2023

Abortion Pills

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DRAFT 2/1/23 - Please cite to 76 STAN. L. REV. __ (forthcoming 2024)
IF QUOTING, PLEASE INDICATE THIS IS A DRAFT

ABORTION PILLS

David S. Cohen, Greer Donley, & Rachel Rebouché

76 STANFORD LAW REVIEW (forthcoming 2024)

*Abortion is now illegal in roughly a third of the country, but abortion pills are more widely available than ever before. Though antiabortion advocates and legislators are attacking pills with all manner of strategies, clinics, websites, and informal networks are openly facilitating the distribution of abortion pills, legally and illegally, across the United States. This Article is the first to explain this defining aspect of the post-*Roe *environment and the novel issues it raises at the level of state law, federal policy, and on-the-ground advocacy.*

This Article first details antiabortion strategies to stop pills by any means necessary. These tactics include a federal lawsuit to remove abortion pills from the market, a revival of the long-unenforced Comstock Act's ban on mailing abortifacients, a redefinition of abortion's location to chill abortion travel, information and supply chain bans, and attempts to criminalize people who take abortion pills. We then consider the opposing movement to increase access to abortion pills: abortion shield laws that protect cross-border telehealth, pharmacist prescription of abortion pills, and efforts to evade abortion bans through missed period pills and advanced provision. Finally, we examine how the US Food and Drug Administration (FDA) can use its powers to increase or decrease access to pills, including lifting the unique restrictions on medication abortion and changing its label or asserting that FDA rules governing medication abortion partially preempt state abortion bans.

The Article concludes by offering the first analysis of how, after Roe*'s reversal, abortion pills and their attendant controversies will transform the abortion debate in this country. With pills, abortion will no longer be controlled by state governments and the medical establishment; rather, informal and underground networks will meet much of the demand for abortion pills, cutting out gatekeepers. Pills' wide availability will also reshape the definition of abortion, which is ill suited for the ambiguities of drug provision, and destigmatize abortion care. At the same time, however, attempts to criminalize people who provide or use pills will exacerbate the public health and criminal justice consequences that new abortion bans have wrought, entrenching existing class and race differences. Thus, as abortion pills proliferate—both within and outside of law—abortion inequities could as well. Ultimately, these emerging legal issues will profoundly alter how Americans think about abortion.*

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ABORTION PILLS

David S. Cohen, Greer Donley, & Rachel Rebouché*

INTRODUCTION

We are at the beginning of a new war on drugs in this country—this time, a war over abortion pills. The existing War on Drugs has spanned decades,[1] yet, despite federal and state bans, drug use in this country has never come close to being eradicated.[2] Instead, the expensive and ineffectual campaign has had severe consequences: institutionalizing longstanding racism and entrenching a punitive approach to drug policy.[3] One clear lesson from this war, as demonstrated here and around the world, is that drug use is difficult to stop, no matter how stiff the penalties.[4] The war on abortion pills already has begun,[5] and it is bound to repeat some of the same mistakes, igniting public backlash that will shape the abortion debate for years to come.[6]

While abortion is now illegal in roughly a third of the states, medication abortion is more widely available than ever before.[7] Due to regulatory changes over the past two years, abortion can be

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[1] See discussion of the history of the regulation and prohibition of drugs in Gonzales v. Raich, 545 U.S. 1, 5-15 (2005).

[2] Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*, *available at* https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health (reporting annual data on national use of tobacco, alcohol, and illicit drugs).

[3] Charles Silver, *The War on Abortion Could Turn the US into a Police State*, HEALTH AFFAIRS (June 27, 2022); *see also* Aziza Ahmed & Mary Ziegler, *Why the War on Abortion is Doomed to Fail*, CNN (Mar. 23, 2022).

[4] *See generally* Meagan K. Nettles, *The Sobering Failure of America's "War on Drugs": Free the P.O.W.s*, 57 CAL. W. L. REV. 275 (2018); Christopher J. Coyne & Abigail R. Hall, *Four Decades and Counting: The Continued Failure of the War on Drugs*, Cato Institute Policy Analysis No. 811, April 12, 2017.

[5] Of course, abortion pills are different from recreational drugs, making them even harder to control. *See* discussion in Part V.

[6] *See* Vanessa Williams & John Hudak, *The War on Abortion Drugs Will be Just as Racist and Classist*, BROOKINGS (May 9, 2022), https://www.brookings.edu/blog/fixgov/2022/05/09/the-war-on-abortion-drugs-will-be-just-as-racist-and-classist/.

[7] Rachel K. Jones, *Medication Abortion Now Accounts for More Than Half of All US Abortions*, GUTTMACHER INST. (Mar. 2, 2022), https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions. *See* PLAN C, https://www.plancpills.org.

accomplished with pills mailed from online pharmacies, ordered on the internet, or picked up at brick-and-mortar pharmacies.[8] State laws have sought to ban medication abortion, and state actors and advocates are advancing all manner of arguments and strategies to stop the use of pills.[9] But, at the same time, websites and informal networks openly facilitate the distribution of abortion pills, legally and illegally, across the United States. Thus, at the moment that abortion bans are proliferating, the antiabortion movement's goal of ending all abortion nationwide seems out of reach.

Because of abortion pills, abortion provision has radically changed in the last several years and faces never-before-answered legal questions. This Article is the first to pose and address these questions in the post-*Roe* legal landscape. Although the future is uncertain in key respects, in this Article, we highlight the impending battles over pills and how those battles will change the entire discourse around abortion in this country.[10]

In *Dobbs v. Jackson Women's Health Organization*,[11] the Supreme Court overturned *Roe v. Wade* and granted states broad leeway to ban abortion at any stage of pregnancy. During the *Roe* era, physical location had been central to how people gained access to abortion. "Abortion deserts" made up large swaths of the South and Midwest—places that had few providers, in part because of state laws restricting abortion services, forcing many people to travel long distances to access care.[12] And, until recently, the federal government required people to pick up abortion pills at clinics, so medication abortion carried the same logistical and financial burdens of travel.[13] Before *Roe*, place mattered even more. If a person did not live in a state that allowed abortion, their options were limited to out-of-state travel or finding an underground, in-state provider, sometimes risking their

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[8] Caroline Kitchener et al., *Abortion is Now Banned in These States*, WASH. POST (Aug. 16, 2022), https://www.washingtonpost.com/politics/2022/06/24/abortion-state-laws-criminalization-roe/.

[9] Kimberly Kindy, *Most Abortions are Done at Home. Antiabortion Groups are Taking Aim*, WASH. POST (Jan. 5, 2022), https://www.washingtonpost.com/politics/2022/08/14/medicated-abortions-drugs-students-for-life/.

[10] Dear Editors: we realize that this fast-changing terrain. We will be able to edit this piece as developments occur, making the final piece very timely. We employed this approach with our last article, *The New Abortion Battleground*, cited below, which was published in January 2023 and is current through November 2022.

[11] Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242-43 (2022).

[12] *See* Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search*, J. MED. INTERNET RESEARCH e186 (2018) (coining the term "abortion desert"); Lisa M. Kelly, *Abortion Travel and the Limits of Choice*, 12 FIU L. REV. 27 (2016).

[13] Greer Donley, *Medication Abortion Exceptionalism,* 107 CORNELL L. REV 627, 633-34 (2022).

lives, health, and future fertility if no competent one was available.[14] In both of these eras, women of color and poor and rural people shouldered the burdens of travel disproportionately.[15]

Our abortion past, however, is not our abortion future. In this new era, abortion provision does not always depend on location.[16] Contemporary abortion, through ten to twelve weeks of pregnancy, can be effectively and safely accomplished using pills.[17] In states where it is legal, virtual clinics counsel patients online before mailing medication abortion to the location of the patient's choice.[18] And even in states that ban abortion (including medication abortion), mailed abortion pills, grassroots distribution networks, and online sources make abortion pills relatively accessible and very difficult to control.[19] When attempts to police out-of-state providers fail, antiabortion legislators and activists will work to regulate, criminalize, and punish anyone else in the information or distribution chain. And abortion providers and activists will find new ways to get pills into the hands of those who want them.

This Article tackles the novel issues raised by the proliferation of abortion pills with two goals. First, we map how impending legal battles will advance or constrain the availability of abortion pills. Then, we highlight the normative consequences of those battles beyond their immediate impact—how abortion pills and their attendant controversies will shape the definition of abortion, who is culpable for abortion crimes, and personal privacy. Though pills cannot be stopped, they can be pushed underground, potentially deepening the public health and criminal justice consequences that new abortion bans already have catalyzed.

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[14] LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND THE LAW IN THE UNITED STATES, 1867-1973 23-30 (1997); CAROLE JOFFE, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE (1996).

[15] *See generally* DAVID S. COHEN & CAROLE JOFFE, OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA (2020); MICHELE B. GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD (2020).

[16] As discussed further infra, this broad statement does not mean that all patients are free from the challenges of place and location. *See* B. Jessie Hill, *The Geography of Abortion Rights*, 109 GEO. L.J. 1081, 1087-90 (2020); I. Glenn Cohen, *Travel to Other States for Abortion After* Dobbs, 22 AM. J. BIOETHICS 42 (2022).

[17] *Mifeprex (Mifepristone) Information*, FED. DRUG ADMIN. (Dec. 16, 2021), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information. In 2000, the FDA approved medication abortion through seven weeks of gestation but in 2016 extended approval to ten weeks. As discussed in Part IV.B., some providers are offering medication abortion off label through twelve weeks of pregnancy.

[18] *See* David S. Cohen, Greer Donley, & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 5-6 (2023).

[19] *See infra* Section V.A.

After describing the regulation of medication abortion and the uptake of online abortion services in Part I, we begin Part II with an exploration of prominent antiabortion strategies to limit access to abortion pills. A high-profile example is a lawsuit that attempts to remove mifepristone—the first drug in the federally-approved medication abortion regimen—from the market by claiming that it was inappropriately approved in the first place. This lawsuit is also one of several efforts that rely on a dormant but extant nearly-150-year-old federal law, the Comstock Act, that threatens the legality of mailing abortion pills anywhere. We then address attempts to criminalize out-of-state providers if any part of the medication abortion process happens within a state's borders, including the consumption of pills—concern over which already has caused some providers to refuse certain abortion services for out-of-state residents. Antiabortion efforts also will target reliable sources of information about medication abortion, as well as the manufacturing and distribution chain. This Part concludes with a section on efforts to criminalize not only providers and those who assist them but also the people who take abortion pills.

Part III then tackles the opposing movement to increase access to abortion pills as a way of mitigating the damage of *Dobbs*. The first are shield laws that protect clinicians who provide telehealth for abortion across state lines. Another effort is early in development: states allowing pharmacists to prescribe medication abortion, creating a workaround that mimics over-the-counter provision without violating federal food and drug law. Activists are also spearheading other strategies that may exploit loopholes in abortion bans, including advanced provision—the dispensation of abortion pills before a potential unwanted pregnancy in the future—and menstrual regulation or "missed period pills"—dispensation to induce a period without taking a pregnancy test.

Next, in Part IV, we explore the role and power of the Food & Drug Administration (FDA) as it faces pressure in both directions over its rules governing medication abortion. Ironically, the agency's strict and unique regulation also provides the building blocks to argue that the FDA has the sole and preemptive authority to regulate this product, potentially invalidating state abortion bans. We then discuss additional agency tools to increase or decrease access to abortion pills, including modifying the mifepristone label to permit its use throughout the first trimester or limit its use to earlier gestational ages.

After surveying these strategies and the legal questions they raise, Part V concludes with an exploration of how these battles will set the terms for the abortion debate after *Dobbs*. We start with a discussion of how informal distribution networks will eliminate gatekeepers and challenge traditional conceptions of abortion as

controlled by doctors. We then emphasize how pills challenge traditional definitions of abortion given that the drugs in a medication abortion are used for various purposes, such as miscarriage management, and blur the line between abortion and pregnancy loss. Abortion pills are also likely to normalize and destigmatize abortion because they are predominately taken privately and early in pregnancy, mimicking the experience of miscarriage, a natural process that is difficult to vilify. We conclude with a discussion of criminalization and surveillance. As people pursue online pills, states will police online activity and personal data. The brunt of investigations and criminalization will fall most heavily on poor people of color. Thus, as abortion pills proliferate—both within and outside of law—abortion inequities will as well.

These emerging legal questions, addressed for the first time by this Article, will profoundly alter how Americans think about abortion. The battle over abortion pills will have unacceptable consequences for health, liberty, and equality that could galvanize even those who might otherwise disfavor abortion rights.[20] The lesson for the War on Abortion Pills from the War on Drugs is clear: invasive, punitive state action will not stop abortion. Rather, it will harm public health, hurt those most vulnerable to state power, and incentivize informal networks to operate.[21] But, unlike the War on Drugs, what is at stake now are medications approved by the federal government and a personal right that people exercised for half a century.

I. The Abortion Pill Revolution

Medication abortion terminates a pregnancy with pills rather than a procedure. There are a variety of different medication regimens available, but the two most common worldwide are (1) 200 mg of mifepristone followed by 800μg misoprostol 24-48 hours later or (2) 800μg misoprostol on its own with additional doses as necessary to complete the abortion.[22] Most medical organizations prefer the two-

[20] Rachel Rebouché & Mary Ziegler, *Why Direct Democracy Is Proving So Powerful for Protecting Abortion Rights,* THE ATLANTIC (Nov. 11, 2022), https://www.theatlantic.com/ideas/archive/2022/11/abortion-rights-midterm-election-ballot-initiatives/672071/ (noting that Kansas and Kentucky, two states with strong anti-abortion politics, nevertheless voted down abortion restrictions in ballot initiatives).

[21] *See generally* GOODWIN, *supra* note 15, at 119 (noting that drug-related "incarceration is not linked to a reduction in drug use or misuse" but increased mortality).

[22] World Health Organization, *Medical management of abortion*, at 13 (2018) https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf.

drug regimen because it has historically been the most effective, and in the United States, it is almost exclusively used.[23]

The two drugs work differently and have different regulatory profiles. Mifepristone blocks the hormone progesterone, which is necessary for a pregnancy to continue, and misoprostol causes uterine contractions that expel fetal tissue.[24] Mifepristone, however, is more expensive and difficult to obtain than misoprostol. It is also the only drug approved by the FDA to end a pregnancy, and as a result, it has always had strict controls on its use.[25] Misoprostol, which the FDA approved as a stomach ulcer medication in 1988, is an inexpensive drug, far cheaper than mifepristone, and sold as freely as most prescription drugs.[26] It is prescribed off label[27] for a variety of obstetric uses, including miscarriage management, labor induction, and abortion.[28]

When the FDA approved mifepristone as an abortifacient in 2000, it required the manufacturer to adhere to distribution limitations that were fairly uncommon at the time and, many have argued, excessive in light of the drug's safety and minimal risks.[29] Indeed, after more than twenty years on the U.S. market, mifepristone has become one of the most studied drugs available and has proven to have an impeccable safety profile[30]—many times safer than common drugs like penicillin or Viagra[31] and eighteen times safer than childbirth.[32] It is currently only FDA-approved through the first ten weeks of

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[23] American College of Obstetricians and Gynecologists, *Practice: Bulletin: Medication Abortion Up to 70 Days of Gestation*, Oct. 2020, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation.

[24] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States*, 2014, 49 PERSP. ON SEXUAL & REPROD. HEALTH 17, 22 (2017).

[25] Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation, U.S. FOOD & DRUG ADMIN (Jan. 3, 2023), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.

[26] Marissa Krugh & Christopher V. Maani, MISOPROSTOL (Jan. 2022), https://www.ncbi.nlm.nih.gov/books/NBK539873/; Cytotec misoprostol tablets, PFIZER (Feb. 2018), https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/019268s051lbl.pdf.

[27] Off label means that the FDA has not evaluated the drug for that purpose. It is common for doctors to prescribe drugs for other uses when evidence surfaces that they are safe and effective for that use. Until the FDA approves the drug for that use, however, the manufacturer can only promote the drug for the use approved in the label. Shariful A. Syed et al., *The Law and Practice of Off-Label Prescribing and Physician Promotion*, 49 AM. ACAD. PSYCH. & L. 1, 1-5 (2021).

[28] Donley, *supra* note 13*,* at 633-34.

[29] For a comprehensive description of the FDA's regulation of mifepristone, see *id.*

[30] *Id.* at 634-35 (describing the data).

[31] *Id.* at 652-53.

[32] *Id.*

pregnancy, but some providers use it off label throughout the first trimester.[33]

Despite the drug's exemplary safety record, the FDA imposed a Risk Evaluation and Mitigation Strategy (REMS) with "elements to assure safe use" (ETASU), which is a tool Congress created to help the FDA regulate particularly risky products.[34] Mifepristone's current REMS has several parts. First, providers must be certified to prescribe mifepristone, something healthcare professionals do not need to prescribe most other drugs. Certification is fairly straightforward: providers submit a form to the drug sponsor certifying that they can "assess the duration of pregnancy accurately," "diagnose ectopic pregnancies," and "provide surgical intervention" or "have made plans to provide such care through others."[35] Next, providers must review and have patients sign a Patient Agreement Form. The Patient Agreement Form sets out mifepristone's benefits and risks, duplicating the informed consent process.[36] Finally, the REMS only allows certified providers or certified pharmacies to dispense the drug (either by mail or in person); these pharmacies must attest that they will engage in a number of recordkeeping, medication tracking, and confidentiality measures.[37]

The pharmacy certification requirement—announced in December 2021, but formalized January 2023—replaced the longstanding FDA rule that patients had to collect the drug at a clinic, which had forced many to travel long distances to pick up a prescription they could take without any provider supervision. This rule had negated much of the promise of abortion pills, subjecting them to the same burdens as procedural abortion. On the heels of changing norms during the COVID-19 pandemic and litigation exposing the arbitrariness of the in-person requirement,[38] the FDA lifted it and thus ushered in a new era of mailed abortion pills.

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[33] *See infra* Section IV.B.

[34] *Mifepristone REMS*, FOOD & DRUG ADMIN, https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_REMS_Full.pdf.

[35] *Questions and Answers on Mifeprex*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex.

[36] GOVERNMENT ACCOUNTABILITY OFF., FOOD & DRUG ADMIN.: INFORMATION ON MIFEPREX LABELING CHANGES AND ONGOING MONITORING EFFORTS 7 (2018); Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 20 CONTRACEPTION 1, 2 (2021).

[37] REMS, *supra* note 34.

[38] *See* American College of Obstetricians and Gynecologists v. U.S. Food & Drug Admin., 506 F. Supp. 3d 328 (D. Md. 2020); Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. REV. 1355 (2022).

In the wake of the FDA's decision, some abortion providers have refashioned their practices to serve patients online, revealing what is possible for medication abortion care when the means of dispensing mifepristone (and, accordingly, misoprostol) have changed. From only a handful of virtual clinics in 2021, there are now over a dozen, and their numbers are increasing.[39] Telehealth for abortion is available in twenty-four states and Washington, DC.[40] Providers have licenses in the states in which they practice and can prescribe pills to patients in those states. Patients receive instructions on the clinic's website and typically complete a questionnaire, which is reviewed by the provider to assess the suitability of medication abortion for the patient. To assess gestational age, patients report the first day of their last menstrual cycle and typically rely on a home pregnancy test. Virtual clinics offer intake and counseling that is asynchronous, synchronous, or both. Consent forms are completed online, and information about what to expect is sent to the patient.[41]

Once the process is completed, the provider or online pharmacy mails the patient the pills. Though delivery times vary, most patients receive pills within three to five days.[42] Two online pharmacies, Honeybee Health and American Mail Order Pharmacy, ship medication abortion to states where it is legal, and both have seen a significant increase in demand since *Dobbs*.[43] Soon, once they develop protocols to comply with the REMS, brick-and-mortar pharmacies like CVS and Walgreens may become certified, allowing patients to pick up their prescription as they do other drugs. The cost of pills through virtual clinics ranges from $145 (Abortion Telemedicine) to $289 (Abortion on Demand) to as high as $375 (carafem), which is still less than medication abortions offered by a clinic.[44] Though several brick-and-mortar abortion clinics have recently started offering telehealth, the rise of virtual clinics has allowed them to focus on patients who need procedural abortions. Many of those patients are people travelling from states with bans.[45] Abortion through telehealth means that early

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[39] Carrie N. Baker, *Online Abortion Providers Cindy Adam and Lauren Dubey of Choix: "We're Really Excited About the Future of Abortion Care,"* MS. MAG. (Jan. 14, 2022), https://msmagazine.com/2022/01/14/abortion-pills-california-colorado-illinois-online-abortion-cindy-adam-lauren-dubey-choix/.

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] Abigail Abrams, *Meet the Pharmacist Expanding Access to Abortion Pills Across the U.S.*, TIME (June 13, 2022), https://time.com/6183395/abortion-pills-honeybee-health-online-pharmacy/.

[44] *Id.*

[45] The rate of abortion in states with restricted access decreased 32 percent in the immediate aftermath of *Dobbs*, while reported abortion in states where abortion remained legal increased by 11 percent. *Society for Family Planning*, #WeCount Report, 2022, https://www.societyfp.org/wp-

abortion is less expensive and can occur in the privacy of one's home and without travel.[46]

As we have noted elsewhere, virtual abortion care is not a cure-all after the reversal of *Roe*.[47] To name two barriers, the digital divide and broader health disparities constrict access to mailed pills.[48] And virtual clinics cannot assist those who need or want in-person care.[49] But the most formidable barriers for mailed pills are state laws. Virtual clinics operate in states where abortion is legal and where telemedicine for abortion is not precluded by in-person requirements, such as facility visits for counseling or ultrasounds.[50] State laws prevent virtual clinics from operating in twenty-six states.

Despite state laws, mailed medication abortion can cross borders in ways that undermine abortion bans.[51] Virtual clinics require a patient's mailing address to be in a state where the provider is licensed and where telehealth for abortion is permitted. But most virtual clinics do not require that patients stay in the state to take the medications. So long as the clinic sends the pills to an address in the state where abortion is legal, the patient—or someone assisting the patient—could pick up the pills when convenient but take the pills somewhere else, including in a state where abortion is illegal.[52] Moreover, information abounds online about how to use mail forwarding to circumvent abortion bans. A new organization, Mayday Health,[53] for example, focuses on those who live in states with abortion bans, giving users step-by-step instructions on how to set up temporary addresses in an abortion permissive state and forward the mail into the banned state.[54]

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content/uploads/2022/10/SFPWeCountReport_AprtoAug2022_ReleaseOct2022-1.pdf.

[46] *Id.*

[47] *New Abortion Battleground*, *supra* note 18.

[48] *Id.*

[49] Rachel K. Jones, Elizabeth Witwer & Jenna Jerman, *Abortion Incidence and Service Availability in the United States,* GUTTMACHER INST. (Sept. 2021), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

[50] As noted, fourteen states ban almost all abortion within their borders, and an additional eight states require a physician to be present upon delivery of medication abortion. *Medication Abortion Requirement,* POL'Y SURVEILLANCE PROGRAM, http://lawatlas.org/datasets/medication-abortion-requirements.

[51] Plan C has been a hub for information about virtual clinics as well as self-managed care. 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.

[52] Jareb A. Gleckel & Sheryl L. Wulkan, *Abortion and Telemedicine: Looking Beyond COVID-19 and the Shadow Docket*, 54 U.C. DAVIS L. REV. ONLINE 105, 120 (2021).

[53] *Our Mission,* MAYDAY HEALTH, https://www.mayday.health/.

[54] Mayday is explicit that its goal is to "share info about access to safe abortion pills in any state." *Id.*

Further, most virtual providers, like those practicing in other areas, ask patients to self-report their locations at the time of prescription. One virtual clinic, Abortion on Demand, tracks IP addresses to confirm patient location at intake and then asks for a form of identification if patients are not where they say they are.[55] But people seeking telehealth services can use VPNs or mail forwarding to obtain pills without the provider knowing their location.[56] That is not to say masking one's location is without risk. Strategies designed to circumvent a state's abortion ban could have profound costs, particularly for those already vulnerable to state surveillance and punishment, as discussed in Part V below.

International providers and pharmacies expand options in banned states even further. With their help, people have abortion pills sent directly to an address in an antiabortion state.[57] A pregnant person can buy medication abortion online from an international distributor or pharmacy; alternatively, they can enlist the help of an organization, Aid Access, that works with European doctors to review a patient consultation form completed online and prescribe the pills through a pharmacy in India, but have no contact with the patient.[58] Aid Access charges $105, which is hundreds of dollars less than medication abortion provided by a brick-and-mortar clinic.[59] But whereas pills arrive 3 to 5 days after a telehealth consultation in the United States (or can be picked up from a certified pharmacy), pills from abroad can take one to three weeks to clear customs and sometimes do not arrive at all.[60] Given that abortion is a time-sensitive intervention with risks and side-effects that increase as the pregnancy progresses, this delay can be significant. Nevertheless, demand for Aid Access has been increasing quickly ever since the Supreme Court overturned *Roe*.[61]

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[55] *Frequently Asked Questions,* ABORTION ON DEMAND, https://abortionondemand.org/faq/.

[56] MAYDAY HEALTH, *supra* note 53.

[57] Chloe Murtagh et al., *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, 97 CONTRACEPTION 287, 289 (2018).

[58] *Id.*

[59] *New Abortion Battleground*, *supra* note 18, at 12-13.

[60] It is unclear whether U.S. Customs pays special attention to Aid Access packages. Marie Solis, *The Unbearable Stress of Waiting for Abortion Pills to Come in the Mail*, VICE, Feb. 26, 2020, https://www.vice.com/en/article/884v7b/aid-access-abortion-pills-stuck-in-customs; *see also* Stephanie Taladrid, *The Post-Roe Abortion Underground*, THE NEW YORKER, Oct. 10, 2022, https://www.newyorker.com/magazine/2022/10/17/the-post-roe-abortion-underground.

[61] Abigail Aiken et al., *Requests for Self-managed Medication Abortion Provided Using Online Telemedicine in 30 US States Before and After the* Dobbs v Jackson Women's Health Organization *Decision*, 328 JAMA 1768-1770 (2022). Once Texas's SB8 became effective, Aid Access saw demand for their services increase 1,180%, leveling out to 245% of the pre-SB8 demand a month later. Abigail R.A. Aiken et al., *Association of Texas Senate Bill 8 With Requests for Self-managed Medication Abortion*, 5 JAMA NETWORK OPEN e221122 (2022).

Aid Access is just one example of the various sources available, both domestic and international, that assist people in obtaining pills. The organization's work is supplemented by abortion activists who publicize all the ways people can obtain pills, even if not all options are entirely legal. Plan C is an organization that offers information on how to find abortion pills in all fifty states.[62] Likewise, detailed instructions on medication abortion are available in 27 languages at HowToUseAbortionPill.org.[63] The Miscarriage and Abortion Hotline has clinicians available to answer questions about medication abortion use, and the website Self-Managed Abortion: Safe and Supported has an online chat portal to speak with trained counselors.[64] As detailed in Part V, informal networks also exist to get pills to people who need them, often operating without the input or help of healthcare professionals.

In addition to Aid Access and telehealth for abortion, another important but under-discussed alternative to the standard medication abortion regime is taking misoprostol alone. Recommended by the World Health Organization (WHO), misoprostol is one of the most common methods of medication abortion worldwide because it is available in many countries without a prescription and at a low cost.[65] Misoprostol requires a prescription, but it is cheaper and much more widely available, as it is a common ulcer medicine. Misoprostol-only abortions are typically viewed as less effective than mifepristone-misoprostol abortions with potentially greater side-effects.[66] One set of studies suggests that misoprostol is at least 80% effective, while more recent research has indicated that misoprostol-only abortions can be as high as 95% effective.[67] Though misoprostol-only abortions have historically raised concerns about a "a 'second tier' product . . . for already disenfranchised groups of women," mifepristone is facing greater attacks and may not always be available or affordable.[68]

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[62] *The Plan C Guide to Abortion Pill Access*, PLAN C, www.plancpills.org.
[63] *Safe at Home Abortion Instructions*, HOW TO USE ABORTION PILLS, https://www.howtouseabortionpill.org/.
[64] *Self-Managed Abortion; Safe & Supported*, SASS/WOMEN HELP WOMEN, https://abortionpillinfo.org/.
[65] Heidi Moseson et al., *Effectiveness of Self-managed Medication Abortion with Accompaniment Support in Argentina and Nigeria (SAFE): A Prospective, Observational Cohort Study and Non-Inferiority Analysis with Historical Controls*, 10 LANCET GLOB. HEALTH e105 (2021); Jessica Cohen et al., *Reaching Women with Instruction on Misoprostol Use in a Latin American Country*, 13 REPRO. HEALTH MATTERS 84, 85 (2005).
[66] Francine Coeytaux & Elisa Wells, *A Tale of Two Methods*: *Applying the Lessons Learned from Emergency Contraception to Misoprostol for Early Abortion*, A BRIEFING PAPER COMMISSIONED BY THE REPRODUCTIVE HEALTH TECHNOLOGIES PROJECT 11-12 (2016) (on file with authors).
[67] Moseson et al, *supra* note 65, at e110-11.
[68] Coeytaux & Wells, *supra* note 66, at 12.

Depending on how the abortion pill battles described in the next Part resolve, clinics may resort to providing misoprostol-only abortions. Fortunately, studies show high levels of patient satisfaction with misoprostol-only abortions when there is proper counseling and support.[69] And, for those who can find it, mifepristone may still be relatively accessible through underground markets, no matter what the FDA or courts do.

Just how revolutionary abortion pills are cannot be understated. Separating abortion from in-person care has created new avenues to safe abortion, even in states that ban it. And this form of abortion will likely be highly resilient; as one method to obtain pills becomes limited or is shut down, another will open. The next part considers the coming conflicts over mailed medication abortion and analyzes what abortion restrictive efforts will look like moving forward.

II. Policing Pills

States with general abortion bans presumptively ban medication abortion.[70] However, abortion pills pose a unique challenge to enforcing those laws. National antiabortion groups have called medication abortion "the new frontier of abortion" that necessitates a "new approach."[71] As a result, state legislators are beginning to focus their energy on pills post-*Dobbs*.[72] This section reviews several of these emerging tactics, such as removing mifepristone from the market nationwide, reviving a long unenforced law to try to ban mailing abortion pills, redefining the location of abortion to prosecute providers in other states, targeting abortion pill information and the supply chain, and criminalizing people who use pills.

a. Efforts to Remove Mifepristone from the Market

The most high-profile attempt to target medication abortion is a recent federal lawsuit in Texas seeking to invalidate the FDA's approval of mifepristone. If successful, it would be illegal for the manufacturer to sell or distribute mifepristone nationwide, even in

[69] *See, e.g.*, Moseson, *supra* note 65, at e112; Daniel Grossman et al., *A Harm-reduction Model of Abortion Counseling About Misoprostol Use in Peru with Telephone and In-person Follow-up: A Cohort Study*, 13(1) PLOS ONE (January 2018).
[70] *See, e.g.*, 18 Pa. C.S. § 3203 (defining "abortion" as the "use of *any means* to terminate the clinically diagnosable pregnancy" (emphasis added)). Note: as explored in Section IV.C., there is the argument that states cannot ban an FDA-approved drug that is regulated as closely as medication abortion.
[71] Kindy, *supra* note 9.
[72] *Id.*

states where abortion is legal.[73] This lawsuit alleges among other things that the FDA inappropriately used its statutory authority in approving medication abortion; that medication abortion is unsafe; and that the Comstock law, discussed in greater depth in the next section, makes all mailed pills illegal.[74]

The first claim relates to the FDA's use of Subpart H to approve mifepristone. Subpart H is a regulatory tool the FDA created in response to the agency's sluggish approval of new drugs to treat HIV at the height of the HIV/AIDS epidemic. Its purpose was to accelerate approval for new drugs to treat serious or life-threatening illnesses; in exchange, the agency could impose post-approval distribution limitations.[75] The Texas litigation alleges that the agency inappropriately used Subpart H because pregnancy is not an illness and that its approval was therefore wrongly accelerated and based on incomplete data.[76]

The reality, though, is that the FDA never relied on Subpart H to accelerate approval of mifepristone.[77] In fact, it rejected the drug's approval twice before finally approving it three years after the manufacturer submitted its application.[78] At the time of mifepristone's approval in 2000, the REMS program did not yet exist; thus, Subpart H was the primary avenue the agency had for limiting the distribution of new drugs after it approved them.[79] In other words, the agency used its Subpart H authority to regulate mifepristone *more* harshly than the vast majority of drugs, not more leniently as the lawsuit suggests.[80] Indeed, mifepristone's sponsor objected to the use of Subpart H for FDA approval because it worried the classification would inappropriately suggest the drug was risky.[81]

Given the concerns about Subpart H, by both abortion opponents and supporters, in 2008 the Government Accountability Office (GAO) published a 55-page audit of the FDA's approval of

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[73] Alliance for Hippocratic Medicine v. U.S. Food & Drug Administration, No. 2:22-cv-00223-Z (N.D. Tex. 2022).
[74] Complaint, *id.*
[75] 21 C.F.R. §§ 314.500-314.560.
[76] Complaint, *supra* note 74.
[77] U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-751, FOOD AND DRUG ADMINISTRATION: APPROVAL AND OVERSIGHT OF THE DRUG MIFEPREX 27 (2008).
[78] *Id.*
[79] Greer Donley & Patricia Zettler, *The Case Against Medical Abortion Rejects Science and Embraces Falsehoods*, THE HILL (Nov. 27, 2022), https://thehill.com/opinion/healthcare/3751672-the-case-against-medical-abortion-rejects-science-and-embraces-falsehoods/.
[80] *Id.*
[81] GAO-08-751, *supra* note 77.

mifepristone.[82] The GAO concluded that "[t]he approval process for Mifeprex [the brand name version of mifepristone] was consistent with the processes for the other Subpart H restricted drugs."[83] In reaching that conclusion, the GAO appeared to find nothing wrong with the FDA's conclusion that "the agency has broad discretion [under Subpart H] to determine which conditions or illnesses may be considered serious or life threatening, and that in the case of Mifeprex it considered the potential in any pregnancy for serious or life-threatening complications—such as hemorrhage—in its determination."[84] This thorough, independent report significantly undermines the plaintiffs' position that the FDA acted inappropriately. Moreover, when the agency created, and each time it modified, the REMS, it arguably provided a new basis for the mifepristone approval that trumps and cures any possible defect in the original Subpart H approval.

The lawsuit makes other unconvincing claims[85]—for instance, that medication abortion is unsafe, or at least, less safe than procedural abortion. First, the Food, Drug & Cosmetic Act and its implementing regulations do not require drugs to be as safe or effective compared to procedural (or even pharmacological) alternatives; they must only be safe and effective on their own—a threshold that medication abortion clearly exceeds.[86] As noted, mifepristone is many times safer than widely-used medications and eighteen times safer than childbirth.[87] Second, medication abortion has almost the same effectiveness as procedural abortion with only slightly higher (though still minimal) complications.[88]

Nonetheless, this case has the potential to succeed. The plaintiffs forum-shopped for a federal judge widely thought to be sympathetic to anti-abortion arguments, sitting in a federal circuit that is as conservative as the Supreme Court on abortion matters, if not more so.[89] If the plaintiffs are successful, it would be the only time a court has revoked a New Drug Approval (NDA) unilaterally and over

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[82] *Id.*
[83] *Id.* at 1.
[84] *Id.* at 22.
[85] The FDA's response brief convincingly argues that the plaintiffs lack standing, that their claims are untimely and unexhausted, and that they are unlikely to suffer irreparable harm. *See* Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction, Alliance for Hippocratic Medicine v. U.S. Food & Drug Administration, No. 2:22-cv-00223-Z (Jan 13, 2023, N.D. Tex.).
[86] 21 U.S.C. § 355(d).
[87] Donley, *supra* note 13, at 652-53.
[88] ACOG Practice Bulletin, *supra* note 23.
[89] *See* David S. Cohen, Greer Donley, & Rachel Rebouché, *The FDA's Step Forward on Medication Abortion Isn't Even Close to Enough*, SLATE (Jan. 5, 2023), https://slate.com/news-and-politics/2023/01/medication-abortion-pills-fda-pharmacies.html.

the FDA's objection, bypassing the procedural protections for NDA holders explicitly required by Congress before the agency can remove a product from the market. A non-expert court overriding the FDA's scientific judgment would have significant implications for food and drug law. Though the FDA could approve mifepristone again without relying on Subpart H—the evidence would be readily available to do so—it could take months or years. In the meantime, the FDA could also exercise its broad enforcement discretion, providing the manufacturer safe harbor, as it has done for other politically-complex drugs.[90]

Without this protection, however, virtual clinics that exclusively prescribe medication abortion would shut down, and brick-and-mortar clinics would be unable to accommodate the increase in demand. Now that clinics have closed in roughly a third of the country, the remaining states already are overwhelmed with an influx of out-of-state patients. More than half of abortions in this country are completed with medication (often through virtual clinics), so if every abortion patient now required procedural abortion, brick-and-mortar clinics could buckle under the strain.[91] Many providers are only trained to provide medication abortions, meaning that they could not easily convert their practice to procedural abortion care, and many clinics lack the physical space to scale up even if providers were available.[92] Weeks-long wait times could become months, turning first trimester patients into second trimester patients or timing some out of an abortion entirely, while others resort to ordering pills from outside the United States.

A nationwide injunction on the sale of mifepristone, however, would not stop the off-label use of misoprostol for abortion.[93] As a result, clinics might respond to an injunction by transitioning to misoprostol-only abortions, although the sudden increase in misoprostol use could trigger drug shortages.[94] As noted, misoprostol-only abortions are often seen as less effective, though recent research questions that assumption.[95] Additionally, the personal use exemption, which allows individual patients to buy unapproved drugs from international markets for their own personal use in certain contexts

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[90] *See generally* Heckler v. Chaney, 470 U.S. 821, 827–38 (1985) (affirming the FDA's broad enforcement discretion in the context of lethal injection drugs).
[91] *See* Cohen, Donley, & Rebouché, *supra* note 89.
[92] *See id.*
[93] A ruling that revives the Comstock Act as a ban on mailing any abortifacient, discussed below, could also threaten misoprostol-only abortions.
[94] *See* Rachel Gilmore, *Canada Has Been Facing an Abortion Pill Shortage. Here's What to Know*, GLOBAL NEWS (Dec. 16, 2022), https://globalnews.ca/news/9354358/abortion-pill-shortage-mifegymiso-canada-access/.
[95] Moseson, *supra* note 65.

without violating FDA laws, should ensure that FDA law does not impose a barrier for using Aid Access and other resources to buy misoprostol online.[96]

b. Comstock Act

A little-known part of an old federal law has become a major component of the legal attacks on pills. The federal law is called the Comstock Act, named after Anthony Comstock, an anti-abortion and anti-birth control crusader.[97] Dating back to 1873, the law prohibited importation and mailing of information on "how or by what means conception may be prevented or abortion produced."[98] In 1876, the law was updated to clarify that the obscene material covered by the Act was "non-mailable matter and shall not be conveyed in the mails or delivered from any Post Office or any letter carrier."[99] In 1909, the law was expanded to include mailing through express mail services or other common carriers.[100]

For the first forty years of its existence, the Comstock Act was successfully implemented. Comstock himself estimated that more than 3,500 people were convicted under the law, and almost 160 tons of literature was destroyed.[101] However, enforcement of the law, and its encroachment in people's private lives, incited public backlash that ultimately culminated in the law's disuse. A series of state and federal court challenges also drastically limited the application of the Comstock Act and its state complements.[102] In 1930, dicta from the Second Circuit indicated that the Act only applies when the sender had an intent to mail or ship items for "illegal contraception or abortion or for indecent or immoral purposes."[103] The Sixth Circuit adopted this reasoning three years later, holding that there must be intent to ship

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[96] *See Personal Importation*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/industry/import-basics/personal-importation. However, under the Bush Administration, the FDA used an import alert to ban the importation of mifepristone for personal use, underscoring the various tools the FDA has to try to limit or expand medication abortion access. *See* Donley, *supra* note 13, at 670-73.

[97] AMY SOHN, THE MAN WHO HATED WOMEN (2021). The Comstock Act is really a series of laws, including state versions, and some people thus use the plural "Comstock Acts" when referring to them. Here, we use the singular but in doing so refer to all of the statutes covered by this moniker.

[98] Margaret A. Blanchard & John E. Semonche, *Anthony Comstock and his Adversaries: The Mixed Legacy of this Battle for Free Speech*, 11 COMM. L. & POL'Y 317, 327 (2006).

[99] *Id.*

[100] U.S. Penal Code, Section 245, March 4, 1909.

[101] Margaret A. Blanchard, *The American Urge to Censor: Freedom of Expression Versus the Desire to Sanitize Society—From Anthony Comstock to 2 Live Crew*, 33 WM. & MARY L. REV. 741, 758 (1992).

[102] *See, e.g.,* People v. Sanger, 118 N.E. 637 (N.Y. 1918).

[103] Youngs Rubber Corp. v. C.I. Lee, 45 F.2d 103, 108 (2d Cir. 1930).

for "condemned purposes."[104] As the Second Circuit explained further in 1936, any other interpretation of the broad language of the Comstock Act would have the anomalous result of making illegal *any* item that *could* be used for contraception or abortion.[105] Cases that narrowly interpreted the Comstock Act are widely considered to have paved the way for broad legalization of birth control,[106] and *Griswold v. Connecticut* put the constitutional nail in the Comstock coffin.[107] Congress deleted references to birth control from the statute in 1971.[108]

Although these cases all dealt with contraception, abortion provisions in the Comstock Act became dead letters as well. Language from each of these cases limited the abortion language to *unlawful* abortions, either because of explicit statutory text or based on the same reasoning used for contraception.[109] As a result, the Comstock Act has never been interpreted to ban mailing material that was related to lawful abortions—which, at the time, included health or life-saving abortions. With *Roe v. Wade*'s legalization of abortion, Comstock became moot despite remaining on the books.[110] Though in 1996 Congress increased the fine under the law, it was only for a related provision about distributing information about abortion, not mailing pills or articles for abortion.[111] The increased penalties were widely considered unconstitutional restrictions on free speech and were never enforced.[112]

Currently, the abortion provisions of the Act are in 18 U.S.C. §§ 1461 and 1462. Relevant to abortion pills, Section 1461 declares as nonmailable matter:

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[104] Davis v. United States, 62 F.2d 473, 475 (6th Cir. 1933).
[105] United States v. One Package, 86 F.2d 737, 739 (2d Cir. 1936); *see also Davis*, 62 F.2d at 475 (explaining that the Comstock Act "must be given a reasonable construction").
[106] Note, *Judicial Regulation of Birth Control Under Obscenity Laws*, 50 YALE L.J. 682 (1941); *see also* United States v. Nicholas, 97 F.2d 510 (2d Cir. 1938); Consumers Union of United States, Inc. v. Walker, 145 F.2d 33 (D.C. Cir. 1944); Poe v. Ullman, 367 U.S. 497, 546 n.12 (1961) (Harlan, J., dissenting).
[107] 381 U.S. 479 (1965).
[108] Sheryl L. Herndon, *The Communications Decency Act: Aborting the First Amendment?*, 3 RICHMOND J. L. & TECH. 2, 2 (1997).
[109] *See Youngs Rubber*, 45 F.2d at 108; *One Package*, 86 F.2d at 739; *see also* Bours v. United States, 229 F. 960, 964 (7th Cir. 1915) (reading a life exception into the Comstock Act's abortion provision).
[110] 410 U.S. 113 (1973).
[111] Herndon, *Communications Decency Act*, *supra* note 108, at 2-3.
[112] *See generally id.* The Clinton Administration noted in a filing in a case challenging part of the 1996 act that "the Department has a longstanding policy that previous such provisions are unconstitutional and will not be enforced" and that no one will be prosecuted under the new law. American Civil Liberties Union v. Reno, 929 F. Supp. 824, 829 n.7 (E.D. Pa. 1996).

> Every article or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use; and
>
> Every article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for producing abortion, or for any indecent or immoral purpose . . . .[113]

Section 1462, which applies to express companies or other common carriers, contains a shorter definition of prohibited items: "[A]ny drug, medicine, article, or thing designed, adapted, or intended for producing abortion . . . ."[114]

Before *Dobbs*, no one considered these provisions enforceable with respect to abortion. The federal government had stopped enforcing the Comstock Act entirely after the Second Circuit case in 1936, long before *Roe*.[115] And the prohibitions on distributing any item that could be used to procure an abortion had never been raised in any modern abortion litigation, including a recent case that challenged an FDA decision to permit the mailing of abortion pills.[116] In the immediate aftermath of *Dobbs*, however, there is a clear, growing interest among abortion opponents to raise Comstock from the dead. The first sign came in now-dismissed litigation in Mississippi challenging the state's abortion pill restrictions under the theory of FDA regulation preemption, discussed in Part IV below.[117] In a responsive pleading filed in the case after *Dobbs*, the Mississippi Attorney General argued that the FDA's regulation of medication abortion could not preempt state laws banning abortion pills because, citing the Comstock Act, "federal law broadly criminalizes distributing those drugs."[118]

Comstock then reared its head in several other states. In Utah, twenty-two state representatives sent a cease-and-desist letter to multiple abortion-related organizations. The letter made several different arguments, but chief among them was that the Comstock Act continues to be in effect and that all organizations must stop shipping

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[113] 18 U.S.C. § 1461.
[114] 18 U.S.C. § 1462.
[115] Greer Donley, *Contraceptive Equity*, 71 ALA. L. REV 499, 509-10 (2019).
[116] FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578 (2021).
[117] GenBioPro, Inc. v. Dobbs, No. 3:20-cv-00652-HTW-LRA (S.D. Miss. Oct. 9, 2020).
[118] Defendant's Memorandum in Opposition to Plaintiff's Motion for Leave to File Amended Complaint, *id.*, at 2, 11-12, 20.

or receiving abortion drugs because of it.[119] In New Mexico and Colorado, local ordinances have appeared that prohibit any person or clinic in the city from using the mail, an express company, or other common carrier to mail the items prohibited by the Comstock Act, including abortion pills.[120] And, in Texas, a pre-litigation deposition notice has been filed against the operator of an off-shore abortion boat raising the possibility of Comstock violations.[121]

More prominently, the current challenge to the FDA's approval of mifepristone, discussed above, also invokes the Comstock Act as a basis for declaring the FDA's approval *ultra vires*.[122] Generally speaking, a statute trumps regulation, so if the Comstock law were upheld, the FDA would be bound by it. Technically, Comstock only declares items nonmailable; it does not make abortion pills illegal and thus does not stop the FDA from approving an abortifacient. However, the Act would erect obstacles to the drug's distribution if it could not be shipped through the mail or an express carrier.

So far, the Comstock Act has not had an impact on the post-*Dobbs* abortion provision landscape. Abortion providers, abortion rights organizations, pharmacies, and drug manufacturers have ignored it. They have done so presumably on the basis of the appellate court decisions described above. As those courts noted, the plain language of the Comstock Act is so broad that it would cover almost every medical instrument, supply, or drug that could possibly be used for any abortion.[123] In other words, absent the narrowing construction applied by the federal circuit courts, the law's plain terms could effectively ban *all* abortion nationwide because almost every pill, instrument, or other item used in an abortion clinic or by a virtual abortion provider moves through the mail or an express carrier at some point.

This possibility is one of the reasons the circuit court precedent discussed earlier held that the Comstock Act applies only to unlawful

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[119] Letter from Utah House of Representatives to Utah Abortion Fund, Sept. 15, 2022, https://npr.brightspotcdn.com/56/82/a94f5aff430bbef410ac9d614ba5/utah-letter-to-utah-abortion-fund.pdf.

[120] Ord. 1147, City of Hobbs, Nov. 7, 2022, https://www.hobbsnm.org/files/legal_notices/2022/Ord%20No.%201147%20-%20Abortion%20Business%20Ordinance.pdf; Grant McGee, *Clovis Passes Anti-Abortion Ordinance*, QUAY COUNTY SUN, Jan. 11, 2023. A similar ordinance was defeated in Pueblo, Colorado. Elliott Wenzler, *Pueblo Rejects Abortion Ban, Tossing First Attempt to Challenge State Law Protecting the Procedure*, Colorado Sun, Dec. 12, 2022.

[121] In re Rachael Diane Jackson-Hisler, Verified Petition to take Deposition to Investigate a Lawsuit 4, Nov. 8, 2022.

[122] Complaint, *supra* note 74, at 6, ¶ 22; 32, ¶¶ 115-17; 107-08, ¶¶ 390-96; 111, ¶ L (N.D. Tex. 2022).

[123] *See* discussion *supra* notes 101-104 and accompanying text.

abortions.[124] But still, those decisions leave some ambiguity. If the term "unlawful" is a reference to federal law, then as of right now, medication abortion is not unlawful under federal law, meaning that the Comstock Act would not apply to abortion pills *anywhere*. However, if the term "unlawful" refers to legality under federal or state law, then the Comstock Act would restrict abortion pills being mailed in states if the purpose is to violate a state's abortion law.

The Department of Justice appears to agree with this latter interpretation, but, even so, notes how difficult applying the Act would be in practice. In January 2023, the Office of Legal Counsel released a memo on the Comstock Act's applicability. After recounting the history of the Comstock Act and the federal appeals court rulings that narrowed it, the memo focuses on the intent required to prove criminality under the Act. Because only mailing for illegal abortions is covered, the memo concludes that the Act does not "prohibit the conveyance of articles intended for preventing conception or producing an abortion where the sender lacks the intent that those items should be used unlawfully."[125] Mailing pills to states where abortion is legal would certainly not meet this standard, but the memo goes further and states that, absent possessing specific intent to accomplish an illegal abortion, someone mailing pills into a state where abortion is generally banned would also not violate the Act. The memo lists eight possible legal uses for abortion pills within states where abortion is banned, including for health or life-saving abortions, for miscarriage management, or for abortions before the gestational limit. Thus, "USPS could not reasonably assume that the drugs are nonmailable simply because they are being sent into a jurisdiction that significantly restricts abortion."[126] As a result, abortion pills, under this interpretation, remain legally mailable material under federal law throughout the country.[127]

Beyond these judicial and executive interpretations of Comstock, which Congress and the Postal Service may have ratified through subsequent acts,[128] prosecuting someone for violating a statute that has been unenforced for almost a century raises questions of fundamental fairness.[129] As former Judge Robert Bork has explained the concept, "the sudden revival of a long forgotten law carrying harsh

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[124] *Id.*

[125] Office of Legal Counsel, *Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions*, Dec. 23, 2022, at 16 [hereinafter "OLC Memo"].

[126] *Id.* at 20.

[127] Of course, the OLC memo only covers whether mailing pills violates the federal Comstock Act and does not express any view on state law implications.

[128] OLC Memo, *supra* note 125, at 11-16.

[129] Corey R. Chivers, *Desuetude, Due Process, and the Scarlet Letter Revisited*, 1992 UTAH L. REV. 449.

penalties [ ] might encounter the defense of desuetude."[130] Despite the doctrine's grounding in democratic self-governance and the fair warning requirements of the Due Process Clause, American courts have been loath to adopt the defense of desuetude due to a growing reliance on textualism.[131] But a new prosecution under the Comstock Act's prohibitions on mailing abortion pills would arguably present unique and untested questions that renew interest in this defense. Moreover, now that the Department of Justice has publicly stated that the law does not apply to those mailing pills without a specific intent to procure illegal abortions, prosecuting someone under a different interpretation raises even more serious questions of government entrapment.[132]

Nonetheless, just because the Comstock Act has been ignored so far does not mean that courts in the future will agree that it no longer has force, especially in the wake of *Dobbs*. The growing number of recent attempts from antiabortion advocates to resurrect the Comstock Act seem to be on a trajectory to force the courts to consider this issue.

c. The Location of Abortion

In the wake of *Dobbs*, questions about the extraterritorial effect of antiabortion laws have loomed large. In a previous article, the three of us charted how such extraterritorial application of abortion laws could work.[133] We noted that states could pass laws that specifically target extraterritorial conduct or try to prosecute extraterritorial abortions under already-existing criminal laws.

In the context of abortion pills, the question of extraterritorial application is even more complicated because states will try to claim an abortion occurred in their territory. First, telehealth means that a provider could be in an abortion-supportive state like Massachusetts, but meeting (either knowingly or unknowingly) with an abortion patient online who is physically in an antiabortion state like Texas. As described in Part III below, the standard for telehealth is that the care occurs where the patient is located.[134] So Texas could argue that the

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[130] *See* Central Nat. Bank of Mattoon v. U.S. Dept. of Treasury, 912 F.2d 897, 906 (7th Cir. 1990) (Judge Posner paraphrasing the Bork argument, though suggesting this should be reserved for "extreme cases").
[131] Joel S. Johnson, *Dealing with Dead Crimes*, 111 GEO. L.J. 95, 108-13 (2022).
[132] *See, e.g.*, Cox v. Louisiana, 379 U.S. 559, 571-72 (1965); United States v. Cox, 906 F.3d 1170, 1191 (10th Cir. 2018).
[133] *New Abortion Battleground*, *supra* note 18, at 22-53; *Dobbs*, 142 S. Ct. at 2337 (joint dissent).
[134] *See infra* Section III.A.

abortion occurred in Texas where the patient was located for the telehealth consultation, received the pills by mail, or consumed them even though the provider was in a state that permits telehealth for abortion. Prosecuting an out-of-state provider in this context would still raise issues of extraterritorial application of Texas law, but it would be much easier for Texas to argue that its laws should govern when the patient remained in Texas rather than when the patient traveled to another state for care.

Second, where does a medication abortion take place for people traveling from a state where abortion is banned to a state where abortion is legal? Consider four different possible locations related to an in-person visit to obtain abortion pills:

> 1) Where the patient interacts with the medical professional and receives the pills.
>
> 2) Where the patient ingests the mifepristone. This could be in the medical office, or it could be later when the patient returns home.
>
> 3) Where the patient ingests the misoprostol. This usually occurs twenty-four hours after the mifepristone is taken.
>
> 4) Where the patient expels the products of conception. This could occur within hours of taking the misoprostol or up to a few days later.[135]

With the time lapse that can occur between these four different steps, it is theoretically possible that the abortion patient could be in four different locations over the course of completing the abortion. Telehealth further complicates this point as the provider and patient could be in separate locations for the initial consultation.[136] The more likely scenario for a traveling patient, though, is that the patient would be in an abortion-supportive state for steps 1 and 2 but then return to their home state (where abortion is banned) for steps 3 and 4. This is

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[135] *New Abortion Battleground*, *supra* note 18, at 42.

[136] Imagine a provider in New York communicates via telehealth with a patient physically located in Pennsylvania. Because of Pennsylvania rules, the provider cannot mail the pills into that state, so mails them to a P.O. box in New Jersey, where the patient picks them up. The patient, who is traveling to see family, then travels to Delaware, where she takes the mifepristone. Then she goes to Maryland a day later where she takes the misoprostol. Then, when she finally arrives in Virginia, she expels the products of conception. There are six different states in this admittedly far-fetched hypothetical—when and in which one did the abortion take place?

already happening around the country.[137] Like the situation above, the antiabortion state will argue that they are not trying to punish extraterritorial conduct but rather that the abortion occurred in their state.

Given that abortion is statutorily defined, there will be no consistent answer to the questions raised here. One state could consider an abortion to have taken place where the medication is prescribed or given to the patient. This is the approach taken by North Dakota in its provisions regarding medication abortion: "For purposes of this chapter, an abortion accomplished by the use of an abortion-inducing drug is deemed to occur when the drug is prescribed, in the case of a prescription, or when the drug is administered directly to the woman by the physician."[138] Other states, though, could choose to follow a different rule, considering an abortion to take place wherever either the mifepristone or misoprostol is ingested or where the products of conception are expelled. Thus far, no state statute has explicitly followed this path, but antiabortion states could change their statutes to define abortion to occur where any part of the abortion process occurs.

Even without a statutory change to abortion laws, states also could attempt to interpret existing law to apply when any part of the abortion occurs in their borders. For instance, a group of legislators in Texas sent letters to groups that are helping Texans leave the state to access legal abortion elsewhere, stating that Texas "criminal prohibitions extend to drug-induced abortions if any part of the drug regimen is ingested in Texas, even if the drugs were dispensed by an out-of-state abortionist."[139] Prosecutors might try to charge based on this theory, though there are practical challenges to this interpretation. As described in Section V, most abortion bans exclude any prescription or act done with the intent to remove dead pregnancy tissue.[140] Typically, medication abortion is described in this way: mifepristone stops the pregnancy from developing and misoprostol induces contractions to expel the tissue.[141] Thus, an abortion provider's intent when prescribing misoprostol might be to expel non-viable pregnancy tissue after the mifepristone. Though research is

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137 AFP, *Across the Missouri-Illinois Border, an Abortion Sanctuary in US Midwest*, FRANCE 24 (June 30, 2022), https://www.france24.com/en/live-news/20220630-across-the-missouri-illinois-border-an-abortion-sanctuary-in-us-midwest.

138 2011 N.D. Sess. Laws ch. 109, § 6; *see also* MKB Management Corp. v. Burdick, 855 N.W.2d 31 (N.D. 2014) (in fragmented opinions, discussing the contours of the state's medication abortion restrictions).

139 Complaint, *supra* note 74, at 4.

140 *See infra* Part V.B.

141 *See e.g., How does the abortion pill work?,* PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/how-does-the-abortion-pill-work.

inconclusive on how long a pregnancy survives after mifepristone alone,[142] this uncertainty could create enforcement challenges.

More significantly, ambiguity breeds confusion and chills care. The fear that antiabortion states could prosecute providers or helpers for conduct legal in their home state, but potentially illegal elsewhere, has led to changes in care for out-of-state patients. Multiple abortion clinics have publicly announced that they now require patients to consume all pills in the state where abortion is legal or that they will not provide pills to patients who are from states where abortion is banned.[143] Some abortion funding groups will not offer financial support to patients returning to states with an abortion ban that could apply to those who fund abortion or otherwise assist patients.[144] This uncertainty is accomplishing just what antiabortion activists want—barriers to accessing pills.

d. Information Bans, Misinformation, and Supply Chains

One of the widely-recognized threats to antiabortion efforts is the proliferation of information about abortion pills online. As noted in Part I, websites help people all over the country, including in states that ban abortion, access abortion pills. The Comstock Act's ban on information dispensation, to the extent the Act is revived, already provides an opportunity to attack this information.[145] But state legislation attacking those who provide information about pills is also on the horizon. The National Right to Life's (NRLC) model antiabortion bill includes specific provisions addressing abortion information,[146] language copied almost verbatim in a South Carolina

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[142] In a meta review of many published studies, mifepristone alone ended a pregnancy 53-88% of the time, depending on the dosage, with a pregnancy continuing 8-46% of the time. Daniel Grossman, *Continuing Pregnancy After Mifepristone And "Reversal" Of First-Trimester Medical Abortion: A Systematic Review*, 92 CONTRACEPTION 206, 209 (2015).

[143] Katheryn Houghton & Arielle Zionts, *Montana Clinics Preemptively Restrict Out-of-State Patients' Access to Abortion Pills*, NPR (July 7, 2022), https://www.npr.org/sections/health-shots/2022/07/07/1110078914/montana-abortionpills.

[144] Caroline Kitchener, *New Restrictions From Major Abortion Funder Could Further Limit Access*, Washington Post, Aug. 25, 2022, https://www.washingtonpost.com/politics/2022/08/25/national-abortion-federation-restrictions/. If an abortion provider does not change their practices and a state attempts to prosecute, providers could argue that the relevant statute, with its unclear definitions and application, is void for vagueness under the due process clause. Clarissa Byrne Hessick, Johnson v. United States *and the Future of the Void-for-Vagueness Doctrine*, 10 N.Y.U. J. L. & LIBERTY 152, 165 (2016).

[145] 18 U.S.C. § 1461.

[146] Memorandum from James Bopp, Jr., Gen. Couns., Nat'l Right to Life Comm. (June 15, 2022), https://www.nrlc.org/wp-content/uploads/NRLC-Post-Roe-Model-Abortion-Law- FINAL-1.pdf.

bill introduced soon after *Dobbs*.[147] This bill did not move out of committee, but bills banning abortion-related information are expected to reappear in state legislatures this spring.[148] Legislators in Texas, for example, have said they will propose requiring internet providers to block abortion pill websites, such as Aid Access and possibly Plan C, though it is unclear how this would work in practice.[149] Of course, impeding information on abortion pills will only mean that people will seek out alternative sources and possibly rely on inaccurate information.

Though the First Amendment[150] should protect information about abortion pills online, even in states where abortion is illegal,[151] the threat of a bill like the NRLC's model is that online platforms may prophylactically censor abortion pill information out of fear that they could face liability or criminal sanctions.[152] As we have seen with providers preemptively altering clinical practice in response to fears of extraterritorial prosecution, the threat of bills such as these, even if ultimately unenforceable, could accomplish the same goal by shaping the availability of online abortion pill information.

A related tactic is to flood the internet with misinformation to thwart people's attempts to find pills. Fake abortion clinics, often called crisis pregnancy centers, have long had an online presence as part of their mission to prevent people from obtaining abortions.[153] That has included inaccurate information about abortion, such as misestimating gestational dates to time people out of abortion care, exaggerating the risk of abortion, peddling the inaccurate idea of abortion reversal, and promoting unfounded theories such as

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147 S. 1373, S.C. Gen. Assembly, 124th Sess. (2021-22).

148 Cat Zakrzewski, *South Carolina Bill Outlaws Websites That Tell How to Get an Abortion*, WASH. POST (July 22, 2022), https://www.washingtonpost.com/technology/2022/07/22/south-carolina-bill-abortion-websites.

149 Caroline Kitchener, *Conservatives Complain Abortion Bans Not Enforced, Want Jail Time for Pill "Trafficking"*, WASH. POST (Dec. 14, 2022), https://www.washingtonpost.com/politics/2022/12/14/abortion-pills-bans-dobbs-roe/.

150 It is beyond the scope of this paper to outline all the contours of the First Amendment related to abortion pill information, but at a high level, the Amendment should protect truthful information about abortion pills and how to obtain them, so long as it does not cross the line into advocacy to break the law. *See* John Villasenor, *The First Amendment and Online Access to Information About Abortion: The Constitutional and Technological Problems with Censorship*, 20 NW. J. TECH. & INTELLECTUAL PROP. 87 (2022).

151 *Id.*

152 Paige Collings, *Victory! South Carolina Will Not Advance Bill That Banned Speaking About Abortions Online,* EFF (Aug. 26, 2022), https://www.eff.org/deeplinks/2022/08/victory-south-carolina-will-not-advance-bill-banned-speaking-about-abortions.

153 COHEN & JOFFE, *supra* note 15, at 39-43, 70-72.

abortion's link to infertility, breast cancer, and depression.[154] An online version of this model could do even more: purport to sell abortion pills, telling consumers that they are backordered but never sending them; sell fake pills, hoping to delay or thwart people from getting real pills; or use websites to entrap and report potential abortion patients, threatening criminal liability if an abortion is completed.[155] Delays and threats may be very effective: abortion pills are generally not recommended beyond the first trimester, potentially timing out abortion seekers, and the possibility of criminal liability will be a significant deterrent. People pretending to need abortions could also try to entrap the people delivering pills through informal networks. Some of these efforts could run afoul of consumer fraud and protection laws, but there is already serious concern about misinformation and sham or ineffective pill websites proliferating on the internet.[156]

In addition to misinformation, laws also will attempt to stop the supply chain of pills. The NRLC model bill, discussed above, recommends criminalizing the manufacture, sale, or distribution of abortion pills.[157] The specific model language, under the section header "Trafficking in Abortifacients Prohibited," bans these activities "when the person knows, or has reason to know, that a person to whom the person sells or distributes an abortifacient intends to use it to cause an abortion."[158] A bill pre-filed for the next legislative session in Missouri adopts this approach.[159]

This type of a provision, if enacted, could sweep in a wide variety of conduct. It would certainly constrain the activity of abortion pill manufacturers and pharmacists. Nothing on the face of the model law limits the text to illegal abortions, and even though abortion pill manufacturers are not intentionally sending pills into antiabortion states, those states will argue that manufacturers know that pills nevertheless enter state borders. The threat of potential liability could

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154 *Id.*

155 Greer Donley, Rachel Rebouché & David Cohen, *Abortion Pills Will Change a Post-Roe World*, N.Y. TIMES (June 23, 2022), https://www.nytimes.com/2022/06/23/opinion/abortion-pills-online-roe-v-wade.html.

156 Marcia Frellick, *More Illegal Sites Running Online Abortion Pill Scams*, WEBMD (Aug. 4, 2022), https://www.webmd.com/women/news/20220804/illegal-sites-running-online-abortion-pill-scams; Women on Waves, *Warning, Fake Abortion Pills for Sale Online!!*, https://www.womenonwaves.org/en/page/974/warning-fake-abortion-pills-for-sale-online; Wall Street Journal Podcasts, *The Booming, Unregulated Marketplace for Abortion Pills*, WALL. ST. J. (Aug. 30, 2022), https://www.wsj.com/podcasts/the-journal/the-booming-unregulated-marketplace-for-abortion-pills/86f05cb0-3861-4400-b04b-c1c5ea0125df.

157 Memorandum from James Bopp Jr., *supra* note 146, at 6-7.

158 *Id.* at 9, 14, 18-20.

159 HB163, Mo. Gen. Assemb., 102d Sess. (2022).

encourage the manufacturers and distributors of mifepristone and misoprostol to create controls to try to prevent pills from ending up in antiabortion states.[160] Combining these theories with a state's general aiding and abetting statute, this provision could also capture someone who tells a friend or family member about Aid Access or any pill distribution resource under the theory that the person is assisting with the distribution of pills. Under this theory, the Mississippi Attorney General subpoenaed documents from Mayday Health for allegedly aiding and abetting the distribution of abortion pills in the state.[161]

e. Criminalization

So far in the post-*Dobbs* landscape, the abortion bans that exist criminalize the behavior of abortion providers and, through general criminal aiding and abetting law, those who assist them. They do not apply to pregnant people who have abortions, though there have been proposals in state legislatures,[162] supported by some in the antiabortion movement, that punish pregnant people and those who help them is on the horizon.[163] But at present, there are only three states whose abortion laws criminalize a person who self-manages their own abortion—Oklahoma, South Carolina, and Nevada.[164]

Other criminal provisions, however, have been applied against at least sixty-one people since 2000.[165] Roughly three-quarters of these cases have been against the person procuring an abortion, and the other quarter against people helping them.[166] These cases

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[160] *See generally* In re: National Prescription Opiate Litigation, 589 F. Supp. 3d 790 (N.D. Ohio 2022) (litigation attempting to hold opioid manufacturers liable for intentionally dispensing drugs in a way that led to an oversupply into the illegal market).

[161] Yascha Mounk, *Why Freedom of Speech Is the Next Abortion Fight*, THE ATLANTIC (Aug. 22, 2022), https://www.theatlantic.com/ideas/archive/2022/08/freedom-speech-mississippi-abortion-rights/671202/.

[162] And in Texas, antiabortion activists have found a prosecutor who is looking for the perfect test case. Kitchener, *Conservatives Complain*, *supra* note 149.

[163] Rick Rojas & Tariro Mzezewa, *After Tense Debate, Louisiana Scraps Plan to Classify Abortion as Homicide*, N.Y. TIMES (May 12, 2022), https://www.nytimes.com/2022/05/12/us/louisiana-abortion-bill.html; The Daily, *The Effort to Punish Women for Having Abortions*, N.Y. TIMES (Aug. 23, 2022), https://www.nytimes.com/2022/08/23/podcasts/the-daily/abortion-abolition-roe-v-wade.html.

[164] NEV. REV. STAT. ANN. § 200.220; OKLA. STAT. ANN. § 1-733; S.C. CODE ANN. § 44-41-80(B).

[165] Laura Huss, Farah Diaz-Tello, & Goleen Samari, *Self-Care, Criminalized: August 2022 Preliminary Findings*, IF/WHEN/HOW, https://www.ifwhenhow.org/resources/self-care-criminalized-preliminary-findings/.

[166] *Id.* at 2.

disproportionately included women of color, and a majority were against people who used pills as their method of abortion.[167]

Discussed in greater depth in Part V, these non-abortion laws are statutes that prohibit feticide, child abuse, practicing medicine without a license, or desecrating a corpse.[168] The Alabama Attorney General, for instance, declared in January 2023 that, since the state's abortion law does not apply to the pregnant person, the state's chemical endangerment law could be used to prosecute people using abortion pills.[169] People who use pills later in pregnancy, often near or after viability, are particularly at risk of criminalization as some states have interpreted their child abuse laws to apply to any fetus after viability.[170] And though the pregnant person is typically excluded from abortion bans, prosecutors have nevertheless charged patients under abortion statutes.[171] And there is a long history of pregnant people accepting plea deals in cases that should never have been prosecuted.[172] Not only will women of color be disproportionately charged, their disempowerment and marginalization in the criminal justice system may make them vulnerable to accepting bad plea deals.

Prosecutions for the use of abortion pills, both in states where abortion remains legal and those where it is not, are likely to continue, and possibly increase.[173] With the risks of reporting from health care providers, intermeddlers, and digital surveillance,[174] some portion of people who obtain and/or use abortion pills in the post-*Dobbs* landscape will confront aggressive prosecutors who will try to use a variety of criminal laws to punish them. There are organized efforts to combat these prosecutions,[175] but not everyone charged will have access to these resources and legal help may be unsuccessful. It is hard to imagine a future in which more people are not in jail for abortion pill related crimes.

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167 *Id.*
168 *See infra* Section V.D.
169 Craig Monger, *'Self-Managed' Abortions Could Still Bring Criminal Prosecution Under Child Chemical Endangerment Laws*, 1819 NEWS (Jan. 10, 2023), https://1819news.com/news/item/self-managed-abortions-could-still-bring-criminal-prosecution-under-child-chemical-endagerment-laws.
170 *See, e.g.*, Whitner v. State, 492 S.E. 2d 777 (S.C. 1997).
171 Jolie McCullough, *After Pursuing an Indictment, Starr County District Attorney Drops Murder Charge Over Self-Induced Abortion*, TEX. TRIBUNE (Apr. 10, 2022), https://www.texastribune.org/2022/04/10/starr-county-murder-charge/.
172 *See, e.g.*, Commonwealth v. Dischman, 195 A.3d 567 (Pa. Super. Ct. 2018).
173 *See* Part V.D.
174 Elizabeth E. Joh, *Dobbs Online: Digital Rights as Abortion Rights*, *in* FEMINIST CYBERLAW (AMANDA LEVENDOWSKI & MEG LETA JONES, EDS., forthcoming 2023).
175 *Repro Defense Fund*, IF/WHEN/HOW, https://reprolegaldefensefund.org/.

The strategies detailed in this Part are not exhaustive. More creative attempts to ban abortion pills are on their way.[176] As Steven Aden, the chief legal officer and general counsel at Americans United for Life explained about pills, "From our discussions with state lawmakers and policy leaders, it's clear that this is the No. 1 issue for those who desire to protect life and women going into the 2023 state legislative sessions."[177] The battle over pills is of similar importance to those supporting abortion. The next part explores the prominent legal and practical means to increase access to abortion pills.

III. Promoting Pills

As Rebecca Gomperts, a Dutch doctor and the founder of Aid Access, said in the wake of *Roe* being overturned, "We will continue to serve women who need it. We're not going to stop."[178] Adopting a similar ethic, states are exploring ways to protect providers who ship pills to people in states that ban abortion. Some states will experiment with pharmacist prescription to mimic the benefits of over-the-counter abortion pills without running afoul of the FDA. And advocates are already considering taking advantage of possible loopholes in states' definitions of abortion to ship pills into antiabortion states for other uses, like menstrual regulation, or in advance of a pregnancy. We detail these strategies below.

a. Telehealth Rules

As noted, standard telehealth practice is to consider medical care to have occurred where the patient is located.[179] The provider must therefore be licensed to practice in the state where the patient is

[176] For instance, in November 2022, antiabortion activists signaled a very new strategy by petitioning the FDA to require all users of medication abortion to collect the products of conception in a medical waste bag and return it to providers for proper disposal, claiming that abortion pills were an environmental problem. Citizen Petition from Students for Life to FDA, Nov. 15, 2022, https://thisischemicalabortion.com/citizen-petition/.

[177] Rachel Roubein, *The Fight Over Medication Abortion Is Just Getting Started*, WASH. POST (Nov. 29, 2022), https://www.washingtonpost.com/politics/2022/11/29/fight-over-medication-abortion-is-just-getting-started/.

[178] David Ingram, *A Dutch Doctor and the Internet Are Making Sure Americans Have Access to Abortion Pills*, NBC NEWS (July 7, 2022), https://www.nbcnews.com/tech/tech-news/dutch-doctor-internet-are-making-sure-americans-access-abortion-pills-rcna35630.

[179] "A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located." *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine,* THE FEDERATION OF STATE MEDICAL BOARDS, https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf.

located and follow that state's laws.[180] Thus, a state with an abortion ban would consider a provider to have broken its laws (both an abortion ban and its medical licensing laws) if that provider used telehealth to provide abortion for a patient located in its state regardless of whether the provider was located in a state where abortion by telehealth is legal. The provider's abortion-supportive state might also view this conduct as practicing medicine without a license. This creates a significant barrier to a provider's willingness to provide abortion via telehealth and mail pills into states that ban abortion—the legal and professional risks are too high. As a result, states are considering ways to protect providers offering telehealth for abortion to out-of-state patients.

The first is through shield laws. Immediately before and after *Dobbs*, a number of states crafted laws or executive orders designed to shield their citizens from extraterritorial lawsuits and prosecutions related to abortion.[181] But Massachusetts is currently the only state that has specifically addressed the issue of cross-state telabortion by defining protected reproductive health care, within its shield law, as care provided "regardless of the patient's location."[182] This means that a Massachusetts provider, licensed and located in Massachusetts, might be covered by the state's shield protections when providing abortion care for a patient via telehealth no matter where the patient is located.[183] Legislators in other states, including New York and Vermont, have introduced legislation that follows this model. Importantly, the Massachusetts model does not change any aspect of state law with respect to the location of care.

Another option would be for a state to define explicitly the location of abortion care as where the provider physically is (rather than the patient), both in a shield law and in the state statutes governing abortion generally. Thus, the state from which the provider offers telehealth would not consider the provider to be practicing without a license or in violation of its own state's abortion laws when the provider treats patients who are in other states. This would not change

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[180] *Id.*

[181] *New Abortion Battleground*, *supra* note 18.

[182] Mass. Gen. Laws ch. 12, § 11.5(a).

[183] Massachusetts providers, under the shield law, still must comply with Massachusetts law and the relevant standard of care; the shield law does not cover an action against a provider if "a cause of action exists under the laws of the commonwealth if the course of conduct that forms the basis for liability had occurred entirely in the commonwealth, including any contract, tort, common law or statutory claims." Mass. Gen. Laws ch. 12, § 11.5(f). One interpretation is that if the provider does not have a license in the state where the patient is located, then that provider is acting contrary to Massachusetts licensure laws. Another interpretation, taken here, is that for the provision of protected reproductive health services, the relevant question is only whether the care complied with the state's abortion law (and the relevant standard of care assumed under that law).

how the *patient's* home state defines where care occurs. But if the provider was sued in a court in the *provider's* home state, that court could consider all the conduct—the provider's (in prescribing medication abortion) and the patient's (in accepting abortion care)—to have occurred in the provider's state.[184] No state has yet passed a provision of this sort, though New York has considered such a bill.[185]

To be clear, shifting the locale of care is a significant departure from the standard of care, provisions of state medical practice acts, and the guidance of professional organizations.[186] To take the medical practice acts, a typical act includes some version of this statement: "the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient."[187] And under a model medical practice act authored by the Federation of State Medical Boards, "a physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the [state medical board] should be deemed guilty of a felonious offense."[188] State medical boards, established and operating under state medical practice acts, are authorized to take disciplinary action against "practicing medicine in another state or jurisdiction without appropriate licensure."[189]

There are important reasons for defining care where the patient is—the state where the patient resides typically has the strongest interest and best means of protecting the safety of the resident patient.[190] Telehealth regulation has followed this standard in line with efforts to treat telehealth and in-person care the same, from how providers are reimbursed to how patient-physician relationships are formed. One way to mainstream and expand telehealth is to ensure

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[184] A conflict of laws can occur when the place of conduct—where provider operates from—differs from the place of purported injury—where the abortion occurs. Joseph William Singer, *Conflict of Abortion Laws* (draft on file with the authors).

[185] New York Senate Bill 1066-A, 2023-34 Regular Legislative Session, General Assembly, Jan. 9, 2023, https://legiscan.com/NY/bill/S01066/2023.

[186] Section 10(a) of the Uniform Telehealth Act locates care at the location of the patient, in accordance with the current practice, though it does not preclude states from later deciding to locate care elsewhere. Unif. Telehealth Act § 10(a) (Unif. L. Comm'n 2022).

[187] FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT, TENTH EDITION 4 (2003), https://www.medicallicensedirect.com/files/A_Guide_to_the_Essentials_of_a_Modern_Medical_Practice_Act.pdf

[188] *Id.* at 19.

[189] *Id.* at 11.

[190] American Medical Association, Support for Board Report 22-3: Report of the Federation of State Medical Boards (FSMB) Workgroup on Telemedicine: *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine* 1 (Apr. 21, 2022).

that states facilitate cross-border care. The assurance states receive for such recognition is that their residents' interests will be protected and out-of-state providers will be held accountable.[191]

Take for example interstate licensure compacts.[192] The Interstate Medical Licensure Compact (IMLC) was created by the Federation of State Medical Boards to offer physicians a streamlined, less cumbersome process to seek permission to practice outside their home states.[193] In fact, the impetus for the IMLC was the emergence and uptake of telehealth. About half the states in the country participate in the IMLC, and, to facilitate states enacting laws that encourage cross-border licensure, the IMLC assures member states that physicians subject to discipline in one state will be subject to discipline in another.[194] It also obligates member states to document and share health information.[195] The reasons for those assurances are, again, a state's interests in protecting its residents from negligence, fraud, or harm.[196]

Perhaps for these reasons, expanding shield laws to apply regardless of the location of the patient or shifting the location of patient care is a dramatic shift, and one unlikely to be adopted for other types of healthcare.[197] Professional organizations and medical boards in abortion-supportive states could carve out more explicit exceptions for abortion care given the increasing number of abortion travelers and the increasing need for telehealth for abortion after *Dobbs*.[198] One place

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[191] Singer, *supra* note 184, at 114.

[192] *See* Interstate Medical Licensure Compact Commission, Information Release, July 29, 2022, https://www.imlcc.org/wp-content/uploads/2022/06/IMLCC_Information-Release_June-29-2022_Physicians-licensed-in-multiple-states-1.pdf

[193] Interstate Medical Licensure Compact Commission, *Who Developed the Compact?*, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/#WhoDevelopedTheCompact.

[194] Interstate Medical Licensure Compact Commission, *Rule on Coordinated Information System, Joint Investigations and Disciplinary Actions*, Adopted Nov. 16, 2018, Amended Nov. 8, 2022, https://www.imlcc.org/wp-content/uploads/2022/11/IMLCC-Rule-Chapter-6-Coordinated-Information-System-Joint-Investigations-and-Disciplinary-Actions-Adopted-November-16-2018-Amended-11-8-2022.pdf.

[195] Federation of State Medical Boards, *supra* note 190, at 2.

[196] *Id.*

[197] Massachusetts' shield law also applies to gender-affirming care. Mass. Gen. Laws ch. 12, § 11.5(a).

[198] The Uniform Telehealth Act seeks, as far as possible, to put telehealth on par with in-person care. In so doing, it applies the rules of the patient's, not the provider's, home state. Unif. Telehealth Act § 5 cmt. (Unif. L. Comm'n 2022) ("Out-of-state practitioners must be mindful . . . that … any requirements with respect to the delivery of health care within this state will apply, including . . . limitations on the prescription of controlled substances."). Arguably, abortion provision lawful in the provider's home state could be an exception to this rule, though it would contradict the established practice.

to do that is in licensure laws, making clear that providers in states who provide telabortion to out-of-state patients are practicing within the scope of their medical licenses so long as they comply with the standard of care and the laws of their home state.[199] The sheer complexity of interstate abortion conflicts on the horizon, which are arguably unique, as well as the health consequences of unwanted pregnancies being carried to term, militate for treating abortion differently post-*Dobbs*.[200]

b. Missed Period Pills & Advanced Provision

Another strategy to increase access to abortion pills involves prescribing them without a known pregnancy. As discussed in greater depth in Part V, almost all abortion bans require the intent to terminate a pregnancy, often times a "known pregnancy."[201] This intent element is crucial because abortion pills are prescribed for a variety of uses—miscarriage care, Cushings Syndrome, labor induction.[202] But it also exposes a loophole—can providers prescribe the pills without intent to end a pregnancy because there is no *known* pregnancy?

Missed period pills involve prescribing the same drugs used for medication abortion but without a pregnancy test and with the intent to induce a period, not to provide an abortion.[203] This practice is also called menstrual regulation and has been practiced for centuries. Before home pregnancy tests were available in the late 1970s, it could take months after a missed period for a person to know she was pregnant.[204] After all, missed periods happen for all sorts of reasons: illness, stress, malnutrition, and irregular cycles. And miscarriages

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[199] The Federation of State Medical Boards affirms that physicians must be licensed in the state where the patient is located, though, in 2022 advice, notes exceptions to promote continuity of care, allow patients to obtain an initial consultation through physician-to-physician consultations, or allow prospective patient screening by a specialist. Federation of State Medical Boards, *supra* note 190, at 4-5.

[200] We recognize, of course, that abortion exceptionalism has historically created more burdens for abortion access. *See generally* Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047 (2014). Nonetheless, given the post-*Dobbs* crisis for access, we believe treating abortion different in the way described in this section would be beneficial to facilitating access in the current environment.

[201] *See* David S. Cohen, Greer Donley, & Rachel Rebouché, *50-State Survey of Abortion Definitions* (on file with authors) [hereinafter "*50-State Survey*"].

[202] *See* Brittni Frederiksen et al., *Abortion Bans May Limit Essential Medications for Women with Chronic Conditions*, KFF (Nov. 17, 2022), https://www.kff.org/womens-health-policy/issue-brief/abortion-bans-may-limit-essential-medications-for-women-with-chronic-conditions/.

[203] *See* Wendy R. Sheldon et al., *Exploring Potential Interest in Missed Period Pills in Two US States*, 102 CONTRACEPTION 414 (2020).

[204] Andrea Tone, *Medicalizing Reproduction: The Pill and Home Pregnancy Tests*, 49 J. SEX RESEARCH 319 (2012).

occur in up to 25% of pregnancies—people frequently never know if a late period was actually an early miscarriage.[205] As a result, historically, even when abortion was illegal in the century before *Roe*, products of "menstrual regulation" were sold openly.[206]

Menstrual regulation, however, is not a bygone practice. Though home pregnancy tests exist that can quickly and cheaply diagnose a pregnancy, other countries have allowed menstrual regulation alongside abortion bans. For instance, in Bangladesh, abortion is illegal except to save a pregnant person's life, but menstrual regulation with medication is permitted through nine weeks from a person's last period.[207] Missed period pills could provide a similar option in the United States because state laws that ban the intentional ending of a pregnancy would not apply if the provider intended to induce a period, not terminate a pregnancy, and never tested or confirmed whether the patient was pregnant.[208] Though period pills are primarily being offered in research protocols in states that permit abortion, they could also become a mechanism to evade abortion bans in a post-*Roe* environment, absent changes to state's abortion definitions (discussed in Part IV below).[209]

A similar strategy that is further along in development is advanced provision of abortion pills. Abortion pills are prescribed to end pregnancy but for future use, before someone knows or thinks they might be pregnant.[210] If an unintentional pregnancy arises in the future, the person would have the pills in their medicine cabinet. Already, many abortion providers, including Aid Access, have started offering advanced provision.[211] Advanced provision has many benefits, but it will only evade abortion bans that require a known (or knowable) pregnancy at the time of the provider's interaction with the patient. Twenty-one state abortion laws require a provider to know a woman is pregnant.[212] In the remaining states, however, the intent element may be met because the pills are prescribed to terminate a future pregnancy.

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[205] Greer Donley & Jill Wieber Lens, *Abortion, Pregnancy Loss & Subjective Fetal Personhood*, 75 VAND. L. REV. 1649, 1687 (2022).
[206] *Id.*
[207] Susheela Singh et al., *The Incidence of Menstrual Regulation Procedures and Abortion in Bangladesh*, 43 INT'L PERSPS. SEX. & REPRO. HEALTH 1 (2017).
[208] Studies suggest that some patients prefer taking pills with the intent to induce a period without having to learn if they are pregnant. Wendy R. Sheldon et al., *Exploring Potential Interest in Missed Period Pills in Two US States*, 102 CONTRACEPTION 414 (2020); *see also A Little Bit Pregnant*, INVISIBILIA PODCAST, https://www.npr.org/programs/invisibilia/1122473567/a-little-bit-pregnant.
[209] *Providers*, THE PERIOD PILLS PROJECT, https://www.periodpills.org/providers.
[210] Katherine Ehrenreich, M. Antonia Biggs, & Daniel Grossman, *Making the Case for Advance Provision of Mifepristone and Misoprostol for Abortion in the United States*, 48 BMJ SEXUAL & REPRO. HEALTH 238 (2022).
[211] *Id.*
[212] *See 50-State Survey*, *supra* note 201.

There are downsides to advanced provision. Prescriptions expire, which can reduce efficacy if taken past the expiration date, and the medications not used are wasted at a time when abortion pills are in high demand. Moreover, any counseling the patient received could be forgotten by the time the pills are needed. For these reasons, many providers are uncomfortable prescribing in advance, especially for a condition (unwanted pregnancy) that may never arise. Nevertheless, advanced provision, like missed period pills, is another method of expanding the reach of abortion pills.

c. Pharmacist Prescribing

Beyond strategies to get pills into antiabortion states, medication abortion could become easier to access in states that support abortion rights. This would not only help in-state patients, but also ease the burdens of patients traveling into abortion supportive states for pills. The federal drug regulatory scheme, which preempts state law, leaves little leeway in how states can veer from federal policy in regulating drugs. But there is at least one way that abortion-supportive states could push the boundaries: pharmacist prescribing.

Pharmacist prescribing is a tool states can use to obtain many of the benefits of moving a drug over the counter (OTC) without waiting for the FDA to approve the OTC switch. Without the FDA's OTC approval for a drug, it cannot be sold without a prescription.[213] Obtaining FDA approval for OTC use typically requires a showing that consumers can safely and effectively use a drug without the help of a provider.[214] (Advocates want to move abortion pills OTC, but this is a long-term goal that will first involve removing intermediate barriers, like the mifepristone REMS.[215]) Though states cannot circumvent the FDA and allow a drug to be sold OTC, they can allow pharmacists to prescribe the drug.[216] States have general police powers to control the practice of medicine in their states, including what types

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[213] *Prescription-to-Nonprescription (Rx-to-OTC) Switches*, U.S. FOOD & DRUG ADMIN. (June 28, 2022), https://www.fda.gov/drugs/drug-application-process-nonprescription-drugs/prescription-nonprescription-rx-otc-switches.

[214] *Id.*

[215] Mifepristone certainly will not be approved for OTC use when it is still deemed by the agency to be risky enough to need extra controls through its REMS program. *See* discussion *supra* Section I. The first step in a long-term push for OTC abortion pills would thus be to remove the REMS. It is also worth noting that the agency still has not approved birth control for OTC use, and the courts had to demand the agency approve emergency contraception for OTC use because the agency refused to do so itself. In other words, this uphill battle will take time.

[216] *See, e.g.,* Ned Milenkovich, *Pharmacist Prescribing: Road Less Traveled Is Getting Busier*, 88 PHARMACY TIMES 6 (2022); .

of providers can prescribe what types of drugs.[217] Of course, this would not be a possibility in the twenty-nine states that only permit physicians to offer medication abortion.[218]

Pharmacists typically do not have the power to prescribe, but states have been increasingly granting them this power for some products, including vaccines, opioid antagonists, and time-sensitive COVID-19 treatments.[219] But the most relevant example is birth control. Advocates have long argued that the FDA should approve birth control for OTC use, but while the agency has delayed those requests, many states have passed laws that allow pharmacists to prescribe some or all forms of FDA-approved birth control.[220] Twenty-four states now allow this in some capacity.[221]

Making this change does not violate federal law because patients can still access the medication only with a prescription from a provider—in this case, a pharmacist. But when a pharmacist is the provider, patients do not schedule an independent appointment with a doctor; instead, they can go to a neighborhood pharmacy, talk to the pharmacist about birth control, and pick up the prescription and medication at the same visit.[222] Permitting pharmacist prescribing for abortion pills would be safe as well, as there is ample data from both the United States and abroad demonstrating that medication abortion can be safely and effectively used without any provider (and in this case, the pharmacist is the provider).[223] In order to create this power, states could enact legislation or modify regulations establishing statewide protocols for pharmacists or allowing collaborative practice agreements. The former is more permissive, as it outlines the conditions under which all pharmacists can prescribe a medication.[224] The latter is less permissive because it empowers only those pharmacists who have entered into an agreement with a prescriber who

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[217] *Id.*
[218] *Medication Abortion,* GUTTMACHER INST. (Jan 1, 2023), https://www.guttmacher.org/state-policy/explore/medication-abortion.
[219] Milenkovich, *supra* note 216.
[220] *Beyond the Beltway*, POWER TO DECIDE 1, 3-7 (2022), https://powertodecide.org/sites/default/files/2022-03/Pharmacist%20Prescribing.pdf.
[221] *Id.*
[222] *Id.*
[223] *See e.g.,* Abigail Aiken et al., *Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine In The United States: A Population Based Study*, LANCET REG'L HEALTH, Feb. 17, 2022; *See also* Moseson, *supra* note 65.
[223] Moseson et al, *supra* note 65.
[224] *See* Alex J. Adams & Krystalyn K. Weaver, *The Continuum of Pharmacist Prescriptive Authority*, 50 ANNALS OF PHARMACOTHERAPY 778, 780-81 (2016).

effectively serves as a supervisor.[225] Most states used statewide protocols for birth control.[226]

Pharmacist prescribing could have many benefits. For one, it could reduce the strain on abortion providers in abortion-supportive states.[227] Clinics in some of the states that border antiabortion states now face weeks-long wait times due to the influx of interstate abortion patients,[228] so increasing the options for patients in those states is essential to providing timely care for everyone needing it. It could also help abortion travelers access abortion medication more quickly by allowing them to drive to the closest participating pharmacy over the border and get the medication the same day, rather than needing to find an appointment at an overburdened clinic or resort to mail forwarding.

This strategy, however, faces challenges. First, unlike birth control, which is on the market without a REMS, mifepristone cannot be prescribed or dispensed outside of the REMS program. Theoretically, a pharmacist could comply with a REMS as any other healthcare provider—indeed, in 2016 the FDA removed a requirement that only physicians can become certified to prescribe mifepristone.[229] To become certified, a provider must attest that they can: (1) assess the duration of a pregnancy; (2) diagnose ectopic pregnancies; and (3) provide (or have a plan in place for others to provide) emergency medical care, to the extent it is needed.[230]

Though this might initially sound outside of a pharmacist's purview, many healthcare providers, including ophthalmologists and radiologists, who do not have direct expertise in any of these areas have become certified to prescribe mifepristone.[231] The first condition can be met by asking patients about their last missed period and calculating the gestational age.[232] The second condition is met by asking patients standard questions about whether they have experienced the

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225 *Id.*
226 *Beyond the Beltway, supra* note 220.
227 We first suggested this as a strategy here: Rachel Rebouché, David S. Cohen & Greer Donley *The Coming Legal Battles Over Abortion Pills*, POLITICO (May 24, 2022), https://www.politico.com/news/magazine/2022/05/24/coming-legal-battles-abortion-pills-00034558.
228 *See e.g.,* Margot Sanger-Katz, *Interstate Abortion Travel Is Already Straining Parts of the System*, N.Y. TIMES (July 23, 2022), https://www.nytimes.com/2022/07/23/upshot/abortion-interstate-travel-appointments.html.
229 Donley*, supra* note 13, at 641.
230 REMS, *supra* note 34.
231 Donley, *supra* note 13, at 654.
232 *See e.g.*, Ushma D. Upadhyay, *Outcomes and Safety of History-Based Screening for Medication Abortion a Retrospective Multicenter Cohort Study*, 182 JAMA INTERNAL MEDICINE 482 (2022).

symptoms of ectopic pregnancy.[233] Before the COVID-19 pandemic, it was common for providers to conduct ultrasounds to date the pregnancy and rule out ectopic pregnancy, but that is no longer the standard of care for medication abortion unless the patient is unsure of her last missed period or experiencing symptoms of ectopic pregnancy.[234] As to the third condition, abortion providers have long relied on emergency rooms to provide the very rarely needed emergency care, and pharmacists could do the same.[235] There is, of course, a significant difference for pharmacists: unlike licensed physicians, they are not accustomed to diagnosing or treating patients.

Second, even though a pharmacist could become certified to prescribe mifepristone if the states granted them prescribing powers, the REMS imposes another requirement: pharmacy certification. In January 2023, the FDA announced that for pharmacies to become certified to dispense mifepristone, they would need to institute protocols for tracking shipments, keeping records, reporting certain adverse events, and maintaining provider confidentiality.[236] Certification also requires the pharmacy to designate a representative in charge of certification and compliance.[237] This strategy depends on brick-and-mortar pharmacies' willingness to jump through the hoops of certification—if a pharmacy is not certified to dispense, then it is irrelevant if the pharmacist is certified to prescribe. At the time of writing, pharmacy chains such as CVS and Walgreens have announced plans to seek certification and to carry medication abortion at certain locations.[238]

Abortion-supportive states could also allow pharmacists to prescribe misoprostol-only medication abortions. Because misoprostol was initially approved to treat ulcers, and is on the market without a REMS, pharmacists could prescribe it like birth control, if states permit it. And like with birth control, there are tools available to screen out patients with higher risk factors.[239] However, one concern with misoprostol-only pharmacy prescriptions is that pharmacists would be prescribing for an off-label use. There is precedent for this: emergency

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[233] *Id.*
[234] *Id.*
[235] *See* Response Letter from FDA CDER to American Association of Pro-Life Obstetricians and Gynecologists and American College of Pediatricians, FOOD & DRUG ADMIN. (Dec. 17, 2021), https://www.regulations.gov/document/FDA-2019-P-1534-0016.
[236] *See* REMS, *supra* note 34.
[237] *Id.*
[238] Pam Belluck, *CVS and Walgreens Plan to Offer Abortion Pills Where Abortion is Legal*, N.Y. TIMES (Jan. 5, 2023), https://www.nytimes.com/2023/01/05/health/abortion-pills-cvs-walgreens.html.
[239] Thoai Ngo, *To Protect Access to Medication Abortion in the US, Make the Misoprostol-Only Regimen a Reality*, HEALTH AFFAIRS, Sept. 23, 2022.

contraception.[240] Before there was a dedicated emergency contraceptive product, research had shown that regular birth control pills could be used off label to delay ovulation and prevent pregnancy.[241] Advocates in Washington state worked on getting pharmacists the power to prescribe repackaged birth control products off label and distribute them to patients under a collaborative agreement.[242] They eventually succeeded a year before Plan B entered the market.[243] If states gave pharmacists prescribing power for mifepristone and misoprostol, in combination or alone, under conditions specified, this could open the door for misoprostol-only abortions directly through a pharmacy.[244] This would mirror the experience of other countries, where misoprostol is sold over the counter purportedly for ulcers but used to induce an abortion.[245]

Third, other barriers related to reproductive health care would remain. For instance, individual pharmacists may refuse to prescribe, making it harder for patients to find a pharmacist willing to dispense.[246] Willing pharmacists might face difficulties securing reimbursement for their time.[247] Moreover, they would be subject to all of a state's abortion laws, which could be a significant deterrent in many places. And some pharmacists, who have never been abortion providers previously, might lack the sensitivity that patients would find at clinics or be unable to provide the privacy that patients may desire.

Even with these caveats and limitations, pharmacist prescription of abortion pills would be a novel way for abortion-supportive states to increase abortion access. This, and the other strategies described in this part, are state strategies that push the boundaries of how medication abortion is delivered and defined. The

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[240] There is also (unsettling) recent precedent: after the FDA refused to approve ivermectin to treat COVID-19—the drug was already on the market to treat parasites—Tennessee passed a law allowing pharmacists to prescribe it, presumably for any use, intending them to prescribe it for COVID. Blake Farmer, *Tennessee Will Make Ivermectin Available Without a Prescription, Despite Research Showing No Benefit For COVID Treatment*, WPLN NEWS (Apr. 7, 2022), https://wpln.org/post/tennessee-to-make-ivermectin-available-without-a-prescription-despite-research-showing-no-benefit-for-covid-treatment/.

[241] Coeytaux & Wells, *supra* note 66, at 8-9.

[242] *Id.*

[243] *Id.*

[244] Some states require providers to follow the FDA label for abortion drugs.

[245] *See, e.g.*, Deborah L. Billings et al., *Pharmacy Worker Practices Related to Use of Misoprostol for Abortion in One Mexican State*, 79 CONTRACEPTION 445 (2009); S.H. Costa, *Commercial Availability of Misoprostol and Induced Abortion in Brazil*, 63 INT'L J. GYN. & OBST. S131 (1998).

[246] Holly Teliska, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER, L., JUSTICE 229 (2005)

[247] Erin N. Deja et al., *Pharmacists Prescribing Birth Control: Improving Access and Advancing the Profession*, 82 PHARMACY TIMES 1, 2-3 (2016).

next Part assesses potential interventions of the federal government, through the FDA, in expanding or restricting the availability of medication abortion.

IV. The Food & Drug Administration: The Politics of Pills

The federal government has its own role to play—and that role may change depending on the President. The Biden Administration has attempted to use executive power to mitigate some of the *Dobbs* damage.[248] The agency with the most power over abortion medication—the FDA—has so far acted conservatively, opting for characteristically slow and incremental change. Nonetheless, we discuss how the FDA could impact abortion pill access by altering the mifepristone REMS and the mifepristone label. We also discuss the FDA's role in asserting a preemption argument to blunt state abortion bans.

At the outset, however, we note that though the agency will face pressure for more dramatic changes—like to revoke its approval of abortion pills under a Republican president or to make them over the counter (OTC) under a Democrat—these are unlikely changes in the near future. Before the FDA can remove a product from the market, the agency bears the burden of proving that the drug's risks outweigh its benefits, which is the inverted burden drug sponsors bear in obtaining FDA approval.[249] This burden would be difficult to meet given the extensive research supporting the safety and efficacy of abortion pills.[250] The reality is that the FDA only removes drugs from the market in the rarest of circumstances, and is required by statute to first hold a formal hearing and make a scientific finding, which can be appealed to the Commissioner and the federal courts.[251] Rather, almost all drug recalls are achieved by the agency pressuring the drug sponsor, which is often a repeat player before the FDA with incentives to

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[248] *See generally New Abortion Battleground*, *supra* note 18, at 52-80.

[249] 21 U.S.C. § 355(e)

[250] *See* Eli Y. Adashi, I Glenn Cohen, et al., *The Next Two Decades of Mifepristone at FDA: History as Destiny*, 109 CONTRACEPTION 1, 6 (2022) (describing how Congress could pressure the FDA to remove mifepristone from the market). The litigation unfolding in Texas is designed to undermine mifepristone's safety record and to cast doubt on prior FDA decision-making, perhaps in anticipation of an FDA under different leadership. But still, it does not present evidence that could come close to meeting this burden.

[251] *See* 21 U.S.C. § 355(e)(1)–(3).*See generally* Agnes Vitry et al., *Regulatory Withdrawal of Medicines Marketed with Uncertain Benefits: The Bevacizumab Case Study*, 8 J. PHARMACEUTICAL POLICY & PRACTICE 1 (2015) (describing the "hotly contested" FDA decision to remove an indication from the label of a popular cancer drug—one of the rare examples in recent memory).

acquiesce, to remove the product from the market *voluntarily*.[252] Of course, a voluntary removal of mifepristone or misoprostol is unlikely in this climate.

Similarly, as noted above, an OTC switch is unlikely because the mifepristone REMS would first need to be released—a big battle of its own—followed by a period of time with the drugs on the market without a REMS. Thus, this Part focuses on the more realistic tools for the agency to alter the accessibility of abortion pills.

a. Mifepristone REMS

Since the FDA approved mifepristone in 2000,[253] it has imposed distribution limitations, originally under Subpart H, but later, under a REMS.[254] As explained in more detail in Section I above, the FDA's current REMS includes a Patient Agreement Form, provider certification, and a new element: pharmacy certification. Pharmacy certification replaces the in-person dispensing requirement, which had barred pharmacies from dispensing the drug and forced patients to pick up medication abortion at a healthcare facility.[255] Though removing the in-person dispensing requirement was an important step forward, the agency did not need to replace it with pharmacy certification. Without certification, licensed pharmacies would have been able to dispense mifepristone like most prescription drugs.[256]

In recent years, the medical community has called for the agency to remove the REMS, with every major medical organization agreeing that it is unnecessary and harmful.[257] But due to the COVID-19 pandemic, most of the attention has been focused on removing the in-person dispensing requirement and allowing abortion by telehealth with mailed pills.[258] In 2021, the FDA announced that it would review the entire mifepristone REMS, concluding in December 2021 that it must be maintained, but modified to remove the in-person dispensing requirement.[259] In January 2023, the FDA formalized its decision and released the new REMS documents, but this is far from the last time it

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[252] *See* FDA Urges Companies to be 'Recall Ready' to Protect Public Health as Part of Final Guidance for Voluntary Recalls, FOOD & DRUG ADMIN. (March 3, 2022), https://www.fda.gov/news-events/press-announcements/fda-urges-companies-be-recall-ready-protect-public-health-part-final-guidance-voluntary-recalls.
[253] *See generally* Donley, *supra* note 13.
[254] *Id.* at 639-40.
[255] *Id.*
[256] *Id.* at 643-48.
[257] *Id.* at 651; Julia Kaye, Rachel Reeves, & Lorie Chaiten, *The Mifepristone REMS: A Needless and Unlawful Barrier to Care*, 104 CONTRACEPTION 12 (2021).
[258] *Id.*
[259] *See* Letter to Am. Ass'n of Pro-Life Obstetricians and Gynecologists, *supra* note 235.

will be asked to reconsider the REMS. Importantly, the agency is duty bound to respond to sponsor requests through a process known as an sNDA (Supplemental New Drug Application) to amend the REMS.[260] And now that the previous review has been concluded, another sNDA could begin the next battle of trying to remove other aspects of the REMS. Removing the REMS would be the easiest way for the federal government to expand abortion access, as it is squarely within the agency's expertise and fully consistent with its statutory mandate and the scientific evidence.[261]

If the FDA removed the REMS, the effects would be limited to states that permit abortion (unless the preemption argument described below is successful).[262] But in those states, people would be able to get a prescription for abortion pills from any provider that complies with the state's abortion requirements—their OB, primary care provider, or a new provider—and pick up their prescription at any pharmacy.[263] Removing the REMS also would help mainstream and de-stigmatize abortion provision in abortion supportive states.[264] Moreover, removing restrictions will help abortion travelers by increasing the number of providers in abortion-supportive states and reducing wait times.[265] If average pharmacies start dispensing pills, then it might make it easier for patients to use telehealth and pick up the pills at the pharmacy, instead of relying on temporary addresses and mail forwarding.

On the other hand, an administration opposed to abortion rights could strengthen or add to the REMS, making mifepristone harder to access. The agency might try to reinstate the in-person dispensing requirement, in effect banning telabortion nationwide. Or it could also require patients to ingest each medication in person, meaning patients must be physically present multiple times to access medication abortion, which the original mifepristone REMS required before the FDA modified it in 2016.[266] Advocates could also push new elements as well, such as requiring medical waste from the abortion be disposed of consistent with certain protocols—the subject of a recent Citizen's Petition.[267] These efforts, if successful, would have the effect

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[260] *Step 4: FDA Drug Review*, U.S. FOOD & DRUG ADMIN. (Jan. 4, 2018), https://www.fda.gov/patients/drug-development-process/step-4-fda-drug-review.
[261] Donley, *supra* note 13, at 663-67.
[262] *New Abortion Battleground*, *supra* note 18, at 53-71.
[263] *Id.*
[264] In states that permit abortion, ninety-five percent of abortions occur in abortion clinics. *Id.* at 630.
[265] *New Abortion Battleground*, *supra* note 18, at 10-11; Donley, *supra* note 13, at 695.
[266] Donley, *supra* note 13, at 641.
[267] Alice Ollstein, *The Next Abortion Fight Could Be Over Wastewater Regulation*, POLITICO, https://www.politico.com/news/2022/11/23/abortion-pills-opponents-environmental-laws-00070603.

of constricting abortion access throughout the whole country, with the primary effect felt in the states that have not banned abortion.

Though certainly any action on the mifepristone REMS sets the agency up for accusations of playing politics and would be subject to legal challenge, releasing the REMS is in line with decades of research showing that mifepristone does not need a REMS to be prescribed and dispensed safely.[268] Indeed, in light of this research, imposing additional restrictions under the REMS could be invalid as arbitrary and capricious action under the Administrative Procedure Act.[269] And imposing additional REMS would constrain abortion nationwide, making the agency vulnerable to claims that it is interfering with a state's ability to set its own abortion policy; lifting the REMS would, in contrast, have an impact only in states that permit abortion and would be consistent with those states' abortion policies.

b. Changing the Mifepristone Label

In addition to removing the mifepristone REMS, the FDA could change the drug's label. For instance, in 2016, the agency recognized the extensive data showing that medication abortion was safe and effective through ten weeks of pregnancy, beyond the previously approved seven weeks.[270] As a result, the drug's label was modified to approve the product through ten weeks.[271] Advocates on both sides of the abortion question have been promoting arguments that medication abortion's label should be modified—either to extend or limit the gestational age.

Extensive evidence shows that medication abortion is safe and effective through twelve weeks and even beyond.[272] For instance, the World Health Organization has concluded that "[e]vidence has demonstrated that in gestational ages less than 12 weeks, pregnant persons can safely and effectively manage their own medical abortions using mifepristone and misoprostol in combination or misoprostol alone."[273] The WHO recommends the same abortion protocol for

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[268] Donley, *supra* note 13, at 651.
[269] *See generally id.* at 684-89.
[270] *Id.* at 641.
[271] *Id.*
[272] *Medical Management of Abortion*, *supra* note 5, at 26-30 (describing the studies relied on by the WHO to expand the recommended medication abortion protocol through twelve weeks gestation).
[273] *WHO Recommendations on Self-Care Interventions, Self-Management of Medical Abortion*, World Health Org (2022 Revision), https://apps.who.int/iris/bitstream/handle/10665/332334/WHO-SRH-20.11-eng.pdf.

anyone ending a pregnancy twelve weeks or less.[274] In reliance on this recommendation, some providers in the United States have started prescribing medication abortion off-label through eleven or twelve weeks.[275] Other organizations have a separate protocol with slightly higher doses for terminations between 10-13 weeks.[276] (Though people can and do self-manage abortions in the second trimester with medication, it is less effective and carries higher risks as the pregnancy progresses.[277])

The sponsor of mifepristone could submit an sNDA to modify the drug's approval through twelve or thirteen weeks, which would require the FDA to respond within six to ten months.[278] If the FDA were to approve the medication abortion regimen for additional weeks, it would make abortion cheaper and more accessible for people needing abortions in that timeframe. Most providers prescribe to the current label, requiring many patients to obtain a procedural abortion after ten weeks. Procedural abortions require patients to travel to brick-and-mortar clinics, which can be more expensive, legally risky, and logistically difficult.[279] Due to the weeks-long wait times that have become common in a post-*Dobbs* America, many people are not able to access abortion in the first ten weeks.[280]

Alternatively, an antiabortion administration could attempt to shrink the approved use of medication abortion. For instance, in a 2019 Citizen's Petition that was ultimately rejected in 2021, the American Association of Pro-Life Obstetricians and Gynecologists requested that the agency revert to the seven-week approval period; Students United for Life made a similar request in 2022 that the agency rejected in 2023.[281] Though off-label prescribing mitigates some of the concerns of label changes, a label change can nevertheless impact prescribing practices due to fears about liability and reimbursement.

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[274] *Id.*

[275] Many providers offer medication abortion through eleven weeks: Juniper, Forward Midwifery, Pills by Post, and Lilith Care. Only one offers medication abortion through twelve weeks: Abortion Telemedicine.

[276] *Mifepristone and misoprostol: Recommended regimen*, IPAS PARTNERS FOR REPRODUCTIVE JUSTICE (Feb. 7, 2021), https://www.ipas.org/clinical-update/english/recommendations-for-abortion-before-13-weeks-gestation/medical-abortion/mifepristone-and-misoprostol-recommended-regimen/.

[277] *See e.g.,* Moseson*, supra* note 65 (concluding that the efficacy of second trimester, self-managed abortion was around 75% with at least 12% needing a procedure to complete the abortion).

[278] *Step 4: FDA Drug Review*, *supra* note 260.

[279] *New Abortion Battleground*, *supra* note 18, at 15.

[280] *Id.*

[281] *Final Response from FDA CDER to Students for Life of America*, FOOD & DRUG ADMIN. (Jan 24, 2023), https://www.regulations.gov/document/FDA-2022-P-3209-0003, *supra* note 235.

Most people do not discover an unintended pregnancy until around week six, after which it takes time to decide and schedule an appointment if chosen. This label change would, as a result, make it harder for people to access medication abortion in this timeframe, forcing people back into clinics for procedural care and increasing the costs and burdens of abortion. Just as was the case with strengthening the REMS, this decision would be highly controversial and subject to an arbitrary and capricious challenge under the Administrative Procedure Act on the grounds that it had no scientific basis.[282]

Finally, the mifepristone label could also be modified to add new indications. For instance, in 2022, over fifty medical organizations submitted a Citizen's Petition requesting that the FDA work with the mifepristone sponsor to add miscarriage management to the drug's label.[283] Though adding miscarriage management to the mifepristone label will not have a direct impact on abortion access, it can play an important role in destigmatizing the medication and thwarting state abortion bans that might otherwise target mifepristone. For instance, a handful of states last legislative term introduced bills that would ban mifepristone entirely.[284] This would be much harder if mifepristone is approved for multiple uses.[285]

c. Preemption

As we have explained elsewhere, FDA regulation of mifepristone should preempt state abortion bans to the extent they ban the sale and distribution of abortion pills.[286] The Constitution's Supremacy Clause demands that federal law trump state law when the two conflict. However, absent an explicit preemption statement from Congress, determining when there is a true conflict can be complicated. In the case of FDA's regulation of drugs—where Congress was silent on preemption—the question is whether a state can overregulate or ban a drug the FDA has approved, especially one that has been regulated under a REMS, like medication abortion.[287] If not, the implications could be enormous: every state's abortion ban

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[282] *See generally* Donley, *supra* note 13, at 684-86.
[283] Citizen Petition from Am. Coll. of Obstetricians and Gynecologists on a Supplemental New Drug Application to Add Miscarriage Mgmt. to the Drug's Label (Oct. 4, 2022), https://emaaproject.org/wp-content/uploads/2022/10/Citizen-Petition-from-the-American-College-of-Obstetrician-and-Gynecologists-et-al-10.3.22-EMAA-website.pdf
[284] *Id.*
[285] OLC Memo, *supra* note 125.
[286] *New Abortion Battleground supra* note 18, at 43-67; *see also* I. Glenn Cohen, Melissa Murray, & Lawrence Gostin, *The End of* Roe v. Wade *and New Legal Frontiers on the Constitutional Right to Abortion*, 328 JAMA 325 (2022).
[287] *New Abortion Battleground*, *supra* note 18, at 45.

would have to include an exception for medication abortion that is prescribed and dispensed according to the FDA's REMS.

Since we first made this argument, the Biden Administration has signaled interest in the theory. The day that *Roe v. Wade* was overturned, Attorney General Merrick Garland announced that "the FDA has approved the use of the medication Mifepristone. States may not ban Mifepristone based on disagreement with the FDA's expert judgment about its safety and efficacy."[288] The Department of Health and Human Services reiterated this statement and said that it was working with the Department of Justice "to help ensure access to care and preserve FDA's role in determining what is safe and effective for patients."[289] This statement was issued in a report outlining the agency's response to the *Dobbs* decision in a section titled, "Federal Preemption—Protecting Access to Medication Abortion."[290]

In January 2023, the first post-*Dobbs* preemption lawsuits were filed.[291] The mifepristone drug manufacturer, GenBioPro, challenged West Virginia's general abortion ban.[292] On the same day, an abortion provider challenged North Carolina's laws, which permit abortion, but burden medication abortion provision by requiring only physicians to prescribe mifepristone, pills be dispensed in person at a surgical facility, and another layer of informed consent.[293] These cases represent two different threads of preemption theory—challenges to general abortion bans and challenges to health laws that regulate medication abortion differently than the FDA.[294] The West Virginia lawsuit has the potential to be much more significant, as a win could create an exception for mifepristone in state abortion bans. In many ways, it is the inverse of the litigation in Texas seeking to remove mifepristone from the market nationwide. The North Carolina litigation could have important effects in the few states that overregulate, but do not ban, abortion, but will likely only impact those handful of states.

One of the principal questions surrounding any such litigation is whether the FDA will or should get involved. The agency could do

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[288] Press Release, U.S. Dep't of Just., Attorney General Merrick B. Garland Statement on Supreme Court Ruling in Dobbs v. Jackson Women's Health Organization (June 24, 2022), https://www.justice.gov/opa/pr/attorney-general-merrick-b-garland-statement-supreme-court-ruling-dobbs-v-jackson-women-s.

[289] U.S. DEP'T OF HEALTH AND HUM. SERV., HEALTH CARE UNDER ATTACK: AN ACTION PLAN TO PROTECT AND STRENGTHEN REPRODUCTIVE CARE, at 7 (2022).

[290] *Id.*

[291] In 2020, GenBioPro sued Mississippi for regulating medication abortion beyond the FDA's REMS, but after *Dobbs*, GenBioPro voluntarily withdrew its case without opinion.

[292] GenBioPro, Inc. v. Sorsaia, No. 2:23-cv-11111 (S.D. W. Va. Jan. 25, 2023).

[293] Bryant v. Stein, No. 1:23-cv-77 (M.D. N.C. Jan. 25, 2023).

[294] For an in-depth discussion of these two strands, see *The New Abortion Battleground*, *supra* note 18, at 53-71.

this in a few different ways: (1) the DOJ could work with the FDA to bring its own preemption lawsuit; (2) the FDA could promulgate a rule or publish a policy related to preemption, which would become the subject of litigation; or (3) the FDA could support preemption litigation filed by another party, like the drug manufacturer, in an amicus brief.[295] The Biden Administration is under pressure to do whatever it can to promote abortion access, which might make it difficult for the agency to resist at least minimally supporting preemption litigation. On the other hand, the FDA under a Republican administration could do the opposite: place its thumb on the scale *against* preemption, either in litigation or regulation.

Beyond the political calculations of the current president, the FDA likely has its own concerns. The agency has seen its credibility suffer significantly through the opioid crisis[296] as well as its handling of the COVID-19 pandemic;[297] as a result, it might want to avoid appearing political. There are times when the FDA is duty-bound to act, like when it must respond to an sNDA or a Citizens Petition, even if its decision will have political implications. But here, the FDA has no statutory obligation to take any action regarding preemption. Furthermore, preemption would make the FDA's policy the law of the country, even in states with abortion bans, setting up battles between state and federal powers that the FDA might want to avoid. By contrast, adding an indication to the label, changing the label, or removing the REMS would not have any impact on state abortion bans without preemption.

Finally, there is the concern that the FDA's involvement—particularly if intended to support preemption arguments—could harm the effort. The Supreme Court has shown intense skepticism toward the administrative state for decades now.[298] If the FDA becomes actively involved in preemption, it could transform a case about a company's right to sell its FDA-approved product into a case about government overreach and the role of executive agencies. A court might apply the newly-developed major questions doctrine, which provides an exception to the traditional default of judicial deference to agency action when the agency's decision concerns a

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[295] *Id.* at 57-58.

[296] Andrew Kolodny, *How FDA Failures Contributed to the Opioid Crisis*, 22 AMA J. OF ETHICS 743 (2020).

[297] Celine Castronuovo & Jeannie Baumann, *Trump Covid Report Stirs Calls for FDA to Rebuild Public Trust*, BLOOMBERG L. (Aug. 26, 2022), https://news.bloomberglaw.com/coronavirus/trump-covid-report-stirs-calls-for-fda-to-rebuild-public-trust.

[298] *See* Gillian E. Metzger, *The Roberts Court and Administrative Law*, 2019 SUP. CT. REV. 1 (2002); Gillian E. Metzger, *Foreword: 1930s Redux: The Administrative State Under Siege,* 131 HARV. L. REV. 1, 17-28 (2017).

major economic or political issue, to negate any benefit the FDA's statement might have provided.[299]

Despite these political quandaries, there are health and safety issues militating for FDA involvement. Under abortion bans, infant mortality and maternal mortality rates will increase.[300] Abortion bans also cause delays in life-saving care that impair maternal health.[301] And because abortion bans also prohibit abortions for fetal anomaly, there will be more stillborn babies or infants who will die quickly after birth.[302] Finally, the underground markets for abortion pills might increase the risks of abortion—people may start taking drugs too late in pregnancy or drugs with unknown potency or authenticity if they are not using vetted sources.[303] The FDA could help mitigate these public health problems by supporting a preemption argument.

V. How Pill Battles Will Set the Terms of the Abortion Debate

Though the individual victories and losses over pills that occur in legislative chambers and courtrooms will influence how and where abortion pills are accessed, pills are here to stay. Like the War on Drugs, federal and state policy will determine not whether people can obtain pills but rather how much the criminal justice system will be involved and whether public health will be compromised. As abortion pills cause states to lose control of abortion, they will respond by attempting to tighten their grip. Attempts to close all of the avenues to

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[299] *See* Daniel T. Deacon & Leah M. Litman*, The New Major Questions Doctrine,* 109 VA. L. REV. 1, 6-7 (forthcoming 2023) (noting how the major questions doctrine could be used to invalidate agency action to secure abortion rights). Though courts, including the Supreme Court, might disparage the FDA's involvement, lower courts might find differently. David S. Cohen, Greer Donley, & Rachel Rebouche, *Rethinking Strategy After* Dobbs, 75 STAN. L. REV. ONLINE 1, 12 (2022). Other administrative law doctrines, like deference to agency action, could bolster a case for preemption. *New Abortion Battleground*, *supra* note 18, at 68-69.

[300] Early estimates suggest maternal mortality will grow 24% in states that ban abortion. *See* Elyssa Spitzer et al., *Abortion Bans Will Result in More Women Dying*, CAP (Nov. 2, 2022), https://www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying/.

[301] *See*, Anjali Nambiar, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women At 22 Weeks' Gestation or Less With Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 AM. J. OBSTETRICS & GYNECOLOGY 648 (2022).

[302] Donley & Lens*, supra* note 205, at 1716.

[303] The FDA has made clear in statements online that it disapproves of people buying medication abortion from international sources, which have different packaging and labeling and are thus not FDA approved. Preemption is the best way to make the FDA-approved medication abortion product more available, thus reducing the need for underground markets. The FDA has changed course before for products with alternative markets that carry potential public health risks. *See* Rachel E. Sachs & Carolyn A. Edelstein*, Ensuring the Safe and Effective FDA Regulation of Fecal Microbiota Transplantation*, 2 J. L. & BIOSCIENCES 396, 404–05 (2015).

obtain abortion pills—both formal and informal, legal and extralegal—will require actions and policies most Americans will find unpalatable, catalyzing paradigm shifts in how people think about and talk about abortion.

We outline a few of these significant changes below, including how abortion pills travel through informal and extralegal networks, changes to abortion's definition and historic stigmatization, and attempts to police the actions of abortion seekers that will compromise privacy and undermine the pursuit of racial equity. Each of these developments will challenge everyone's assumptions about abortion, not just those actively engaged in the debate. In short, pills will disrupt the status quo in ways that touch far more people than ever before. We should expect adverse public health consequences, infringements on basic civil liberties, and racial as well as class inequities. But, in resisting and minimizing those intolerable costs, we also may witness a sea change in the broader acceptability of abortion.

a. Informal Networks and Removing Gatekeepers

Already, there has been a rise of domestic and international networks that assist people in obtaining pills.[304] Their work is supported by abortion activists who are working to publicize all the ways people can obtain pills, even if not legal. Though we have no reliable data on how many people are being served by these resources, we know they are already getting pills to people in states that ban abortion.[305]

Domestically, there are community support networks that provide free pills to people across the country. For instance, Red State Access serves residents of Arkansas, Guam, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, West Virginia, and Wisconsin.[306] Because of the need for secrecy given the legal risks involved, the network's website has very little information other than billing itself as "an information source" that does not "give medical or legal advice or sell abortion pills" but instead mails pills for free to people who contact it.[307] The site lists an email

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[304] *See* Caroline Kitchener, *Covert network provides pills for thousands of abortions in U.S. post Roe*, WASH. POST (Oct. 18, 2022), https://www.washingtonpost.com/politics/2022/10/18/illegal-abortion-pill-network/.

[305] *See* Claire Miller & Margot Sanger-Katz, *The (Incomplete) Revolution in Counting Abortions,* N.Y. TIMES (Dec. 8, 2022), https://www.nytimes.com/2022/12/08/upshot/abortion-roe-dobbs-drugs.html.

[306] Red State Access, https://www.redstateaccess.org/; Steph Black, *The Other Front Line*, THE PROGRESSIVE, 65-66 (Dec./Jan. 2022-23).

[307] *Id.*

address for people to use; it gives almost no other information and strongly encourages the use of privacy apps or browsers while exploring the site and contacting the network. The website Plan C includes Red State Access among the options for people in these states,[308] which indicates Plan C vetted the site for reliability and safety.

Internationally, a variety of groups in Mexico have facilitated the transit of pills into the U.S. These networks rely on the ability to purchase misoprostol in the country without a prescription; other operations also buy in bulk from India where the drugs cost less.[309] Activists purchase pills in bulk, sometimes with mifepristone and sometimes without.[310] Then, individuals provide the pills to people who can travel into Mexico to agreed-upon locations near the border, or transport the pills across the border and then distribute them to people in need using more networks of underground activists.[311] The Washington Post profiled one of the groups, Las Libres, which indicated that it was on track to help 20,000 people in America terminate pregnancies in 2022.[312]

These networks would be hard-pressed to reach people if it were not for the work of other organizations spreading the word about abortion pills and the places where they can be obtained. As mentioned, the website Plan C has information about the organizations.[313] Another organization, Shout Your Abortion, has put up billboards, used guerilla light projections, flown advertising airplanes with banners behind them, distributed abortion pill boxes that, rather than having pills inside, have information about where to find them, and promoted abortion pills onstage at the People's Choice

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[308] *See, e.g.*, *Louisiana*, PLAN C PILLS, https://www.plancpills.org/states/louisiana#community.

[309] Kitchener, *supra* note 304. Many of these networks were formed when abortion was illegal in Mexico. In 2021, the Supreme Court of Mexico legalized abortion. Acción de Inconstitucionalidad, Suprema Corte de Justicia [SCJN], 148/2017, 106/2018, 107/2018 (Mex. 2021).

[310] Stephanie Taladrid, *The Post-Roe Abortion Underground*, NEW YORKER (Oct. 10, 2022), https://www.newyorker.com/magazine/2022/10/17/the-post-roe-abortion-underground; Alexa Ura & Greta Diáz González Vázquez, *Volunteer Networks in Mexico Aid At-Home Abortions Without Involving Doctors or Clinics. They're Coming to Texas*, TEXAS TRIBUNE (Aug. 4, 2022), https://www.texastribune.org/2022/08/04/texas-abortion-mexico-volunteer-networks/; Yvonne Marquez, *How Mexican Activists Are Providing Texans with Medication Abortions*, TEXAS STANDARD (July 13, 2022), https://www.texasstandard.org/stories/mexican-activists-las-libres-help-provide-medication-abortions/.

[311] Elizabeth Navarro, *An Abortion Network That Works*, LUX (2022), https://lux-magazine.com/article/an-abortion-network-that-works-las-libres/.

[312] Kitchener, *supra* note 304.

[313] *See, e.g.*, *Louisiana*, *supra* note 308; *Texas,* PLAN C PILLS, https://www.plancpills.org/states/texas#community; *Mexico,* PLAN C PILLS, https://www.plancpills.org/states/mexico.

Awards.[314] Many other organizations and websites share the goal of making it easier for people to discover and obtain abortion pills outside the normal health care system.[315]

Perhaps the most significant paradigm shift resulting from these informal and extralegal networks of abortion pills is the move away from a medical gatekeeper model.[316] When the Supreme Court held that the constitution protected a right to abortion in *Roe*, the Court framed the decision as "'inherently, and primarily, a medical decision' to be made in consultation with a 'responsible physician.'"[317] Scholars have argued that abortion jurisprudence over time solidified this medical gatekeeper model,[318] with Reva Siegal arguing that this framework subjugated women as rights holders below doctors.[319] This model of abortion traces back to the first wave of abortion laws in this country, in the mid- to late-1800s, when states, at the behest of the medical profession, removed abortion provision from the work of informal providers.[320] But as the right to abortion as articulated by *Roe* is now gone, medication abortion available through informal and extralegal networks offers fresh critiques of a medical gatekeeper model.[321] People can and are accessing abortion entirely on their own, without doctor supervision.[322]

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[314] Rewire News Group Staff, *'It's Time to Raise Hell': Activists Today Are Shouting About Abortion Pills*, REWIRE NEWS GROUP (Dec. 1, 2021), https://rewirenewsgroup.com/2021/12/01/its-time-to-raise-hell-activists-today-are-shouting-about-abortion-pills/; Nardine Saad, *Lizzo used People's Choice Awards Speech to 'Amplify Marginalized Voices' of these 17 Activists*, L.A. TIMES (Dec. 7, 2022), https://www.latimes.com/entertainment-arts/music/story/2022-12-07/here-are-the-17-activists-lizzo-amplified-during-her-peoples-choice-awards-speech.

[315] Organizations, such as Reproaction, have also focused on informing the public about pills now that *Roe* has been overturned. *Understanding and Advocating for Self-Managed Abortion*, REPROACTION, https://reproaction.org/campaign/self-managed-abortion/.

[316] *See generally* Maya Manian, *A Health Justice Approach to Abortion* (2022), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3786341.

[317] Yvonne Lindgren, *When Patients Are Their Own Doctors:* Roe v. Wade *In an Era of Self-Managed Care*, 107 CORNELL L. REV. 151, 161 (2021) (quoting *Roe v. Wade* 410 U.S. 113, 153, 166 (1973).

[318] *Id.* at 166-180.

[319] *See* Reva B. Siegel, Roe*'s Roots: The Women's Rights Claims That Engendered Roe*, 90 B.U. L. REV. 1875, 1897 (2010); 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).

[320] Clyde Spillenger, Jane E. Larson, & Sylvia A. Law, *Brief of 281 American Historians as Amici Curiae Supporting Appellees*, 12 PUBLIC HISTORIAN 57, 65-67 (1990).

[321] Lindgren, *supra* note 317, at 207 ("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.").

[322] Key players in both the anti-abortion and abortion right movements have historically understood abortion pills as potentially disrupting the gatekeeper model. *See* MARY ZIEGLER, ABORTION AND THE LAW IN AMERICA: ROE V. WADE TO THE PRESENT 137, 160 (2020).

The impulse to reaffirm the medical gatekeeper model will not fade away with the absence of *Roe*. Many of the battles mentioned above will involve debates about the role of providers, and certainly, at times in the past, the medical profession has been a barrier to progress.[323] But there are reasons for the involvement of the medical establishment. Informal networks operating outside of government regulation and control will inevitably make mistakes. Pills might be distributed with impurities, improper labels, or doses. Networks routinely distribute pills through fifteen weeks of pregnancy, raising questions about efficacy and disposal of fetal remains.[324] But this proliferation of abortion pills suggests that the model for care can evolve—self-managed care with the support of accurate information and reliable products.

b. Definition of Abortion

In Section II.C. above, we explored how the process of a medication abortion (where medications were obtained, the mifepristone was taken, the misoprostol was taken, or the fetal tissue was expelled) complicates *when and where* the abortion occurred.[325] Telehealth adds another complexity because the patient and provider may be in separate states.[326] But beyond the abortion's location, abortion pills also challenge defining *if* an abortion has occurred.

The demise of *Roe* and the rise of abortion pills have caused the definition of abortion to come under pressure in a variety of ways. One main source of ambiguity for abortion is the fact that all of the medications that can end a pregnancy have other uses. As a result, banning any particular abortion-inducing drug means depriving patients of treatments they rely on for other medical conditions. Mifepristone, for instance, is also used for Cushings Syndrome and

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[323] Coeytaux & Wells, *supra* note 66, at 9 ("The medical community's hesitancy to let go of control of the product held back changes in medical practice and contributed to the slow pace of progress in moving emergency contraception from a prescription-only product, to "behind-the-counter" (women had to ask a pharmacist for it and meet certain age requirements), to its current status as fully available over-the-counter.").

[324] *Id.*

[325] As we have argued elsewhere, generally, Americans expect to be able to take advantage of another state's laws when they spend the time and money to travel there. For people to expend great resources to obtain pills legally—instead of more cheaply and easily buying them online—only to have the abortion deemed illegal because of antiabortion prosecutors exploiting statutory ambiguity about when and where the abortion occurs will encroach upon abortion-supportive states' policy and people's understanding of their basic right to travel. *New Abortion Battleground*, *supra* note 18.

[326] *See supra* Section II.C.

miscarriage;[327] misoprostol is also used for ulcers, miscarriage, IUD insertion, and labor induction.[328] Another drug, methotrexate, which is the primary drug used to treat ectopic pregnancy (technically an abortion under some states' definition) is more commonly prescribed for arthritis, cancer, and psoriasis.[329] States that have made abortion illegal following *Dobbs* have seen consequences related to the other uses of these drugs.

Abortion bans theoretically account for these other uses in the following way: almost all states define abortion by reference to intent.[330] For instance, Alabama—a fairly representative statute—defines abortion as "[t]he use or prescription of any instrument, medicine, drug, or any other substance or device with the intent to terminate the pregnancy . . . ."[331] So if a drug is used for a different intent—to treat arthritis or induce labor, for example—then the abortion ban should not apply. This sounds simple, but it gets complicated quickly for many reasons.

First, even when the primary healthcare provider, like the doctor or nurse practitioner, knows that an abortifacient is being prescribed for another use, other providers in the chain—especially pharmacists—may not be privy to the intended use of a drug.[332] Prescriptions typically are sent to the pharmacy without any indication for purpose, so the pharmacist has no way to know if the drug was being used for abortion or some other use. This explains why, after *Dobbs*, some pharmacists have refused to dispense drugs that could be used for abortion.[333] As a result, many people lost access to needed medications.[334] Bigger chains, like CVS, have instituted procedures in states that ban abortion to verify the use of misoprostol or methotrexate for non-abortion purposes before dispensing the drug.[335] Patients relying on smaller pharmacies might struggle to access these

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327 *See Mifepristone (Mifeprex)*, MEDLINE PLUS (May 15, 2016), https://medlineplus.gov/druginfo/meds/a600042.html.
328 *See Misoprostol*, MEDLINE PLUS (November 15, 2017), https://medlineplus.gov/druginfo/meds/a689009.html.
329 *See Methotrexate*, MEDLINE PLUS (April 15, 2017), https://medlineplus.gov/druginfo/meds/a682019.html.
330 *See 50-State Survey*, *supra* note 201.
331 ALA. CODE § 26-23E-3.
332 *See generally* Celine Castronuovo, *Abortion Drug Bans Make Pharmacies Wary of Common Arthritis Pill*, BLOOMBERG (July 14, 2022), https://news.bloomberglaw.com/health-law-and-business/arthritis-drug-access-delays-spur-demands-for-post-roe-guidance.
333 *See e.g., id.*
334 *Id.*
335 *Id.*

medications if their pharmacists continue to have concerns about abortion liability.[336]

Second, even when a provider is prescribing a drug for an alternative use, the possibility of a prosecutor proving inferentially an "intent to terminate a pregnancy" has caused providers to change their prescribing habits for abortifacients.[337] For instance, rheumatologists frequently prescribe methotrexate for arthritis.[338] Though this should not come under the ambit of an abortion ban because there is no intent to end a pregnancy, what happens if they prescribe it to a person who is pregnant? Would a jury believe that there was no provider intent to end a pregnancy? Rheumatologists typically do not prescribe methotrexate to pregnant patients, but they do prescribe it to patients capable of becoming pregnant, raising questions about how they would ensure their patients are not pregnant.[339] Is it enough to ask the patient? Should they require their patient use birth control or provide proof of sterility? Or require their patient to take a monthly pregnancy test in their office before getting a refill? Unfortunately, news stories have surfaced that include every one of these scenarios.[340] These practices condition healthcare on avoiding pregnancy, raising questions about sex discrimination given that male patients of reproductive age do not have their healthcare conditioned on their use of birth control.[341]

Third, one of the most common alternative uses of these drugs is for pregnancy loss. Though people like to imagine that the line between abortion and miscarriage is clear, there are many situations that belie that assumption.[342] Both mifepristone and misoprostol are used as a treatment for missed miscarriage—a miscarriage that is

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336 Katie Barlow, *CVS Requiring Verification on Drugs with Possible Abortion Use in 5 States*, FOX (July 22, 2022), https://www.fox5dc.com/news/cvs-requiring-verification-on-drugs-with-possible-abortion-use-in-5-states.

337 *See e.g.,* Ian Millhiser, *Can Pharmacists Refuse to Fill Prescriptions for Drugs that Can Be Used in Abortions*?, VOX (July 15, 2022), https://www.vox.com/23207949/supreme-court-abortion-methotrexate-prescription-pharmacist-refuse.

338 *Id.*

339 *See* Rob Volansky, *'Strange Times': Prescribing Methotrexate Legally 'Low Risk' Post-*Roe, HEALIO RHEUMATOLOGY (Nov. 14, 2022), https://www.healio.com/news/rheumatology/20221114/strange-times-prescribing-methotrexate-legally-low-risk-postroe.

340 *See e.g.,* Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASH. POST (Aug. 8, 2022), https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis/.

341 *See HHS Issues Guidance to the Nation's Retail Pharmacies Clarifying Their Obligations to Ensure Access to Comprehensive Reproductive Health Care Services*, DEPT HEALTH & HUMAN SERV. (July 13, 2022), https://www.hhs.gov/about/news/2022/07/13/hhs-issues-guidance-nations-retail-pharmacies-clarifying-their-obligations-ensure-access-comprehensive-reproductive-health-care-services.html.

342 Donley & Lens, *supra* note 205, at 1707-10.

discovered, usually after an ultrasound, before the pregnant person's body has recognized it.[343] It often takes weeks or longer for that bodily recognition to occur, and even when it does, the body can sometimes struggle to expel the tissue on its own (known as an incomplete miscarriage). In these situations, patients are given a few options: wait to see if the miscarriage will resolve on its own, known as expectant management, or use medical interventions—drugs or procedures—to finish the miscarriage.[344]

Miscarriage management should not fall under the ambit of abortion bans because there is no longer a living pregnancy that someone intends to terminate. In fact, over half of states specifically exclude removing a dead fetus from the definition of abortion.[345] Nevertheless, now that abortion is a crime, physicians are afraid to offer care that could blur the line between abortion and pregnancy loss.[346] For instance, miscarriages that occur before the documentation of a fetal heartbeat, which is most miscarriages, are difficult to diagnose—providers distinguish between a live and dead pregnancy by seeing fetal cardiac activity.[347] But if cardiac activity was never identified, then miscarriage is diagnosed with blood tests or ultrasound imaging over the course of a few days or weeks to see if pregnancy hormones are decreasing and whether the embryo's growth has stopped.[348] Sometimes these tests, however, are unnecessary: for instance, when the person is sure of her last missed period or ovulation date and therefore knows the pregnancy is measuring weeks behind when it should be.[349] In a post-*Roe* environment, physicians are afraid to use active measures, like medication, to treat these patients without independent confirmation the pregnancy has ended.

Definitional blurriness also has impacted ectopic pregnancy treatment. Ectopic pregnancy occurs when a pregnancy implants outside of the uterus, such as in the fallopian tube, where it cannot survive. Eventually, the pregnancy will outgrow the tube, causing it to rupture, killing the embryo and threatening the pregnant person's life.[350] When ectopic pregnancy is caught before rupture, it can be treated with methotrexate, which ends the pregnancy.[351] However, that

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[343] *Id.* at 1711-12.

[344] Though some people prefer to avoid medical intervention, expectant management can take up to eight weeks and comes with higher risks. Many people prefer active measures to speed up the miscarriage process and reduce their risks. *See* EMAA Citizen's Petition, *supra* note 283.

[345] *See 50-State Survey*, *supra* note 201.

[346] Donley & Lens, *supra* note 205, at 1711-12.

[347] *Id.*

[348] *Id.*

[349] *Id.*

[350] Beata E. Seeber & Kurt T. Barnhart, *Suspected Ectopic Pregnancy*, 107 OBSTETRICS & GYNECOLOGY 399 (2006).

[351] *Id.*

treatment occurs *before* the pregnancy has ended on its own. As a result, unless an abortion ban specifically excludes ectopic pregnancy from its definition of an abortion (as only eight states do[352]), the use of methotrexate to end a pregnancy would, both legally and medically, be an abortion. Though the ectopic pregnancy will eventually become life-threatening and should be covered under the life exceptions in abortion bans, doctors have refused to treat pregnant patients until their lives are threatened after the pregnancy ruptures, compromising the person's health and future fertility.[353] These are just a few examples demonstrating that the distinctions inherent in abortion bans are often impossible to assess in the real world, making it hard for providers to know when prescribing abortion pills is legal, threatening all of reproductive healthcare.

Fourth, there are serious practical challenges in deciphering the difference between self-managed abortion and miscarriage because the two events are physically identical and the same medications can be used for both.[354] Said another way, when someone presents at an emergency room pregnant and bleeding, the person could be experiencing complications from either a miscarriage or an abortion.[355] Unless the person confesses that they took medications to end the pregnancy, the only way to tell the difference would be to report them to the police and investigate, as there is no blood test or physical exam that can discern the difference.[356] For all the reasons discussed in Section C below, these types of investigations will be problematic invasions of privacy—ones that will inevitably harm poor women and women of color disproportionately and ones that will inevitably capture patients genuinely experiencing miscarriage.

Finally, missed period pills, described in Part III, are explicit challenges to the definition of abortion. What happens when there is an intentional obfuscation of the use of an abortifacient? This is what missed period pills test—the same abortion drugs, but used to start a period, not terminate a pregnancy.[357] In this situation, an intentional decision to avoid discovering pregnancy could evade abortion bans

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[352] *See 50-State Survey*, *supra* note 201.
[353] *See* Caroline Kitchener, *The Texas Abortion Ban Has a Medical Exception. But Some Doctors Worry It's Too Narrow to Use,* LILY (Oct. 22, 2021), https://www.thelily.com/the-texas-abortionban-has-a-medical-exception-but-some-doctors-worry-its-too-narrow-to-use/.
[354] Donley & Lens, *supra* note 205, at 1707-11.
[355] *Id.*
[356] When misoprostol is inserted vaginally in a medication abortion, in rare occasions, fragments of the pills can be identified. *See Society of Family Planning Interim Clinical Recommendations: Self-Managed Abortion,* SOCIETY OF FAMILY PLANNING at 6 (Sept. 8, 2022), https://www.societyfp.org/wp-content/uploads/2022/06/SFP-Interim-Recommendation-Self-managed-abortion-09.08.22.pdf.
[357] Baker, *supra* note 39.

and create an after-the-fact impossibility of knowing whether a live pregnancy was ended.[358] State legislatures could respond to this by requiring a pregnancy test before any abortifacient is prescribed, but this would burden people who use these drugs for other uses. Why should someone's arthritis or ulcer medications be dependent on taking a pregnancy test? Such a requirement could chill access to healthcare for patients who can become pregnant, potentially running afoul of sex discrimination laws.[359]

There are no easy answers for an antiabortion movement that wants to stop the proliferation of abortion pills. Current bans could have much more generous health exceptions to avoid some of these horrible outcomes, but this has been rejected. Instead, the antiabortion movement has tried to manipulate its own definitions, arguing that certain abortions are not really abortions.[360] But linguistic gymnastics will have a hard time convincing people the antiabortion movement is "pro-woman, pro-life"[361] when the collateral damage of its abortion bans piles up. Indeed, sacrificing people's health in the name of eradicating all abortion plays out in the national spotlight and will continue to impact the public perception. People are learning first-hand that abortion bans create harsh consequences for everyone, including ten-year-old rape victims, people facing life-threatening pregnancy loss, and people facing a fatal prenatal diagnosis. Boundaries about "good" and "bad" abortions are breaking down as bans become the great equalizer, capturing people who never thought they could be impacted.

c. Undermining Abortion Stigma

Medication abortion also will influence abortion stigma, "the discrediting of individuals as a result of their association with abortion."[362] Historically, the antiabortion movement stigmatized abortion by stigmatizing abortion *procedures*.[363] Abortion *pills*, however, will be harder to villainize.

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[358] *Id.*
[359] *See* HHS Guidance, *supra* note 341.
[360] Anne Flaherty, *Case of 10-Year-Old Rape Victim Challenges Anti-Abortion Rights Movemen*t, ABC NEWS (July 16, 2022), https://abcnews.go.com/Politics/case-10-year-rape-victim-challenges-anti-abortion/story?id=86814201.
[361] Reva Siegel, *Why Restrict Abortion? Expanding the Frame on* June Medical, 2020 SUP. CT. REV. 1.
[362] Alison Norris et al., *Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences*, 21 WOMEN'S HEALTH ISSUES S49, S49 (2011); *see generally* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA (2017).
[363] Greer Donley & Jill Wieber Lens, *Second Trimester Abortion Dangertalk,* 62 B.C. L. REV. 2146, 2157-63 (2021).

Antiabortion advocates have a longstanding strategy of attacking second-trimester abortion procedures by characterizing them "gruesome."[364] In the 1990s, the anti-abortion movement focused on a specific procedure, dilation and extraction (D&X).[365] Ninety-five percent of abortions in the second trimester are completed with a dilation and evacuation (D&E) procedure, where the fetus is extracted, typically in parts, because it cannot fit through the cervix.[366] The less common D&X, however, was able to remove the fetus whole, by puncturing and collapsing the fetus's skull and delivering it.[367] The benefits of the D&X procedure included fewer risks to the pregnant patient and the possibility of holding the fetus afterward, which was especially helpful for patients terminating wanted pregnancies for maternal health or fetal anomaly.[368] Nevertheless, the antiabortion movement dubbed this procedure "partial birth abortion" and developed a campaign to convince the public that this procedure was inhumane.[369]

The campaign was largely successful. First, it convinced state legislatures and Congress to pass laws banning the procedure completely.[370] Second, it convinced five justices on the Supreme Court that the government could constitutionally protect people from these "gruesome" procedures and the purported regret that would allegedly follow if women found out later that their provider used this procedure.[371] Third, it enabled the antiabortion movement to focus the national conversation on the mechanics of a rare second-trimester abortion procedure, accounting for 1% of all abortions, when the vast majority of abortions, 93% in 2020,[372] occur in the first trimester. These legal battles had an impact: during this period where D&X procedures were being debated nationally, "Americans supporting legal abortions 'under all circumstances' fell by nearly a third, from about 34% to only 22%."[373]

In the last few years, the antiabortion movement pursued a very similar strategy to try to ban the more common form of second-

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[364] *Id.*
[365] *Id.* at 2157-60.
[366] Amy M. Autry et al., *A Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion*, 187 AM. J. OBSTETRICS & GYNECOLOGY 393 (2002).
[367] Donley & Lens, *supra* note 363, at 2156.
[368] *Id.* at 2158.
[369] *Id.*
[370] *Id.*
[371] Maya Manian, *Irrational Women: Informed Consent and Abortion Regret*, *in* FEMINIST LEGAL HISTORY: ESSAYS ON WOMEN AND LAW (TRACY A. THOMAS & TRACEY JEAN BOISSEAU, EDS. 2011).
[372] *CDC's Abortion Surveillance System FAQs*, *Centers for Disease Control & Prevention*, (Nov. 17, 2022),
https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.
[373] ZIEGLER, *supra* note 322, at 156.

trimester abortion, D&E.[374] They dubbed these abortions "dismemberment abortions" because the fetus was removed in parts.[375] Many states passed D&E bans, and after a circuit split emerged, the bans were destined for the Supreme Court had *Dobbs* not mooted the issue.[376] The public response to this issue could have had an equally detrimental impact on public opinion by focusing its gaze once again on the mechanics of later abortion.

Medication abortions, however, flip the script. Almost all are early abortions, and pregnancy tissue in early pregnancy, especially in the first ten weeks, is difficult to personify as it does not bear any resemblance to a newborn.[377] The six-to-eight-week image pregnant patients see during their first ultrasound looks like a circle with a miniscule flutter in the middle, if cardiac activity is detected. To the naked eye, early pregnancy tissue looks predominately like blood clots and tissue, which is what people see after an early abortion or miscarriage.[378] Not until closer to the second trimester are fetal parts easily discernable without magnification.[379] And because so many people have an actual experience with what early pregnancy tissue looks like, both to the naked eye and on ultrasound, it will be harder to manipulate people's impression by planting images that contradict this lived experience.[380]

Moreover, medication abortion is almost identical to the experience of miscarriage—a natural occurrence that a million people experience every year.[381] Antiabortion activists might be able to decry that an "unborn life" was prematurely ended with medication, but targeting the *way* it was ended will be challenging because the pregnancy ends the way many pregnancies end: expulsion from the pregnant person's body without a provider's procedural intervention. Indeed, abortion providers have long been the scapegoat of the

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374 Donley & Lens, *supra* note 363, at 2160-63.
375 *Id.* at 2160.
376 *Id.* at 2160-63.
377 *See* Poppy Noor, *What A Pregnancy Actually Looks Like Before 10 Weeks – In Pictures*, THE GUARDIAN (Oct 19, 2022), https://www.theguardian.com/world/2022/oct/18/pregnancy-weeks-abortion-tissue; Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351 (2008).
378 *See* Kate Daley, *What to Expect at Your 6-Week Ultrasound Appointment*, TODAY'S PARENT (Oct. 28, 2019), https://www.todaysparent.com/pregnancy/being-pregnant/what-to-expect-six-week-ultrasound/.
379 Noor, *supra* note 377.
380 *Id.*
381 CARLA DUGAS, MISCARRIAGE 1 (VALORI SLANE ED., 2022) (26% of pregnancies end in miscarriage).

antiabortion movement,[382] but with abortion pills, the pregnant person ends the pregnancy herself.

Not only are abortion providers more removed from the abortion experience, but so are abortion clinics. Clinics have long been dubbed by abortion opponents as "abortion mills" and accused of not taking proper care of patients.[383] Clinics are often isolated outside of the traditional healthcare system and then targeted with harassment and violence.[384] This environment has played a role in the stigmatization of abortion care. But medication abortion, on the other hand, happens in a person's private space, usually in their homes.[385] The timing of medication abortion, its similarity to miscarriage, and its changed relationship to clinics and providers all work in concert to rebut many of the stereotypes and myths that have surrounded abortion.

There is a significant caveat, however. If medication abortion is used later in pregnancy, it simulates childbirth of a more developed fetus. Because abortion bans delay care and increase desperation, they may also increase the likelihood that people will self-manage abortions later in pregnancy, potentially undermining the destigmatizing benefits discussed above.[386] The post-*Dobbs* environment could also change these narratives as well. When abortion was legal nationwide, an antiabortion strategy was to cast the people who eschewed legal care as irresponsible, especially if they were past the gestational limit.[387] But without legal abortion, reports of people using abortion pills later in pregnancy could become an indictment of abortion bans themselves. The reason the person followed this path would no longer be the pregnant person's delay, but rather the lack of available options that forced them to find abortion extralegally and later in pregnancy.[388] The best way to reduce the incidence of people using abortion pills later in pregnancy is to increase access to pills earlier in pregnancy.[389] That is the opposite of what abortion bans do. In the same way that bad outcomes in the pre-*Roe* era only served to underscore that abortion bans were heartless and ineffective, bad outcomes in the post-*Roe* era could do the same.

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382 *See* DAVID S. COHEN & KRYSTEN CONNON, LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM (2015).
383 Donley, *supra* note 13, at 690-94.
384 *Id.*
385 *Id.*
386 For instance, the antiabortion movement can focus the public's attention on whether the fetus was born alive. *See* Aziza Ahmed*, Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions,* 100 B.U. L. REV. 1111 (2020).
387 *See* Huss, Diaz-Tello, & Samari, *supra* note 165, at 2.
388 *See* Ushma D. Upadhyay, *Barriers Push People into Seeking Abortion Care Later in Pregnancy*, 112 AM. J. PUBLIC HEALTH 1280, 1280 (2022) (arguing that abortion bans delay care and lead to later abortions).
389 *See id.*

d. Surveillance, Investigation, and Backlash

As has been true with the War on Drugs, state actors increasingly will insert themselves into people's private affairs in alarming ways as abortion bans proliferate and individuals seek to self-manage their abortions with pills.[390] Investigation into people's abortion decisions will occur in emergency rooms, through their mail, and in their homes, the spaces that have long been targeted for state surveillance of reproductive decisions.[391] But, in the coming era, investigations will also extend into digital tech as more personal data are collected and stored in apps, phones, and smart devices. What people search for on the internet, order online, and express in their electronic communications could be used to target those who self-managed abortions. These new invasions of privacy may be particularly unpalatable to the public and will continue to raise questions about race and class disparities.

As noted above, over the last couple of decades, there were at least sixty-one criminal cases against people for self-managed abortion, using a variety of (mainly non-abortion) laws.[392] Most cases were first reported to law enforcement by healthcare providers or social workers, but there were also reports from close acquaintances and other reports from 911 calls or anonymous tips.[393] Among the adult defendants, people of color were disproportionately represented compared to the general population, and a majority involved people who live with low

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390 *See generally,* GOODWIN, *supra* note 15, at 119 ("The drug war drafts police, prosecutors, and judges to carry out its mission and metaphorically casts some of America's most vulnerable as enemy combatants to be tracked, policed, and – if caught – jailed.").

391 Though we focus on digital privacy here, we are cognizant of the rich literature on home and mail searches as well as scholarship on the law enforcement exceptions for health information protections. To contrast previous interventions with contemporary, digital tracking, see Aziz Huq & Rebecca Wexler, *Digital Privacy for Reproductive Choice in a Post-*Roe *Era*, N.Y.U. L. REV. (forthcoming 2023); *see also* Eric Boodman, et al*., HIPAA Won't Protect You if Prosecutors Want Your Reproductive Health Records,* STAT NEWS (June 24, 2022), https://www.statnews.com/2022/06/24/hipaa-wont-protect-you-if-prosecutors-want-yourreproductive-health-records/.

392 Huss, Diaz-Tello, & Samari, *supra* note 165; *see also Arrests and Other Deprivations of Liberty of Pregnant Women, 1973-2020*, NAT'L ADVOC. FOR PREGNANT WOMEN (Sept. 2021).

393 *Id.* at 26. 39% of the cases were reported to law enforcement by healthcare providers and 6% by social workers. About a quarter of cases (26%) were reported to law enforcement by acquaintances entrusted with information, such as friends, parents, or intimate partners, and 18% of cases came to the attention of police by other means, including police recovery of fetal remains, anonymous tips to police, or a 911 call. [11% was unknown]." *Id.*

or very low incomes.[394] The complicity of healthcare providers in reporting these individuals is particularly troubling as it leaves abortion-seekers with even fewer options to seek medical advice and care.[395]

These pre-*Dobbs* cases showcase how suspicious health care providers and data surveillance can result in criminal actions against those who use pills even when it was not clear the individual committed a crime.[396] For instance, in 2012, Jennifer Whalen brought her daughter to the local emergency room for bleeding after her daughter took abortion pills obtained online.[397] Days later, hospital personnel reported Whalen to local authorities, and the police showed up at their house with a warrant and found the empty pill box. The local district attorney charged Whalen with four different crimes, and she ultimately pled guilty to offering medical advice without a license and was sentenced to serve twelve to eighteen months in prison.[398]

Once law enforcement is involved in an investigation, other pre-*Dobbs* cases reveal how evidence will be mounted against people ending pregnancies.[399] In 2018, a Mississippi woman, Latice Fisher, was charged with second-degree murder for the death of her newborn child on the theory that the child was born alive and then died by asphyxiation.[400] The primary basis for the prosecution's theory, which ultimately was rejected by a grand jury, was the use of Fisher's cell phone data that revealed searches for buying abortion pills, suggesting her premature labor was induced.[401]

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394 *Id.* at 5 n.5.

395 GOODWIN, *supra* note 15, at 85-86.

396 *Id.* at 85-86 (describing the "troubling pattern of states unconstitutionally depriving pregnant women of their bodily integrity, privacy, and civil liberties, with doctors as overseers to that politicized agenda . . .").

397 Emily Bazelon, *A Mother in Jail for Helping Her Daughter Have an Abortion*, N.Y. TIMES (Sept. 22, 2014), https://www.nytimes.com/2014/09/22/magazine/a-mother-in-jail-for-helping-her-daughter-have-an-abortion.html.

398 *Id.*

399 Views differ on whether law enforcement should be able to use different types of data in criminal investigations. Brooke Auxier et al., *Americans and Privacy: Concerned, Confused and Feeling Lack of Control Over Their Personal Information*, PEW RSCH. CTR. 34 (Nov. 2019), https://www.pewresearch.org/internet/2019/11/15/americans-and-privacy-concerned-confused-and-feeling-lack-of-control-over-their-personal-information/.

400 Teddy Wilson, *'Prosecution in Search of a Theory': Court Documents Raise Questions About Case Against Latice Fisher*, REWIRE NEWS GRP. (Feb. 21, 2018), https://rewirenewsgroup.com/2018/02/21/prosecution-search-theory-court-documents-raise-questions-case-latice-fisher/.

401 *Id.*; Pregnancy Justice, *Victory for Latice Fisher in Mississippi*, Sept. 24, 2020, https://www.pregnancyjusticeus.org/victory-for-latice-fisher-in-mississippi/. Similarly, in 2013, Purvi Patel ordered abortion pills online from an overseas supplier. The prosecution offered evidence from Patel's iPad, which included a customer service email from a company that sold abortion pills as well as text messages to a friend in which Patel had expressed a desire to get an abortion. A

Investigations like these are continuing in a post-*Roe* America. Lizelle Hererra made headlines when she was charged in Texas for murder for allegedly terminating a pregnancy—presumptively with pills—after a health care provider reported her to local authorities.[402] Importantly, there was no law in Texas that permitted this prosecution, and the charges were later dropped, but the very act of charging her likely had a chilling effect throughout the state.[403] In another 2022 case that is still ongoing, a Nebraska mother obtained abortion pills for her daughter, who was 29-weeks pregnant but successfully used the pills to terminate her pregnancy.[404] Law enforcement obtained a warrant to search the daughter's private Facebook messages, in which she told her mother of her urgent desire to end her pregnancy.[405]

As these cases reveal, even if no state expands its abortion bans to apply to the person who was pregnant, prosecutors can nevertheless use a variety of criminal laws to punish people who use pills with the help of digital surveillance and the reports of healthcare providers.[406] As Cynthia Conti-Cook notes, "[d]igital evidence fills a gap for prosecutors keen on prosecuting women for their pregnancy outcomes."[407] This type of evidence seems especially relevant when there are questions about whether an abortion or pregnancy loss occurred, though "sift[ing] through an accused person's most personal thoughts, feelings, movements, and medically-related purchases during their pregnancy" is often not dispositive of how the pregnancy ended.[408] Miscarriages are common and inevitably occur while people are assessing their options following an unwanted pregnancy.

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jury convicted her of child neglect and feticide, and she was sentenced to twenty years in prison. On appeal, the feticide conviction was overturned but the child neglect conviction was upheld. Patel v. State, 60 N.E.3d 1041, 1044, 1046-47, 1062 (Ind. Ct. App. 2016).

[402] Herrera's arrest took place before *Dobbs* but while Texas's extremely restrictive SB8 was in effect. McCullough, *supra* note 171; Carrie N. Baker, *Texas Woman Lizelle Herrera's Arrest Foreshadows Post-Roe Future,* MS. MAGAZINE, Apr. 16, 2022, https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/.

[403] *Id.*

[404] Shaila Dewan & Sheera Frenkel, *A Mother, a Daughter and an Unusual Abortion Prosecution in Nebraska*, N.Y. TIMES (Aug. 18, 2022), https://www.nytimes.com/2022/08/18/us/abortion-prosecution-nebraska.html.

[405] Austin Svehla, *Hearing Held on Defense's Motion to Quash Two Charges in Illegal Abortion Case*, NORFOLK DAILY NEWS (Nov. 7, 2022), https://norfolkdailynews.com/news/hearing-held-on-defense-s-motion-to-quash-two-charges-in-illegal-abortion-case/article_1ae4d1f6-5ebd-11ed-9bd6-ff990daa8d57.html.

[406] Joh, *supra* note 174; Anya E.R. Prince, *Reproductive Health Surveillance*, 64 B.C. L. REV. (forthcoming 2023) (manuscript at 27-40).

[407] Cynthia Conti-Cook, *Surveilling the Digital Abortion Diary*, 50 U. BALTIMORE L. REV. 1, 4 (2020).

[408] *Id.*; *see also* Prince, *supra* note 406, at 27-40.

The policing of pregnant people is not at all new.[409] But with the increasing size of people's digital footprints and the proliferation of abortion pills, anti-abortion states and advocates will have the tools and the motive to police those who terminate pregnancies (and those that help them) either through new, post-*Dobbs*, anti-abortion laws or ordinary criminal laws.[410] A 2019 Kaiser Family Foundation survey found that an estimated 51% of an almost thousand-person sample of adults had used some sort of app to track their health, and that one in three women interviewed had used a menstrual tracking app at some point in their lives.[411] For individuals considering an abortion or otherwise managing their reproductive health, using internet-based resources might appear more secure than other analog methods.[412] The information housed in such products is deeply personal, from menstrual cycle dates to sexual activity or alcohol use, and often it is not secure.[413]

Some state actions are sure to be unpopular, and, indeed, the cases cited above have provoked outrage for many. They in many ways represent a regression to the use of criminal law for policing the morals of intimate life, including "the unwelcome presence of the police officer under the bed."[414] With pills, abortions are moving from clinics to the home, and investigations into abortion crimes increasingly involve home searches, potentially testing people's tolerance for abortion investigations. Yvette Lindgren has argued that "[m]edication abortion in the home, both self-induced and under a doctor's supervision, falls squarely within privacy law's traditional framework of zonal privacy."[415] But even if courts refuse to extend privacy doctrines to protect the home in the context of abortion, many will be dismayed at discovering how vulnerable their private spaces are.

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[409] Grace Howard, *The Pregnancy Police: Surveillance, Regulation, and Control*, 14 HARV. L. & POL'Y REV. 347 (2020); GOODWIN, *supra* note 15. Wendy Bach describes the effect of Tennessee's contemporary fetal assault law, which made it a crime for a pregnant woman to transmit narcotics to a fetus in the name of substance abuse assistance, through the cases of 120 prosecuted pregnant people. WENDY BACH, PROSECUTING POVERTY, CRIMINALIZING CARE 1-10 (2022).

[410] Ulrich & Fowler, *supra* note 5.

[411] *Health Apps and Information Survey*, KAISER FAM. FOUND. (Sept. 2019), https://files.kff.org/attachment/Topline-Health-Apps-and-Information-Survey-September-2019.

[412] Leah R. Fowler & Stephanie R. Morain, *Schrödinger's App*, 46 AM. J. LAW & MED. 203, 207 (2020); *see also* Conti-Cook, *supra* note 407, at 24.

[413] *See* Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMMENT 341 (2017).

[414] Melissa Murray, *Griswold's Criminal Law*, 47 CONN. L. REV. 1045, 1071 (2015) (describing the evolution away from criminalizing sexual morality).

[415] Lindgren, *supra* note 413, at 358.

Conservatives, in particular, have long argued that the privacy of the home is sacred, a concept backed by legal doctrines.[416]

The threat to *digital* privacy will be another source of disorientation. Despite a willingness to provide personal data, most people maintain strong beliefs regarding the value of their privacy. Researchers studying this "privacy paradox" find that people tend to hold the dichotomous view that their data should be kept private despite volunteering personal information that one should know could be disclosed.[417] A study conducted by the American Medical Association found that more than 92% of medical patients surveyed felt health data privacy should be a right with few exceptions,[418] though many do not realize the limitations of health privacy laws, especially in the course of a criminal investigation.[419] Indeed, the majority of Americans express concern about how the government and private companies use their data while also feeling that data collection is inevitable.[420] And these opinions hold across the political spectrum, with particular support for privacy rights from those who identify as conservative.[421] Demands for privacy are, of course, made selectively and strategically.[422]

Backlash against government surveillance of personal information will only occur if the costs and the targets of state investigation are visible. As noted, the majority of abortion seekers are

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[416] *Id.* at 357.
[417] *See* Daniel J Solove, *The Myth of the Privacy Paradox*, 89 GEO. WASH. L. REV. 1, 5-8 (2021).
[418] *Patient Perspectives around Data Privacy*, AM. MED. ASS'N (2022), https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.
[419] At issue in the Supreme Court case, *Ferguson v. City of Charleston*, was a substance abuse program for which hospital staff preserved urine drug tests of pregnant patients for future criminal proceedings. 532 U.S. 67, 71-72 (2001). The Court ruled that although the program may have been designed to promote health through increasing uptake of treatment, "the immediate objective of the searches was to generate evidence *for law enforcement purposes*," in violation of the Fourth Amendment. *Id.* at 83-84. However, the Court also made clear that hospital staff might provide evidence for criminal investigations so long as they ensure their patients "are fully informed about their constitutional rights." *Id.* at 84-85. For a full description of health privacy laws in the abortion context, see Stacey A. Torvino, *Confidentiality over Privacy*, 44 CARDOZO L. REV. __ (forthcoming 2023).
[420] *See* Auxier, *supra* note 399. In surveys, people expressed more concern over the information that social media collects than law enforcement data collection. *Id.*
[421] *Id.* (comparing the 42% of Democrats or Democrat-leaning independents who support private data use for social good to only 28% of Republican or Republican-leaning independents support for the same).
[422] For example, privacy rights underpin arguments against transgender recognition but not for abortion *See* Susan Hazeldean, *Privacy as Pretext*, 104 CORNELL L. REV. 1719, 1730-32 (2021); *see also* Rachel Bluth, *My Body, My Choice: How Vaccine Foes Co-opted the Abortion Rallying Cry*, NAT'L PUB. RADIO (July 4, 2022), https://www.npr.org/sections/health-shots/2022/07/04/1109367458/my-body-my-choice-vaccines.

low-income people and disproportionately people of color.[423] In many ways, abortion pills offer important benefits to these communities: they maintain safety and efficacy at a much cheaper price point and allow access in ban states for people who cannot afford to travel for care. For instance, the privacy of mailed pills taken at home can protect people who otherwise might be at a disadvantage if their pregnancy was discovered, such as those in abusive relationships.[424] Requiring a "private doctor-patient relationship to access abortion care resulted in racial and class inequality in access to abortion."[425] As a result, poor people and women of color may choose abortion pills over abortion travel, and this option had the potential to reduce disparities in abortion access.

Yet post-*Dobbs,* the benefits of pills for marginalized populations are met with a devastating catch. These communities will be disproportionately targeted for investigation and criminalization, as they always have.[426] As Michele Goodwin has detailed, in the last few decades of the drug wars, "[s]tates responded by prosecuting Black women under existing child abuse statutes for drug dependence during pregnancy," largely ignoring drug dependency in pregnant white women.[427] Dorothy Roberts similarly has demonstrated that drug prosecutions in pregnancy also have been used as vehicles to extract other reproductive injustices, such as coerced birth control and child removal proceedings.[428] These injustices threaten the liberatory potential of abortion pills if we continue to live in a country in which the privileged can obtain abortions without fear of punishment, but everyone else is at the mercy of the carceral state. This, too, is a lesson from the War on Drugs, which wrought devasting effects on the most marginalized in the country and added to the endemic of mass incarceration.[429] These burdens have also characterized abortion provision for far too long; with the policing of pills, the disproportionate racial and class impact of abortion policies will take on even greater prominence.

Historically, the reproductive rights movement—like the public at large—ignored the plight of Black and other marginalized women. [430] By focusing on rights and not access to abortion, and by

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[423] COHEN & JOFFE, *supra* note 15, at 13-16.
[424] Lindgren, *supra* note 413, at 359.
[425] Lindgren, *supra* note 317, at 168.
[426] GOODWIN, *supra* note 15, at 88-89.
[427] *Id.* at 89.
[428] DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY 150-201 (1997).
[429] MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2010).
[430] ROBERTS, *supra* note 428, at 56-57, 1003 (canvasing the racism that has underscored the reproductive rights movement); Loretta J. Ross et al., *Just Choices:*

defending the right to avoid procreation above the equally important rights to bear and parent the children one wants, the movement prioritized the needs of wealthy, white women over the needs of low-income people and women of color.[431] In recent years, many in the movement have sought to recognize these past wrongs and become allies with communities of color in the work toward true reproductive justice. But the problems pills pose will be a litmus test for this resolution—not only in how the mainstream reproductive rights organizations respond to the unequal criminalization of pills, but also in whether and how they empower people supporting abortion access for those who cannot afford to travel.

Pills can make abortion, at least in the first trimester, less expensive and easier to obtain. They have also inspired an all-out war that will be hard to win—in courts, at ballot boxes, and in the public arena. In ushering in this change, we must learn from the mistakes of an earlier era, which sidelined the material constraints and discrimination that set the terms of who can avail of abortion care and *why* they seek it in the first place. The coming reality of abortion care and law is not just winning hearts and minds, but also pursuing commitments to deeper, systemic change.

Conclusion

In the 1980s, Brazilian women began using the ulcer medicine misoprostol to end pregnancies outside of the medical system despite a strict legal environment prohibiting all abortions.[432] In 1991, the Brazilian government responded to this novel use of the drug with strict controls, but sales and use only increased.[433] The government tried again with even stricter protocols in 1998. Many people faced criminal penalties as a result of the new laws, but the informal clandestine market for misoprostol continued, with the pills being sold openly in the country and studies estimating that more than half of those in Brazil who end their pregnancies do so with pills.[434] As one

Women of Color, Reproductive Health and Human Rights, *in* POLICING THE NATIONAL BODY: SEX, RACE, AND CRIMINALIZATION 147, 147 (JAEL SILLIMAN & ANANNYA BHATTACHARJEE EDS., 2002); JENNIFER NELSON, MORE THAN MEDICINE: A HISTORY OF THE FEMINIST WOMEN'S HEALTH MOVEMENT 167–92 (2015) (describing the ways in which the mainstream reproductive rights organizations ignored issues of race).

[431] Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. SOC. SCI. 327, 343 (2013); Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 CAL. L. REV. 791, 794 (2014).

[432] Mariana Prandini Assis & Joanna N. Erdman, *In the Name of Public Health: Misoprostol and the New Criminalization of Abortion in Brazil*, 8 J. L. & BIOSCIENCES 1, 2-3 (2021).

[433] *Id.* at 3-4.

[434] *Id.* at 17.

court in Brazil recognized, the supply and demand associated with the drug made it futile to try to control the pills by law and only exacerbated the dysfunctions in the legal and health systems.[435]

Here, as in Brazil, antiabortion law and policy will not be able to stop abortion pills. Instead, rather than affecting *whether* they are accessed, the battles over pills will only affect *how*—if pills are harder to access legally, or information about them is censored, people will be forced to access them in extralegal and possibly less safe ways. In addition, removing mifepristone from the legally approved market will only increase reliance on misoprostol and international, non-FDA approved versions of mifepristone, and criminalizing buying or using these medications will only lead to delays in care, public health catastrophes, and more poor, marginalized people surveilled and jailed. Simultaneously, the expanded use of pills will change the terms of the abortion debate in a way that destigmatizes abortion and refocuses the public's attention away from the state and the medical profession and onto the individual pregnant person, the public health consequences of bans, and systemic disparities related to surveillance and criminalization.

When people can access medication abortion legally, or find safe and legitimate sources extralegally, abortion pills will blunt some of the worst effects of *Dobbs*. Abortion pills enable safe, effective, and cheap abortion access throughout the country, even despite bans. Try as the antiabortion movement might, abortion pills will continue to be available to those who seek them out. The abortion pill battles we describe in this Article will not change that; they will only change the consequences of doing so.

[435] *Id.* at 17.