar. 25, 2020, 10:00 AM), https://twitter.com/DrDGrossman/status/1242813666157871105 [https://perma.cc/TV9C-PSMK].

ment, the alleged rationale behind designating abortion as a non-essential surgery during the pandemic.[339]

The global COVID-19 pandemic has thus brought the issue of the medical gatekeeper into sharp relief. During the pandemic, the risk of seeking abortion in a medical facility was greater than in receiving medication abortion through the mail or at a pharmacy.[340] This was particularly true since many states' onerous waiting periods require patients to stay overnight near an abortion facility, thereby increasing the risk of exposure to COVID-19. In July, a federal district court in Maryland issued an injunction in *ACOG v. FDA*,[341] a case brought by medical providers and organizations against the FDA challenging enforcement of the FDA requirement of in-person mifepristone dispensing during the COVID-19 pandemic. Later in January, the Supreme Court stayed the injunction and thus reinstated the in-person dispensing requirement.[342] The injunction permitted providers to mail medication abortion pills to their patients. In the wake of the injunction, a handful of new start-ups began offering abortion care via telemedicine.[343] The new virtual clinics screened patients and then mailed the

---

339 In a letter to Health and Human Services Secretary Alex Azar, a coalition of anti-abortion organizations urged federal health officials to both designate abortion services as non-essential and "cease operations" and to donate masks, gloves, and hospital gown to the corona virus response *and* to prohibit the expansion of medication abortion via telemedicine. *See* Sarah McCammon, *Anti-Abortion Rights Groups Ask HHS to Urge End to Abortion During Pandemic,* NPR (Mar. 24, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/03/24/820730777/anti-abortion-rights-groups-ask-hhs-to-urge-end-to-abortion-during-pandemic [https://perma.cc/F6UQ-F8TQ]; *see also* Sarah McCammon, *Federal Appeals Court OKs Arkansas' Abortion Ban During Coronavirus Pandemic,* NPR (Apr. 22, 2020), https://news.wgcu.org/2020-04-22/federal-appeals-court-oks-arkansas-abortion-ban-during-coronavirus-pandemic [https://perma.cc/LP56-EKLQ] (noting that politicians sought to suspend abortions in some states and that abortion opponents sought to designate abortions as nonessential, which would lead to the preservation of medical supplies such as surgical masks and hospital gowns).

340 *See* Rebouché *supra* note 4, at 5–7. Justice Sotomayor's dissent in *FDA v. ACOG* noted that the dangers of exposure to the virus while seeking abortions fell disproportionately on people living in poverty and people of color and because they often live in multi-generational households, the risk of exposure is not only to patients but to their families as well. FDA v. ACOG, 141 S. Ct. 578, 582 (2021) (Sotomayor, J., dissenting).

341 ACOG v. FDA, 472 F. Supp. 3d 183, 233 (D. Md. 2020).

342 FDA v. ACOG, 141 S. Ct. 578, 578–79 (2021); Liptak, *supra* note 286.

343 *See* Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.,* MS. MAG. (Nov. 16, 2020), https://msmagazine.com/2020/11/16/just-the-pill-choix-carafem-honeybee-health-how-telemedicine-startups-are-revolutionizing-abortion-health-care-in-the-u-s/?fbclid=IWAR2w5M-t2IUq_hLCVSFb-1nl5NOtZYGiGCIqJWNvUf0jLFXIWUqcVMKcOyk [https://perma.cc/WQ6A-X964].

medication abortion pills to their homes, often using online pharmacies.[344] Medication abortions are significantly less expensive than clinic-based abortions, costing in some cases $199 compared to $500 for an in-clinic medication abortion.[345] The brief window of time between the federal injunction and the Supreme Court's decision to repeal the injunction in January gave a glimpse of how medication abortion access would rapidly expand if the in-person dispensing requirement was removed from mifepristone.

There is a push to expand access to medication abortion pills in those states that are protective of abortion rights. Recently, the state of California became the first in the nation to require that all public colleges provide medication abortion on all of its campuses.[346] A recently filed lawsuit is challenging a Maine law that prohibits advanced practice registered nurses (APRNs) from providing medication abortion.[347] The suit relies on extensive research that proves the safety of APRNs providing early abortion care.[348] APRNs are already providing abortion care in California, Montana, Illinois, and New Hampshire. APRNs are less expensive than seeking care from a physician and are often already serving underserved populations that cannot afford to seek care from a private physician. This is a step toward breaking down the medical gatekeeper model and expanding direct access to abortion. Loosening the gatekeeper restrictions from FDA labeling to expanding providers who can administer medication abortion at the state level is critical for enhancing access in what may one day be a post-*Roe* legal environment. The permeability of state borders means that medication abortion easily accessible through online pharma-

---

344 *See id.*

345 *See id.* (noting that many of the telemedicine startups employ a feminist model of sliding scale fee of between $0 and $350 depending on what the pregnant person can afford).

346 Associated Press, *California Will Require Public Colleges to Stock Abortion Medication*, NBC NEWS (Oct. 11, 2019), https://www.nbcnews.com/news/us-news/california-will-require-public-colleges-stock-abortion-medication-n1065321 [https://perma.cc/M8RQ-W9NY].

347 Complaint at 2–4, Jenkins v. Almy, No. 2:17-cv-366-NT (D. Me. Sept. 20, 2017); *see* Julia Kaye, *ACLU and Planned Parenthood Take on Unconstitutional Abortion Restrictions in Maine*, ACLU (Sept. 20, 2017), https://www.aclu.org/blog/reproductive-freedom/abortion/aclu-and-planned-parenthood-take-unconstitutional-abortion [https://perma.cc/EAC2-V268].

348 A recent study published in the *American Journal of Public Health* found that APRNs can safely and effectively provide abortion care in early pregnancy. Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Waiver*, 103 AM. J. PUB. HEALTH 454, 458–59 (2013).

cies in one state can more easily flow across state lines to reach those in need living in states with potentially complete abortion bans. The next section examines the harm of leaving the medical gatekeeper framework intact in an era of self-managed care: rising prosecutions of people suspected of terminating their pregnancies.

D. Challenging the Criminalization of Self-Managed Abortion Under the Gatekeeper Model

Stripping the medical gatekeeper framing from the abortion right will also meet important public health and reproductive and criminal justice goals. As described earlier, access to clinic-based abortion care is disproportionately denied to vulnerable and marginalized communities, including people living in poverty who are disproportionately of color, people with compromised immigration status, and people living in rural areas. Pregnant people who cannot access clinic-based care due to cost, waiting periods, distance, and immigration surveillance are pushed to self-managed care because medication abortion significantly lowers the cost and difficulty of accessing abortion in a landscape in which abortion opponents have targeted the provider-patient relationship to restrict abortion access.[349] While self-managed care offers an opportunity to increase access to abortion, the transformative potential of self-managed care is disproportionately denied to those whose reproduction is surveilled, restricted, and criminalized by the state. These communities are more likely to have their pregnancies subject to surveillance as the result of receiving public assistance, being supervised by parole officers, and under the care of public health systems.[350] Thus, individuals who rely on public health and low-cost clinics and who do not have access to private physicians may choose to self-manage their abortion to avoid

---

349 Journalist Linda Greenhouse summed it up: "if you think about it, it's evident why opponents of abortion have begun to focus on the early nonsurgical procedure. Medical abortion is the ultimate in women's reproductive empowerment and personal privacy." Greenhouse, *supra* note 175.

350 *See* Patel Amicus Brief, *supra* note 212, at 22–28; *see also* KHIARA M. BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 66 (2011) (expressing that a woman in need exchanges government assistance for the surveillance of her body). *See generally* DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 8–12 (2002) (discussing the impact of state surveillance on communities of color); Dorothy Roberts & Jeffrey Vagle, *Racial Surveillance Has A Long History*, THE HILL (Jan. 4, 2016), https://thehill.com/opinion/op-ed/264710-racial-surveillance-has-a-long-history [https://perma.cc/XH65-WCX8] (noting that the wide-ranging system of welfare surveillance of communities of color strips recipients of their dignity and privacy).

surveillance and the gauntlet of aggressive harassment and public shaming at abortion facilities in many cities.[351]

Prosecutors have relied on a myriad of criminal statutes, from pre-*Roe* criminal abortion statutes designed to protect pregnant people from third parties performing abortions, to child endangerment, and child abuse and neglect laws.[352] To date, there have been at least twenty-one arrests of people who have ended their pregnancies or assisted another person in doing so.[353] The range of laws that can be brought to bear to prosecute an individual for self-managing an abortion include pre-*Roe* era laws that criminalize self-induced abortion,[354] fetal harm laws,[355] laws regarding the disposal of fetal remains and concealing a birth,[356] and pre-*Roe* criminal abortion laws that were never repealed and have languished in the criminal code to be revived by prosecutors seeking to punish pregnant people

---

351 *See* DAVID S. COHEN & KRYSTEN CANNON, LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM 58–60 (2015). For descriptions by the Supreme Court of aggressive tactics used by anti-abortion protesters at clinics, see for example, Hill v. Colorado, 530 U.S. 703, 709–10 (2000) (describing that demonstrations in front of abortion clinics, "impeded access to those clinics and were often confrontational . . . . [including] counselors who sometimes used strong and abusive language in face-to-face encounters"); Madsen v. Women's Health Center, Inc., 512 U.S. 753, 776 (1994) (upholding thirty-six-foot buffer zone around clinic entrances and driveways); Schenck v. Pro-Choice Network of W. N.Y., 519 U.S. 357, 361 (1997) (invalidating the use of "floating buffer zones"); McCullen v. Coakley, 573 U.S. 464, 472 (2014) (describing protesters "who express their moral or religious opposition to abortion through signs and chants or, in some cases, more aggressive methods such as face-to-face confrontation"); *see also* Brief of Planned Parenthood League of Massachusetts & Planned Parenthood Federation of America as Amicus Curiae in Support of Respondents at 1, 7–8, McCullen v. Coakley, 573 U.S. 464 (2014) (no. 12–1168) (describing "thirty years of violent protests and patient harassment" at abortion clinics including the murder of two clinic employees).

352 *See* Farah Diaz-Tello, *Roe Remains for Now . . .Will it be Enough?*, 45 HUM. RTS. 14, 15 (2020) (noting that "[p]erversely, while abortion has become safer than ever medically, it has become riskier legally in the United States"); *see also* Patel Amicus Brief, *supra* note 212, at 7 (stating that self-induction abortions may be the only accessible ones where legal restrictions and political barriers make clinic-based ones unattainable). For example, Purvi Patel was reported to authorities by a physician in the emergency room after she told hospital staff that she had miscarried. She was charged with feticide and neglect of a dependent. She was convicted of both crimes and sentenced to twenty years in prison. Her conviction was later overturned. Patel v. State, 60 N.E.3d 1041, 1062 (Ind. Ct. App. 2016).

353 Diaz-Tello, *supra* note 352; *see also* THE SIA LEGAL TEAM, ROE'S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL 6, 20 (2018) (noting that a threat of arrest may make an abortion experience traumatic).

354 Only seven states have these laws, which prohibit actions described as "'self-abortion' to 'soliciting,' or 'submitting to' a criminal abortion." THE SIA LEGAL TEAM, *supra* note 353, at 5, 8–12.

355 *Id.* at 13.

356 *Id.* at 19. Critically, these laws were intended to protect, not prosecute, pregnant people who are victims of violence when pregnant. *Id.* at 5.

for self-inducing abortion.[357] Thirty-eight states now allow a pregnant person to be prosecuted for the unlawful death of a fetus, and not all of them exempt the pregnant person themselves from prosecution.[358] These types of laws rely on medical professionals reporting suspected cases of pregnant people having self-induced an abortion.[359] This type of criminal enforcement also raises the possibility of individuals being prosecuted for poor pregnancy outcomes.[360]

While technology has given rise to a new model in which individuals can exercise bodily autonomy outside of a relationship to a medical gatekeeper, prosecutors have responded by seeking to restrict access to self-managed healthcare through criminal prosecution.[361] A public health harm-reduction model as well as reproductive justice call for replacing the gatekeeper model of the abortion right because the reproductive lives of marginalized individuals and communities are disproportionately subjected to both surveillance and criminal prosecution.[362] What is more, in the midst of a global pandemic,

---

357 *See id.* at 17–18.

358 Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL'Y REV. 70, 71 (2015).

359 *See id.* at 73. For example, Purvi Patel was reported to authorities by a physician in the emergency room after she told hospital staff that she had miscarried. *See* Patel v. State, 60 N.E.3d 1041, 1046 (Ind. Ct. App. 2016).

360 *See* State v. Wade, 232 S.W.3d 663, 666 (Mo. 2007) (describing that the logic of allowing such prosecutions "would be extended to cases involving smoking, alcohol ingestion, the failure to wear seatbelts, and any other conduct that might cause harm to a mother's unborn child"); Reinesto v. Superior Ct., 894 P.2d 733, 736–37 (Ariz. Ct. App. 1995) (citing factors that may impact health at birth, including poor nutrition, vitamin and iron deficiencies, poor prenatal care, insufficient or excessive weight gain, and ingesting caffeine); Patel Amicus Brief, *supra* note 212, at 22. In El Salvador, where abortion is completely banned, an estimated 129 women were charged with self-inducing abortion between 2000 and 2011 and at least twenty-six were convicted and given decades-long sentences. *See,* MICHELLE OBERMAN, HER BODY, OUR LAWS: ON THE FRONT LINES OF THE ABORTION WAR, FROM EL SALVADOR TO OKLAHOMA 49–50 (2018); AMNESTY INT'L, ON THE BRINK OF DEATH: VIOLENCE AGAINST WOMEN AND THE ABORTION BAN IN EL SALVADOR 9, 35–36 (2014), http://www.amnestyusa.org/sites/default/files/on_the_brink_of_death.pdf [https://perma.cc/4BSE-3DZM]. For example, in 2010, a pregnant woman suffered a miscarriage after falling down the stairs. She was arrested after she was reported to law enforcement by hospital workers. She was released when it was determined that she was not far enough along to charge her under Iowa's fetal homicide law. *See* Amie Newman, *Pregnant? Don't Fall Down the Stairs,* REWIRE NEWS GRP. (Feb. 15, 2010), https://rewirenewsgroup.com/article/2010/02/15/pregnant-dont-fall-down-stairs/ [https://perma.cc/SJ4M-6SCT].

361 Ironically, as medication abortion has become safer it has also become increasingly criminalized.

362 *See* Patel Amicus Brief, *supra* note 212, at 27–28; *see also* BRIDGES, *supra* note 350, at 66 (expressing that a woman in need exchanges government assistance for the surveillance of her body; ROBERTS, *supra* note 350 (discussing the impact of state surveillance on communities of color); Roberts & Vagle, *supra* note

accessing medical care in person is dangerous and, in the case of medication abortion, is unnecessary. Thus, while individuals may be exercising greater autonomy in accessing care necessary for core constitutional rights of autonomy and privacy outside of regulation by the state, in response, states have begun to criminally prosecute people suspected of terminating their pregnancies outside of clinical supervision.[363]

CONCLUSION

Abortion rates remain constant regardless of its legality, with abortion rates in the decades before *Roe* largely the same as in the decades after *Roe*.[364] There has been a sea-change, however, with the development of medication abortion. When *Roe* was decided, surgical abortion meant that an illegal abortion was potentially lethal; now, a pregnancy can be safely and effectively terminated without the assistance of a medical provider with medication abortion pills procured online. Unlike in the pre-*Roe* period when pregnant people were dependent on finding a doctor willing to perform a surgical abortion or had to face the risks of a back-alley abortion, medication abortion allows people to safely terminate a pregnancy outside of the doctor-patient relationship. The symbolic coat hanger has been replaced by a two-drug regimen.[365] At this historic moment, the medical gatekeeper model must be replaced by a direct access model that comports with modern abortion practice and is best able to protect access in the uncertain times ahead. Both the *Roe* and *Casey* opinions crafted their frameworks guided by the then-current medical technology of abortion. In light of current medical technology and evidence of significant direct access to online medication for self-managed abortion, the time has come to once again revise the con-

---

350 (noting that the wide-ranging system of welfare surveillance of communities of color strips recipients of their dignity and privacy).

363 *See, e.g.*, Shuai v. State, 966 N.E.2d 619, 622–23 (Ind. Ct. App. 2012) (noting prosecution for murder and attempted feticide after attempting suicide while pregnant); State v. Buckhalter, 119 So. 3d 1015, 1017 (Miss. 2013) (prosecuting for manslaughter for ingesting illegal drugs while pregnant); Gibbs v. State, 2010-IA-00819-SCT, Order No. 172566, at *4–5 (Miss. Oct. 27, 2011) (prosecuting for murder for ingesting cocaine while pregnant); State v. Aiwohi, 123 P.3d 1210, 1211–12 (Haw. 2005) (prosecuting for manslaughter for using crystal meth while breastfeeding and pregnant); Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 321 (2013) (documenting that women who either experience miscarriage, stillbirth, or infant death were charged with homicide in forty-eight cases).

364 LUKER, *supra* note 30, at 19–20.

365 *See* Sietstra, *supra* note 269.

stitutional framework of the abortion right to replace the outdated gatekeeper model with a direct-access framework. A constitutional right of abortion that is not dependent upon the role of doctors will allow pregnant people to directly access abortion-related healthcare without compelled doctor involvement. This will lower cost and increase access to those who are most vulnerable and marginalized. This is in line with current trends in consumer-patient-directed care more generally. Self-managed abortion reveals that the medical gatekeeper framing is obsolete, and the undue burden standard that was designed to maintain it is no longer relevant to the way abortion is delivered.