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CHOOSING BETWEEN REPRODUCTIVE HEALTH AND HEALTH FROM CORONAVIRUS:
THE COVID-19 PANDEMIC AND BARRIERS TO ABORTION ACCESS

By

CAITLIN ROSE BROWN

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ABSTRACT OF THE THESIS

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Thesis Director:

Cynthia Daniels

The COVID-19 pandemic in the United States brought to the forefront a new iteration of barriers to abortion access that continue a long history of regulations and restrictions on abortion procedures despite its constitutional protections. During the early days of the COVID-19 pandemic in the United States, individual states following federal recommendations halted healthcare procedures deemed elective/non-essential in an effort to preserve supplies, staff, and space for essential services in an attempt to handle the increasing burden on the healthcare system. In some states, the designation of elective included abortion procedures which quickly brought about several lawsuits from the ACLU and abortion providers. This paper employs a reproductive justice framework to consider the impact of such policies including rhetorical ramifications of designating abortion procedures as elective healthcare and the risk and impact of suspending procedures on marginalized communities through the case study of Texas

and *Planned Parenthood v. Abbott*. Also considered are the differential impacts along racial and class lines via barriers the FDA placed by the reinstatement of in-person dispensing requirements for mifepristone - the primary drug for medication abortion procedures - through the Supreme Court decision in the case of *ACOG v. FDA*. This paper argues for the rhetorical integration of abortion procedures into essential healthcare to minimize the impact of state restrictions on marginalized communities and suggests that an attention to administrative policies and the violence they enact may provide an avenue for tangible action in expanding access to abortion care via utilization of telemedicine technologies.

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CHAPTER 1: Introduction

As the COVID-19 pandemic worsened in the middle of March 2020 in the United States, the federal government began to take action. Amid growing concerns, a national emergency was declared by President Trump on March 13, 2020 (K. Liptak). Part of the measures undertaken included a set of waivers and relaxation of certain regulations for the health secretary to provide more flexibility to healthcare centers responding to the outbreak of COVID-19 (K. Liptak). Following the declaration, confusion was stirred up by a tweet from the U.S. Surgeon General Jerome Adams after he tweeted that hospital and healthcare systems should consider stopping elective procedures to minimize the spread of the virus, conserve personal protective equipment (PPE), and spread health workers thin when they may be needed to combat the growing influx of COVID-19 cases (@Surgeon_General). The Surgeon General's tweet prompted some healthcare groups to ask for clarification on what qualified as "elective" procedures. More clarification came in the form of recommendations from The Center for Medicare and Medicaid Services (CMS) ("Non-emergent").¹ They utilized a tiered system to suggest which policies may be considered essential or elective, but left the decisions "'in the hands of state and local health officials and those clinicians who have a direct responsibility to their patients,'" (Finnegan). Thus, individual states began to undertake measures to combat the growing crisis through public health executive orders.

¹ For more information on the CMS tiered system please see their detailed recommendations here: <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>

Issued by governors or attorneys general, these orders were intended to supplement federal recommendations to the pandemic and provide guidance on a state level. While these orders addressed concerns such as large group gatherings, travel, and telecommuting, and shut down policies, they also sought to address the surge in people requiring medical attention and relying upon the health care system. States argued that, in an effort to address a shortage of staff, space, and supplies, specifically personal protective equipment (PPE), the executive orders sorted surgeries and hospital procedures into two categories: essential and elective. The designation of essential and elective healthcare was designed to funnel resources towards essential healthcare services and preserve PPE materials. While this designation presumably served a practical purpose in responding to the public health crisis, the designation of essential versus non-essential quickly became politicized by anti-abortion politicians to undermine women's² reproductive rights and justify restrictions on abortion care.

² This paper recognizes that not all women are able to get pregnant and not all pregnant individuals are women. It will often refer to pregnant folks or those seeking abortions over the category of women in order to remain as inclusive as possible for those who are often written out of the reproductive health care narrative. However, "woman" as a legal category still holds a lot of weight in decisions around abortion care and since this paper interrogates two court cases, it will still use "woman" as a category to denote this category of folks before the law when relevant or when quoting statements issued about the cases.

Background on Reproductive Rights and Justice

Abortion has a long and complicated political history in the United States.

Abortion access as a right was adopted into the women's movement during what is referred to as the "second wave"³ of feminism, characterized by a focus on white, middle-class women's priorities. As a part of this movement, white women advocated for a pro-choice stance on abortion access, which entailed a right to decision-making power over their body particularly with regard to reproductive choices (Threadcraft 19). This strategy had the effect of centering abortion access as a way to attain equality and end women's oppression in the U.S. (Threadcraft 19). A pro-choice framework stood in opposition to anti-abortion groups, who termed their advocacy against abortion as a "pro-life" stance, albeit one that made exceptions for the extraordinary cases of rape and incest and in the event of dire health consequences to the mother. However, the choice framework fails to capture the experiences of all but white, middle-class women. As Shatema Threadcraft notes, "Black feminist activists were critical of the mainstream liberal and radical second wave's view of women and work and of their body politics, including the politics of reproduction, and this critique turned on the fact that black and white women had been subject to distinct forms of capacity inhibition under patriarchy" (Threadcraft 13). That is, the choice framework ignored the women with constrained or

³ While the history of feminist movements in the United States are often referred to in the wave metaphor (i.e. first wave, second wave, and third wave), these movements typically only encapsulate the white, middle-class women experience and ignore the long history of women of color and queer critique that these movement metaphors fail to capture. For more explanation, check out *No Permanent Waves: Recasting Histories of U.S. Feminism* edited by Nancy A. Hewitt.

no choices, who had a long history of coercion and sterilization via a race, class, and ability-based eugenics movement to “preserve” the body politic.

Indeed, the racially stratified history of reproductive health is clearly seen in the divergent paths of social critique of the women’s movement in the early 1970s. In 1973, the Supreme Court ruled in *Roe v. Wade* that a woman’s right to an abortion fell under the Due Process Clause of the Fourteenth Amendment with respect to the right to privacy, thus making abortion legal (“*Roe v. Wade*”). That very same year, news broke about the Relf sterilization case where two young sisters, Minnie Lee Relf and Mary Alice Relf, daughters of Black Alabama farm hands, were sterilized without consent (Threadcraft 2). Threadcraft notes the bitter irony of this coincidence: “At a time when women’s ability to control their fertility moved from the margins to the center of the struggle for women’s rights, the Relf sisters’ violation was a clear reminder that the very patriarchal control of reproduction that the period’s feminist activists decried had diverged sharply along racial lines historically” (Threadcraft 2). Taken together, Threadcraft’s work demonstrates the devastating effect of racist and classist eugenic ideology and forced sterilization on populations such as inmates of mental hospitals, prisoners of the state, women of color, and pre-pregnant to pregnant individuals in an effort to police the borders of the national body politic to highlight the ways that abortion access as a centering issue fails to adequately achieve justice for all populations in the name of women’s liberation. The active engagement of the state through direct and indirect means must be examined to gain a holistic view of systems and structures that collude in blocking a path to “intimate justice,” a term Threadcraft

uses to indicate “black female intimate freedom and equality” within the U.S. context (Threadcraft back cover). The term points towards how the needs of all women, as well as trans and non-binary folks, are not appropriately accounted for and addressed via a pro-choice framework of reproductive equality.

Threadcraft’s concept of “intimate justice” reflects the particular circumstances around reproductive rights with the U.S., but it also echoes conversations that have been taking place globally. The transnational women’s movement, emerging in the early 1970s out of a long legacy of critiques of mainstream U.S.-focused feminism by women of color, centered on a human rights framework for talking about reproductive rights (Price). “Reproductive justice,” though a longstanding theoretical and activist concept, was officially coined in 1994 during international conversations with women’s rights advocates influenced by UN human rights conferences (Price). Activists utilized a human rights framework, combining the language of reproductive rights and social justice to address more broadly the lived experiences of all women beyond the framing of pro-choice/pro-life (Ross and Solinger 9).

As Kimberly Mutcherson notes, reproductive justice as a framework “rejected the mainstream women’s reproductive health movement’s myopic focus on abortion, and the resulting exclusion or downplaying of other issues that were significant in the lives of poor black women, including sterilization abuse, educational disparities, and inadequate access to reproductive healthcare” (Mutcherson 2). Instead, reproductive justice has “three primary principles: (1) the right *not* to have a child; (2) the right to *have* a child; and (3) the right to *parent* children in safe and healthy environments”

(Ross and Solinger 9). Additionally, it encompasses “sexual autonomy and gender freedom for every human being” (Ross and Solinger 9). A wider and more accessible framework than the one promulgated by second wave feminists in the 1970s, reproductive justice considers the lived realities of a multitude of individuals, their families, their communities, and their society (Price). In contrast to second wave feminism frameworks, reproductive justice builds a movement that is not based on one small demographic’s power of choice that whitewashes and ignores the role of class and ableism in reproductive decisions in the pursuit of alleviating women’s oppression.

To illustrate the strength of a reproductive justice framework as it moves beyond the confines of constitutional rights to human rights Mutcherson says, “This creates a structure that is not bound by U.S. Supreme Court cases and state statutes. Instead, RJ [reproductive justice] recognizes that governments do not grant the rights surrounding procreation and parenting in the first instance, and these rights do not depend on where and how one is born or in which country one has citizenship. The rights inherent in RJ are global and far-reaching, and the narrow confines of any particular societal or governmental structure do not cabin its reach” (Mutcherson 4). The language of human rights as global, rather than determined by and centered around any one country’s legal rights system to declare law through either positive or negative rights, provides a broader alternative view for considering current conditions of reproductive health and access.

Although reproductive justice is not constrained by a focus on legal frameworks, Nancy Ehrenreich draws attention to how the law and state intervention in reproductive

affairs can align with reproductive justice goals. Ehrenreich takes a critical stance of the liberal individualist approach to dealing with law and intervention of the state in individual reproductive affairs that aligns with a reproductive justice approach. She says the liberal individualist approach fails because it fails to consider that the freedom to make a choice (such as granting abortion access) does not address the social constraints within which women pursue choices (Ehrenreich 2). Indeed, as governments take a hands-off approach to decisions, “such *non*intervention is not seen as favoring one group over another” (Ehrenreich 2). Ehrenreich argues how such a nonintervention approach by the government actually serves a race- and class-biased model for it fails to account for the fact that without government intervention, white women have the most access to resources for reproductive services (Ehrenreich 5). “Women of color are disproportionately low-income, so they, along with poor white women, are disadvantaged by this model. They are also the most stigmatized by the focus on choice, for the women most often seen as bad choice makers are low-income women and women of color” (Ehrenreich 5). Social conditions, in part influenced by law and policy, construct the world in which choices are made possible. This is reflected in the alternative to liberal individualist approaches to government intervention, a critical constructivist approach. In contrast, “[a]ccording to the critical constructivist view, individual choices are to a significant degree *socially constructed*; they are a function of preexisting conditions over which individual women have limited control” (3). Law and government policies play an active role in affecting what choices exist and thus, the value of choice attached to different women making different choices at different social

locations. These concerns are relevant here as considering social conditions under which different women exercise choice has negative effects on those who choose to attain an abortion who already are stigmatized for “poor choices” based on previous stereotypes and government policy.

How does looking at the U.S. legal framework and decisions concerning abortion access during the COVID-19 pandemic through the lens of reproductive justice add something new to the conversation? Well, it helps us move beyond this oppositional framework of pro-choice versus pro-life dominated national discourse for decades and that is still prevalent today in the way abortion is talked about. However, utilizing an expansive framework of reproductive justice allows a more nuanced understanding of the injustices faced in ordinary times. But it also highlights how pandemic responses end up entangled with a larger narrative about abortion access and healthcare during a public health crisis. The abortion restrictions and government responses that were seen in *Planned Parenthood v. Abbott* and *ACOG v. FDA* are not new, but rather part of a longer history whereby the United States, at both the federal and local level, have participated in direct and indirect policy with aims to control the reproductive potential of bodies. The COVID-19 pandemic that began to affect the United States severely in the spring of 2020 has merely made visible restrictions that place an undue burden on abortion access that disproportionately affects marginalized individuals. Attention to the impact and intent of these policies that restrict access is important as the burdens of these administrative policies are disproportionately affecting marginalized populations

who are already structurally and systematically denied access to adequate reproductive healthcare.

Pandemic Considerations

In medicine, the designation of “elective” indicates a surgery that can be planned out ahead of time instead of urgently requiring attention (“Types”). The CMS guidelines used a tiered system to designate between low acuity treatment or service and high acuity treatment or service with intermediate falling in between to create a guide for what procedures may fall under the “elective” or postponed category (“Non-emergent”). Those in the “high” category are those treatments or services, that if delayed, the “[l]ack of in-person treatment or service would result in patient harm” (“Non-emergent”). The intermediate category covers treatments or services that, if not provided, “has the potential for increasing morbidity or mortality” (“Non-emergent”). They recommend the use of an initial virtual telehealth evaluation with potential for in-person follow-up if necessary. For all other procedures in the low acuity category, they recommend postponing service (“Non-emergent”). In addition, medical associations and societies also came up with their own recommendations for deciding on the postponement of health care services. One example is the American Dental Association that recommended postponing all but emergency dental procedures (“ADA recommending”). Thus, while federal recommendations were put out by CMS and some healthcare societies and organizations issued their own recommendations, states were given the liberty to enact their own specific policies.

As the pandemic escalated throughout the spring of 2020, the designation in some states, however, quickly became politically contested. Abortion procedures were categorized as non-essential following the passing of executive orders in Alabama,

Alaska, Arkansas, Indiana, Iowa, Louisiana, Mississippi, Ohio, Oklahoma, Tennessee, Texas, and West Virginia with attempts by the Attorney General to include abortion in Kentucky as well (Baker). Categorizing abortions as non-essential, rather than essential health services, suspended access effective immediately. The specificities ranged by state where some required the cessation of *all* abortion procedures, while others required the immediate halt of only surgical abortions, permitting medication abortions to continue. Though the impacts varied by state, all abortion providers and patients were affected as they implemented the halt on procedures.

The purported justification for passing abortion bans during the pandemic relied upon extreme shortages of PPE, ventilators, hospital beds, and healthcare supplies more generally in addition to concerns of safety for the staff at hospitals (Sobel). As an influx of patients with COVID-19 required care and treatment, medical facilities were reaching or already at capacity. Space shortages were expected to be so severe that the U.S. military deployed their two Navy hospital ships, USNS Mercy in Los Angeles, CA and USNS Comfort in New York City to help free up space in overwhelmed hospitals (Cronk). PPE became a daily use object in a way not seen before, as it was known that COVID-19 was contagious, but little else was known yet about the transmission of the disease. In an effort to reduce health concerns for essential healthcare workers, PPE was essential in ensuring their safety. Shortages in some areas were so extreme that nurses and doctors were reduced to wearing trash bags as protection and fashioning makeshift masks from snorkel masks and swimming goggles (Ankel). Part of this issue stemmed from supply chain issues, as demand far exceeded previous needs resulting in huge

shortages globally. Companies like Apple, Ford, GM, and 3M began to pivot towards production of essential materials such as masks, protective face shields, ventilators, gowns and other equipment (Ward). These conditions lead to states limiting healthcare interaction as much as possible in order to maintain the health and safety of their staff while managing supply shortages.

Despite the very real severity of PPE shortages, the conditions for preserving PPE, hospital space, and staff were not, in practice, sufficient to warrant the justification for suspending abortion procedures given the increased strain pregnancy care would place on healthcare centers in contrast to abortion procedures and thus contradicting the space and PPE shortages. As Dr. Jen Villavicencio, an OB-GYN in Michigan highlights, medication abortion, which accounts for upwards of 90% of all abortions, “can be accessed entirely without touch or need for any personal protective equipment” and procedural abortions “requires only the use of eye protection and gloves, neither of which are in shortage” (Villavicencio). In contrast, she notes that “[p]renatal care for ongoing pregnancies, which I also provide, requires use of gowns, gloves, masks, ultrasounds and other equipment on an ongoing basis” (Villavicencio). As pregnant individuals continue to carry a fetus to term, their prenatal care and delivery needs will require more patient-physician interaction and require more medical supplies. The argument for decreasing PPE strain as shortages occurred also fails to account for the increase in contact and equipment necessary for surgical abortions required when those forced to wait for an abortion miss the window for medicine-induced abortion. Additionally, the argument against allowing abortion procedures to continue in order to

conserve PPE fails to consider that many abortion clinics were not spaces where COVID-19 individuals were treated and did not house hospital overflow. As the Guttmacher Institute reports, very few abortion procedures actually take place in a hospital setting, “only 3% in 2017” (Cappello). Suspending these procedures would not free up space for the influx of COVID-19 patients requiring treatment. As individuals sought to circumvent the executive orders to attain an abortion in a neighboring state, they also increased the burden on those states and their clinics, while also increasing their risk of exposure and that of others from longer and unnecessary travel versus attaining a procedure closer to home. All together these factors point to the fact that the inclusion of abortion as an elective procedure was politically, and not practically, motivated.

Given the time-sensitive nature of abortion care and the inevitable progress of pregnancy, why was abortion written out of essential healthcare services during the states’ responses to the COVID-19 pandemic if it did not help to solve PPE shortages or reduce risk of exposure to healthcare workers? In the following chapters, I explore Texas as a specific case to investigate this chain of events. While the courts sided with abortion providers and their clients in most states that brought an action in court, Texas’ ban was upheld by the U.S. Court of Appeals for the Fifth Circuit via various legal ping-ponging until Governor Greg Abbott eased restrictions on elective surgeries in late April, allowing abortions to resume in the state (Méndez). Why was this ban able to be briefly upheld by the Fifth Circuit Court when it was dismissed in other states?

Additionally, as the pandemic continues, other developments at the national level have prompted a consideration into the ways that abortion medication, specifically

the dispensing of mifepristone, is a unique case before the FDA. This paper will also consider those legal developments and potential ramifications for abortion access in the future and how they intersect with the abortion ban seen in Texas. What have we learned from the pandemic and what sort of possibilities for abortion access in the future can we imagine when we consider the expansion of telemedicine?

Unlike other procedures outlined in the executive orders, the inclusion of abortion procedures was highly-contested both at the national level, by the American Medical Association (AMA) (Harris) and the American College of Obstetricians and Gynecology (ACOG) in joint statement with other national healthcare societies and organizations (“Joint Statement”), and the local level by Planned Parenthood and the Center for Reproductive Rights (A. Liptak). In a similar fashion, the refusal on part of the Food and Drug Administration (FDA) to waive in-person dispensing requirements for mifepristone during the pandemic was contested by the ACOG, the Council of University Chairs of Obstetrics and Gynecology, New York State Academy of Family Physicians, and SisterSong Women of Color Reproductive Justice Collective (U.S. District Court). I provide a three-part analysis of this treatment of abortion care that argues: 1) abortion bans, specifically in Texas, are a case of “abortion exceptionalism” where abortion procedures are singled out and treated differently from other time-sensitive procedures, 2) the rhetorical binary placement of “essential” versus “elective” healthcare created an environment that allowed abortion to be divorced from essential healthcare, and finally, 3) the executive orders represented a displacement of risk onto marginalized populations who would bear the burden as the state tried to decrease its

liability, which is seen in the conflict over in-person dispensing requirements for mifepristone. These three moves served to undermine healthcare for pregnant individuals seeking abortions, threatened the stability and functionality of abortion clinics in the states facing criminalization for performing procedures while putting patients and physicians at heightened risk with in-person dispensing requirements, and disregarded the health implications and risk displacement of suspending abortion care during a pandemic, which may set a harmful precedent for abortion access during future public health emergencies. Ultimately, I suggest incorporating abortion rhetorically into a comprehensive healthcare framework so we secure future access to abortion in a similar public health crisis and mitigate the high cost of risk associated with banning abortion during a health crisis, but that we also explore other avenues of possible policy adjustment to more fully consider the expansion of access telemedicine may allow. Abortion access is a public health issue as well and needs to be considered as such.

This project investigates the development and implementation of the emergency order, the court objectives, and the stances of the advocates on both sides of the case to consider the regulatory powers of the state via public health emergency orders with a focus on Texas's legal developments. This will include investigating public documents of the regulations and court cases, news coverage, and public positions of activist and advocacy groups. First, I will demonstrate how Texas and other states like Louisiana and Ohio are examples of abortion exceptionalism in practice in public health policy. I will utilize the work of Grace Howard to showcase how abortion, both surgical and medication procedures, are handled with differential treatment over the course of

establishing restrictions on healthcare procedures in order to combat the growing threat of the COVID-19 pandemic in the spring of 2020. From her work on pregnancy exceptionalism I build a case for abortion exceptionalism as seen in both the treatment of *Planned Parenthood v. Abbott* and *ACOG v. FDA*. Howard tracks how the condition of pregnancy creates a space of reduced citizenship for pregnant individuals related to increased surveillance, regulation, and control by the state (Howard 402). She notes this creates exceptions before the law based on the condition of pregnancy, affecting both those who do and do not intend to carry the pregnancy to term (403). What is important in her analysis is the way that pregnancy as a condition is the justification for difference of treatment before laws that reduce the citizenship of individuals. We see a similar mode of erosion of rights during the pandemic when state officials utilized executive orders to ban abortion procedures, part of a longer legacy of regulations and policies restricting access since the legality granted in 1973 in *Roe v. Wade*. As Howard argues, “When and if the U.S. Supreme Court rules to further restrict abortion, it will do as part of a system which has already established policies, strategies, and practices to surveil, regulate, and control pregnant people” (Howard 417). Pandemic strategies to limit access to abortion represent part of this system of curtailing rights.

After addressing Texas as a case of abortion exceptionalism, I will address how abortion access is tumultuous and argue for rhetorical integration into a broader narrative of healthcare in order to help preserve access and importance in future public health measures. I will highlight how a pro-choice framework fails to account for the issues at hand and how it is weaponized against categorizing abortion as essential

healthcare. I will also cover how the executive orders are a risk management strategy that displaces the risk from the state to marginalized communities, including both patients and healthcare workers. As we see with the inability to terminate pregnancy during an unprecedented time of public health crisis, we see the risk carried disproportionately across populations. A consideration of increased risk of mortality and morbidity in contrast to the goal of saving PPE will be discussed to give context to what abortion bans were asking of pregnant individuals during the initial public health response.

I will also take up the question of telehealth and its role in medicine with regards to in-person dispensing requirements of medications and the FDA's decision to waive regulations for 20,000 FDA approved drugs, but not mifepristone. This act perpetuates a network of administrative violence as showcased in the work of Dean Spade, an Assistant Professor of Law and founder of the Sylvia Rivera Law Project. Spade's work highlights how violence is not necessarily relegated to the sphere of interpersonal relations, but rather than the state perpetuates violence through mechanisms such as state programs and law enforcement which are "sponsors and sites of violence" (Spade 2). Spade identifies a different avenue for attaining transgender rights than anti-discrimination and hate crime laws. Instead, he proposes legal reform in "the administrative realm" to consider how "law structures and reproduces vulnerability for trans population (Spade 3). He considers the role of administrative violence, how "administrative norms or regularities create structured insecurity and (mal)distribute life chances across populations" (Spade 3). Instead, it considers impact over intent (Spade

10). This is relevant for a discussion about how abortion bans and dispensing requirements are supported versus the risk they carry for the vulnerable. This paper considers what role such an attention to administrative practices such as FDA dispensing requirements may change how we consider access and risk for abortion patients and physicians during a pandemic. By restricting access to abortions, the people with the most to lose are forced to bear the burden due to state and federal policies.

It is important to consider the potential ramifications of this precedent as potential new pandemic conditions may force statewide closures to resume in the future. In considering the abortion bans of spring 2020 and the conflict over mifepristone dispensing requirements, this project asks whose health matters during a pandemic? What does it mean to delay and create obstacles to abortion care when the end of a pandemic is indeterminate?

CHAPTER 2: Texas and Executive Order GA-09: A Response to the COVID-19 Pandemic

Starting in March 2020, many states attempted to ban abortion procedures in their states under the designation of a non-essential, or elective, procedure, despite the protection of previous Supreme Court rulings. The right to abortion is constitutionally protected via the Supreme Court's ruling in the case of *Roe v. Wade* under the right to privacy ("Roe v. Wade"). However, despite the constitutional protection, states utilized public health executive orders responding to the COVID-19 pandemic to ban abortion procedures. While the procedures included in the restriction varied by state, restricting abortion access had the effect of suspending care that is necessary for full reproductive health care. I will primarily use the case study of Texas, in the context of other state public health responses, to explore the questions of essential versus elective healthcare concerning the pregnant body and abortion.

In considering abortion access and government policy, the work of Grace Howard is helpful. Howard's work in "The Pregnancy Police: Surveillance, Regulation, and Control" explores the way that pregnancy creates a contradictory socio-legal space and argues that pregnancy serves as an exceptional case undermining fundamental rights, including rights to medical privacy, religious expression, due process, equal protection as well as protection from wrongful detention, and freedom from cruel and unusual punishment (Howard). The contradiction around pregnancy creates a subset of people who are a lesser class of citizens before the law, which Howard describes as "pregnancy exceptionalism" (Howard). While all pregnant women are at risk, some are targeted more than others along lines of race and class. Her work has implications for

the rights of all women, trans, and non-binary folks who can become or are pregnant, with a particular relevance for marginalized bodies that are disproportionately surveilled and controlled by the state (Howard).

Specifically, her work showcases the way that the condition of pregnancy renders individuals more vulnerable to state surveillance, regulation, and control, with disparate impacts based on race, class, citizenship status, and gender identity. This vulnerability is extended by Howard in a rights framework with a consideration of state administrative power and policy and the governing of life and health. In particular, this framework provides a way to think through the context of abortion specifically as a right to terminate a pregnancy, as protected in *Roe v. Wade*, in relation to a right to privacy. How is the provision of abortion services treated differently from other similar time-sensitive services and procedures? I contend that expanding the framework of her theory to a consideration of “abortion exceptionalism” helps to explain state responses in suspending abortion care under a pretext of conserving resources to fight COVID-19 induced shortages. In refusing to file abortion under essential health care services, Texas provides a strong example of how abortion is treated differently from other similar time-sensitive medical procedures creating a case of exceptional violence with other “elective” procedures before the law. Abortion is a procedure that increases in the risk of mortality and morbidity over time. Additionally, there is an increased risk associated with pregnancy, a progressing condition also associated with risk of mortality and morbidity. While these issues will be discussed more at length below, state bans on

access to care during a pandemic perpetuate violence against those who are even more vulnerable during a public health crisis.

Federal recommendations calling to delay elective healthcare procedures were delivered on March 18, 2020, by Seema Verma, a White House coronavirus task force member and Centers for Medicare and Medicaid Services administrator (Yeung et al.). “We believe that these recommendations will help surgeons, patients, and hospitals prioritize what is essential, while leaving the ultimate decision in the hands of state and local health officials and those clinicians who have direct responsibility to their patients” (Finnegan). The logic of the executive orders was to legally mandate the suspension of elective procedures in order to preserve PPE for emergency responses to the growing burden on the healthcare system due to increased cases of COVID-19 and limit exposure of practitioners to COVID-19 as Verma explains “We urge providers and clinicians and patients to seriously consider these recommendations. They will not only preserve equipment, but it also allows doctors and nurses to help those that are on the front lines, and it will protect patients from unnecessary exposure to the virus” (Yeung et al.). While the Trump administration strongly suggested delineating between essential and elective, the CMS provides only the guidelines to empower states and local health officials, as well as clinicians with “direct responsibility to their patients” to make the call. The call from CMS echoes an earlier call from Surgeon General Jerome Adams, another member of the coronavirus task force, for hospitals to consider suspending elective procedures (Finnegan). However, this prompted many healthcare groups for clarification on what “elective” means (Finnegan). The CMS recommendations laid out a

tiered framework to address healthcare provider concerns: tier 1, low acuity treatment or service; tier 2, intermediate acuity treatment or service; and, tier 3, high acuity treatment or service (“Non-emergent”).

Federal recommendations do not touch upon specific procedures like abortion, but rather left the decision to delineate procedures to the state level. However, as explored above, I contend that the mandate to include abortion into the elective category as a way to preserve PPE and limit physician-patient interaction actually fails to meet these specifications. The need for equipment, space, and personnel is exponentially greater when carrying a fetus to term, putting a greater strain on hospitals, risks of exposure, among other concerns. Despite these concerns, states like Texas opted to include abortion procedures within their elective or non-essential procedures list (U.S. District Court). While states differed as to whether they included surgical, medication, or both types of abortion, Texas’s order ultimately covered both types of procedures, despite the minimal to non-existent PPE required of medication abortions (U.S. District Court). In response to the order, Texas became a battleground as abortion practitioners and other medical professional organizations challenged the legality of the ban on abortion procedures in the name of the health of their patients (U.S. District Court). Due to the indeterminate end of the pandemic, the Texas ban suspended care for individuals who may miss the 20-week limitation on legal induced abortions in Texas.

Despite the legality of abortion established in *Roe v. Wade*, individual states have passed regulations and administrative clauses that restrict access or place

additional steps which is no exception in Texas. Texas abortion restrictions include: state-direct counseling and a mandated 24-hour waiting periods between the initial counseling appointment and the procedure; denial of coverage, whether under private insurance policies, health plans under the Affordable Care Act, insurance for public employees, or public funding, except in the case of severely compromised health; mandatory ultrasounds at least 24 hours before; and a limitation on abortions post 20 weeks after fertilization except in the cases of “life endangerment, severely compromised physical health or lethal fetal anomaly” (“State Facts”). As discussed above, states responded to the growing crisis by legally mandating non-essential procedures to be halted and temporarily postponed in order to conserve PPE and limit unnecessary contact. Some states included abortion bans in those orders which restricted access for pregnant individuals.

However, obstacles to abortion care are not new phenomena as the list above indicates. The abortion bans through the public health executive orders are merely additional administrative actions to restrict access that are part of a larger pattern of limiting abortion access piecemeal through regulations and additional requirements. As the Guttmacher Institute illustrates, states have enacted policies that limit and regulate when, under what conditions, and how individuals may attain an abortion. States have enacted policies such as physician and hospital requirements, gestational limits, “partial-birth” abortion bans, limits on public funding, restrictions of coverage by private insurance, mandates for state direct counseling, necessitated waiting periods between counseling and procedure, requirements for parental consent and notification in cases

where the patient is a minor, and allow refusals, both at the individual physician level to medical institutional level, to participate in abortions (“An Overview”). All of these regulations and policies create extra burdens and obstacles for patients seeking care.

The pattern of abortion restrictions is most clearly seen in the ban and legal aftermath in Texas. While many states faced legal challenges when trying to ban abortion, most upheld injunctions against the ban (Baker). In contrast, Texas provides an important case study because of the back and forth within the courts that ultimately upheld the ban on medication and surgical abortions until the expiration of the initial executive order in April 2020, only permitting exceptions for individuals who were nearing the end of the 20-week period. What was it about the Texas case that allowed restrictions on abortion to continue when other states regained access to abortion care?

Texas Lawsuit: *Planned Parenthood v. Abbott*

Amid a flurry of responses from other states, Texas governor Greg Abbott issued Executive Order GA-09 on March 22, 2020, to respond to the emerging crisis in hospitals and capacity (Texas). The order banned non-essential medical procedures as COVID-19 cases continued to increase in a bid to free up hospital space and PPE for medical providers. The next day, March 23rd, attorney general Ken Paxton issued a press release interpreting the March 22nd order to ban “any type of abortion that is not medically necessary to preserve the life or health of the mother” (“Health Care Professionals”). While abortion is listed alongside other procedures such as routine dermatological, ophthalmological, and dental procedures, Paxton calls out abortion providers specifically in resource conservation efforts and lack of exemptions. “No one is exempt from the governor’s executive order on medically unnecessary surgeries and procedures, including abortion providers. Those who violate the governor’s order will be met with the full force of the law” Paxton said of the new restrictions (“Health Care Professionals”). Failure to comply with GA-09 could result in penalties of up to \$1,000 or 180 days of jail time (“Health Care Professionals”). As Carrie Baker of Ms. Magazine notes, this order represents the first time in Texas’ history that abortion is fully banned since *Roe v. Wade* (Baker “Texas Abortion”). The interpretation of the order by Paxton set off a domino effect as providers and organizations in Texas took to the courts to preserve abortion access, culminating in 30 days of legal back and forth regarding the legality of abortion procedures in the state.

In an effort to ensure access to time-sensitive care for their patients, multiple abortion providers including multiple Planned Parenthood centers, Whole Women's Health, and the Austin Women's Health Center filed suit against Greg Abbott, Ken Paxton, and other Texas officials to fight the ban two days after the announcement from Attorney General Ken Paxton on March 25th ("Complaint"). In the meantime, hundreds of appointments were canceled, and patients were turned away from clinics per the interpretation of the executive order (Tuma). On March 30th, a federal court ruled in favor of the abortion providers in the suit, granting a temporary restraining order which would allow abortion services to continue in Texas ("Order Granting"). Judge Lee Yeakel wrote of the case that "Plaintiffs' patients will suffer serious and irreparable harm in the absence of a temporary restraining order. The attorney general's interpretation of the Executive Order prevents Texas women from exercising what the Supreme Court has declared is their fundamental constitutional right to terminate a pregnancy before a fetus is viable" ("Order Granting" 7). Yeakel writes that there cannot be an outright ban on "pre-fetal-viability abortion" without being in contention of the Supreme Court's previous rulings ("Order Granting" 6). Federally protected, Texas officials may not interfere with access to abortion via an outright ban regardless of the current climate of the pandemic. "This court will not speculate on whether the Supreme Court included a silent 'except-in-a-national-emergency clause' in its previous writings on the issue." ("Order Granting" 6). Changes to the ruling can only be restricted by or expanded by the Supreme Court and Yeakel defers to their judgment, as courts are designed to do. The climate of the pandemic does not impact the legality of the protections afforded to

abortion procedures and Texas officials may not exercise the authority to restrict all access to abortion for pre-fetal-viability cases.

Viability debates aside, this argument notes the “silent” justification Texas officials read into the original ruling in an attempt to maintain their original restrictions on all surgical and medication abortions. The ban is in direct violation of previous Supreme Court rulings that allow for individuals to access abortion care via the precedent established in *Roe v. Wade* without imposing an undue burden on those seeking care as established in *Planned Parenthood v. Casey* (“Planned Parenthood”). The court ruled in *Planned Parenthood v. Casey* that a new standard would be used to gauge the legality of abortion restrictions, asking whether the restriction creates an undue burden explained as a “substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability” (“Planned Parenthood”). Restricting all access to abortion, leaving only travel to a neighboring state as an option, most certainly violates the undue burden by creating substantial obstacles to obtaining care, let alone the involvement of the government in suspending access for women seeking care in the first trimester of abortion.

The case of *Planned Parenthood v. Abbott* also argued against the benefit of conservation of PPE from suspending abortion procedures during the pandemic. Yeakel indicates that “The benefits of a limited potential reduction in the use of some personal protective equipment by abortion providers is outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of continuing an unwanted pregnancy, as well as the risks of traveling to other states in search of time-

sensitive medical care. The court finds that a temporary restraining order will not disserve the public interest” (“Order Granting” 8). The court notes the long-term impact of short-term bans, but Judge Yeakel’s ruling is important in considering the unique social conditions of the pandemic in relation to accessing abortion care and the burden that pregnant individuals have in seeking that care. The ruling allowed abortion procedures to resume in the state of Texas, setting off a flurry of activity as abortion providers worked to reschedule patients and open their facilities.

While providers worked to reopen their doors, the decision to ban abortion found support among anti-abortion groups who support Governor Abbott and AG Paxton, claiming the ban was in the interest of protecting public health. As reported in the Dallas News, Joe Pojman, the executive director of the Texas Alliance for Life said “[w]e’re really grateful to the governor for issuing these executive orders that have been intended to protect the public and the medical providers serving the public,” (Méndez). They utilized the rhetoric of protecting healthcare workers to erase the consideration for protection for those seeking banned, time-sensitive care.

Similar restraining orders were granted in other states that attempted to ban abortion procedures via an emergency order responding to the growing concerns of the pandemic. Other states had similar bans in the initial state executive orders that sought to address the crisis caused by rising cases of COVID-19. Regarding their original emergency orders, both Ohio and Oklahoma respectively clarified their positions that abortion was also covered under their executive orders despite no explicit reference in the original document. On March 24, 2020, Governor Stitt of Oklahoma issued his

executive order suspending non-essential procedures (Baker). However, it took him three days later on March 27 to release a statement clarifying that the executive order included the suspension of elective abortions (Baker). Ohio took until March 26 to clarify that the state executive order, published on March 17, included all procedural abortions under the non-essential surgery ban, caving to pressure from anti-abortion groups who continued to file complaints with the Department of Health that abortion clinics were non-compliant with the order (Rowland). These clarifying statements indicate that interpretation was at the discretion of governors and attorneys general. As abortion procedures were suspended, it caused practitioners and providers to scramble to adjust schedules to avoid legal or criminal ramifications of violating the terms of the emergency orders. While Texas provides the most legal back and forth in regards to an abortion ban case, other state abortion bans remained unchallenged entirely such as Alaska, Indiana, and Mississippi (Baker “Roundup”). Additionally, an appeals court upheld the ban in Arkansas until it expired and West Virginia’s ban was also lifted with a change in state orders (Baker “Roundup”).

Texas was not the only state where conflict broke out over whether abortion clinics could remain operational as other battles broke out between state lawmakers and abortion clinic providers. A similar battle over what was included under essential healthcare procedures broke out in Ohio. An order postponing all non-essential and elective surgeries and procedures was issued by the Ohio Department of Health Director Dr. Amy Acton effective starting March 18, 2020 (Sgueglia). Following the order, abortion clinics continued to operate in compliance with the order and received letters

from Attorney General Jonathan Fulkerson to stop performing “nonessential” abortion procedures during the pandemic (Sgueglia). A spokeswoman for the AG’s office argued the letters were not intended to raise an issue of abortion as they also penned a similar cease and desist letter to a urology group in the state that was also allegedly conducting elective procedures despite the Department of Health order (Sgueglia). In at least one of the compliant cases, the Ohio anti-abortion group Right to Life of Greater Cincinnati was credited due to sharing a video of an operational abortion clinic in Cuyahoga Falls, Ohio via email (“BREAKING”). They called upon their email list to contact Governor DeWine, Health Director Amy Acton, and the county health department to report Planned Parenthood of Southwest Ohio (“BREAKING”).

In response to complaints, letters were then sent out to the centers reported from Attorney General Fulkerson, claiming “everyone must do their part to help stop the spread of this disease” and that the Department of Health will “take all appropriate measures” if providers do not comply (Knowles). However, in response to the letters, the clinics maintained they did not fall under elective procedures and would continue running as is with the modified policies to meet the essential procedures mandate. As mentioned in a statement by Planned Parenthood of Southwest Ohio Region, they remain compliant with the order’s mandate on PPE to ensure that “every person can continue accessing essential health care, including abortion. ...Under that order, Planned Parenthood can still continue providing essential procedures, including surgical abortion, and our health centers continue to provide services that our patients depend on,” (qtd. in Sgueglia). These sentiments are echoed by other abortion providers in Ohio

including Planned Parenthood Greater Ohio and Preterm that note abortion is an essential procedure and thus they remain open while in full compliance with the Department of Health's order (Knowles). Both parties interpreted the order differently to justify their stance on maintaining or suspending abortion care.

At the end of the day, interpretation of executive order bans was the biggest determinate on whether abortion providers were or were not in compliance with the state orders. The variance is seen across states where injunctions were passed allowing abortion procedures to remain accessible such as Alabama, Ohio, Oklahoma, Tennessee, and Louisiana (Baker "Roundup"). Iowa was a similar case. Originally Iowa Governor Kim Reynolds' move to suspend essential services on March 30, 2020, included abortion procedures. As in other states, the ACLU filed a lawsuit on behalf of abortion providers to put an injunction on the abortion part of the elective services ban, noting that it violates the Iowa Constitution (Pfannenstiel). Moments before Judge Andrew Chappell was set to review the request on April 1, 2020, the suit was dropped after lawyers from both sides reached a compromise that would allow for services to resume for abortion procedures deemed "essential" namely noting the current Iowa ban on all abortion procedures occurring after 20 weeks of pregnancy (Pfannenstiel). The compromise reached would still allow a suspension of "nonessential" surgical abortions that could be delayed without health risk to the patient (Pfannenstiel). Once again, interpretation of the limits of "essential" and "nonessential" abortion procedures allowed for the legality of abortion operations to be upheld in the state of Iowa.

Despite other states where the restraining orders allowed abortion procedures to continue as they had pre-COVID-19 restrictions, attending to patients seeking abortions in Texas became even more complicated for abortion providers. Dissatisfied by the court's outcome, Texas state officials took action via the courts. At Paxton's urgent request, the U.S. 5th Circuit Court of Appeals placed a stay on Judge Yeakel's order, once again banning abortion. The Austin Chronicle notes that this stay came halfway through the day, affecting clinics that were already back open and attending to patients (Tuma). Dr. Amna Dermish, Planned Parenthood South's abortion provider, said they were in complete disbelief at the speed with which care was once again suspended: "I now had to face patients and tell them 'I am banned from taking care of you' for a second time – it's such a difficult place to be in as a health care provider" (Tuma). The ban remained in effect, suspending care. On April 7th, the 5th Circuit Court of Appeals granted Paxton a writ of mandamus to dissolve Yeakel's order ("Petition for a Writ"). The court, in a 2-1 panel decision, noted various errors of the logic Yeakel used in the restraining order to justify the writ of mandamus. This ruling served to uphold the original bans of executive GA-09 as issued by Governor Abbott.

In response, the federal district court granted a second restraining order on the executive order a day later. Yeakel's second temporary restraining order (TRO) would allow abortion procedures for those seeking termination who were nearing 20 weeks, the cutoff date for legal abortion in the state of Texas (Baker "Texas Abortion"). The TRO would also allow medication abortion, as Yeakel ruled it would not affect PPE usage and he paid particular attention to the rise in people traveling to neighboring states to

access care during the Texas ban, considering that they stood at an increased risk of contracting COVID-19 due to the excessive travel (Baker “Texas Abortion”). Allowing abortion under these conditions would decrease the risk associated with travel, and while the new restraining order still prevented some from accessing care, it also dramatically altered access for those who met the new conditions. Now abortion would be allowable for those reaching the legal threshold for cut-off dates under Texas law, instead of indefinitely banned until the executive order expiration date of late April. However, that still did not guarantee future action on the part of Texas officials to extend the non-essential procedures ban pending future conditions under the pandemic.

While the change towards more direct language fixed some of the initial issues with the TRO, access to abortion services was once again curtailed as the 5th Circuit Court overruled Yeakel a day later on April 10th (Tuma). In response to the 5th Circuit Court’s decision, abortion providers sought immediate emergency relief from the Supreme Court to provide medication abortion as the litigation remained ongoing (“Emergency Application”). They argued that the medication can be given without the need for PPE or hospital space. Abortion providers also argued that “the Executive Order, as interpreted by State officials, singles out medication abortion for differential treatment.” (“Emergency Application” 26). It is noted that no other oral medications have been addressed by the executive order for suspension. On April 15th, the 5th Circuit Court ruled that Texas failed to make a case for why medical abortion should be covered under GA-09, Abbott’s executive order to suspend non-essential procedures,

allowing medical abortions to continue in the state (Tuma). In his concurrence, Judge James Dennis noted that “The petitioners’ stated desire to enforce GA-09 against medication abortions despite the executive order’s apparent inapplicability is a strong indication that the enforcement is pretextual and does not bear a ‘real or substantial relation’ to the public health crisis we are experiencing,” (“On Petition”). Dennis’s comment highlights the core reason why Texas is an important case study in regards to abortion access. In the following litigation since the executive order, it became clear that suspending abortion procedures, specifically, medication abortion, did not serve a real purpose in combating the issues brought on by the COVID-19 pandemic. Instead, it was a convenient way to bar access while appealing to the rhetoric of a public health crisis. As a result of the 5th Circuit Court ruling, abortion providers pulled their request for emergency relief via the Supreme Court (Baker “Texas Abortion”).

It seemed like relief was imminent for abortion care providers and their patients. Yet, the story does not end here, as medication abortions were banned when the 5th Circuit Court decided to reverse its decision on April 20th, a mere five days later (“Petition” Revised). According to the decision: “Once again, the dissenting opinion accuses the majority of treating abortion differently and once again it is wrong. The issue here is whether abortion can be treated the same as other procedures under GA-09. It is the district court that treated abortion differently, issuing back-to-back TROs that did not follow the law” (“Petition” Revised 1-2). The judge’s ruling points towards the reality of differential treatment of abortion and the complexity of maintaining access granted to other healthcare procedures. Instead of recognizing the differential

treatment of abortion procedures in Texas' executive order, it instead found fault in the district court for differential treatment before the law by citing the fact that they did not follow the law in the issuance of the TROs. The decision fails to take into account the fact that suspension of all procedures also violates a constitutional protection of access to abortion care. Following its logic of procedural equality, the court reversed course on previous decisions, requiring a vacating of parts of the April 9th TRO issued by the federal district court. However, surgical abortions remained available via the physician's medical judgment who would be past the legal limit of 22 weeks LMP ("Petition" Revised). During this time, on April 17th, Governor Abbott issued an extension of the original executive order from April 22nd to May 8th but with some loosening restrictions on surgeries (Baker "Texas Abortion"). It was still unclear if this revision would allow abortion procedures to resume in Texas.

Despite the relaxation of procedures, when asked explicitly if the new order still restricted abortion access, Abbott put the question on the courts. As the *Texas Tribune* reported, "'Ultimately, obviously that will be a decision for courts to make,' Abbott said, adding that an allowance for abortion is 'not part of this order. The way that the order is written is in terms of what doctors write about the type of treatment that is provided.'" (Najmabadi "Gov. Greg Abbott"). However, abortion providers stated that their practices met the requirements as spelled out in the revised executive order and the state of Texas did not dispute that, allowing abortion procedures to begin with the expiration of the previous executive order on April 22nd (Najmabadi "Texas clinics"). Both medication and surgical abortions were now available as providers scrambled to

once again open their doors to patients in order to meet the needs of their communities and stay financially afloat during the hard economic conditions brought on by the pandemic.

The timeline of legal action regarding abortion access in the state of Texas during the early days of the COVID-19 pandemic in March-April 2020 highlights the differential treatment of abortion procedures. Other time-sensitive medical procedures were not brought before the court for consideration. Not originally named, Paxton's assessment of the GA-09 and following singling out of abortion providers as no exceptions points towards the optimizing of the pandemic for political gain. As later documents highlight, the ban on oral medication for abortions, despite no other oral medication affected by the ban, makes abortion a unique case before the law. As Howard's work suggests, the relationship between the healthcare provider and the patient is disrupted by the state in order to increase surveillance, control, and regulation of pregnant bodies. Here the regulation comes in the form of denying access to abortion care despite the risk involved for those carrying the pregnancy during a pandemic. Treatment of abortion procedures within the context of the pandemic is exceptional before the law in comparison to the other procedures categorized as essential or non-essential.

Rhetorical Consequences: Essential versus Non-Essential

The framing of essential versus elective healthcare also highlights an issue in arguing for care and access to abortion. In the eyes of some, to argue in favor places advocates against “essential” care - it became tantamount to arguing against resources being allocated for COVID-19 patients and those treating patients. This framework essentializes an argument by denying the nuance that abortion care very rarely interfered with treating COVID-19 patients, placed less strain on healthcare staff and resources, and maintained an essential role in the lives of those seeking the procedure. Instead, it is imperative to ask how abortion became rhetorically outside of healthcare and how it can be rhetorically reincorporated.

Part of rhetorically integrating abortion into essential healthcare is addressing the language used to categorize abortions in general. In “Why We Should Stop Using the Term ‘Elective Abortion,’” Katie Watson lays out the necessity of challenging the binary subcategorization of elective and therapeutic abortions. Watson utilizes the definitions as proposed by a common obstetrics textbook, *Williams Obstetrics*. The textbook indicates that therapeutic abortions refer to pregnancy terminations carried out based on “medical indications” (Watson). Elective abortions refer to terminations carried out at the request of the woman but not due to outstanding medical reasons (Watson). Watson argues that this classification is not explained or justified by the textbook and asks us to consider what goal is accomplished by this designation. She comes to the conclusion the elective designation is “moral judgment dressed up as medical

judgment” (Watson). The distinction to Watson is regressive and only serves to deny coverage.

What really distinguishes abortion patients with medical indications is that these pregnant women are presumed to have initially wanted a child—they would not have asked for an abortion if it weren’t for this health problem—or, in cases of rape and incest, that they did not consent to sex. The allowance hospitals, private practice groups, and insurers make for medically necessary abortions is not a medical line, it is a sex-discriminatory social line: *We will only care for women who accept the social norms that women are meant to be mothers and that women cannot have sex solely for pleasure instead of for procreation. Mainstream medicine will cast out all others.* (Watson, emphasis in original)

The distinction of elective and therapeutic rests upon the assumption that pregnancy as a condition is expected to end in childbirth and that other courses of action are a deviation. The intervention is seen as unnatural, rather than intervention as an assumed norm. This creates the moral judgment that Watson identifies and that medicine perpetuates with the classifications of abortion procedures.

Instead of the current classification system, she proposes the language of “ordinary abortions” to signify abortions for common reasons versus “extraordinary abortions” for those that often fall into the category of increased medical complexity and later gestational periods (Watson). While the language Watson uses still proposes a medical binary for insurance purposes, I find the dichotomy structure of her argument unconvincing as it still retains a distinction in cases deemed “common” versus uncommon rather than a holistic inclusion of all abortion cases. I find it more convincing when she notes: “Most women can’t exercise their right to abortion without the help of a medical professional. As a result, regardless of reason, the proper label for all abortion is health care. The term ‘elective abortion’ obscures the fact that abortion restrictions

and bans are government policies of forced childbearing” (Watson). An attention to language surrounding abortion in medicine is necessary for considering the obstacles to including abortion in a comprehensive health care model in a pandemic/post-pandemic world. As the legality of induced abortion is tied to healthcare providers, as Watson notes, it is intrinsically linked with the system of modern healthcare necessitating rather than some invisible right to care. Without actual access to a healthcare provider, a right to abortion access is meaningless.

Part of what the executive orders highlight is the precarity of preserving access to abortion services. In “Abortion during the Covid-19 Pandemic — Ensuring Access to an Essential Health Service,” Bayefsky, Bartz, and Watson argue that the “Covid-19 outbreak has illuminated several weaknesses in our health care system, and one lesson should be that our system of abortion care delivery must be strengthened in ways that prevent abortion access from being so easily rescinded in times of health system stress, whether minor or substantial” (Bayefsky). They argue that abortion bans based on preservation of PPE do not hold up when considering women will require more care during prenatal visits and delivery or may try to induce an abortion on their own - both leading to more contact with health care providers thus requiring more PPE (Bayefsky). “In ordinary times, access to abortion is essential because deciding whether and when to bear a child is central to women’s self-determination and equal participation in society” (Bayefsky). But are there other ways to frame this argument that rely on a health model? Or does the argument of preservation of and access to abortion rely on the ability for women to equally participate in a patriarchal, capitalist worker world?

The abortion bans that resulted from the state executive orders were also against the best practices advice of healthcare providers. This is clearly seen in a joint statement penned by the American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, along with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine on March 18, 2020, which expressed concern over orders that complicated access to abortion care during the pandemic, noting, “[a]bortion is an essential component of comprehensive health care” (“Joint Statement”). The statement made clear that these organizations would not support actions that would cancel or delay abortion care as “[i]t is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible” (“Joint Statement”). The support for reproductive care was echoed by the President of the American Medical Association in a statement released on March 30, 2020. While not explicitly about abortion, Patrice Harris argued that “elected officials in some states are exploiting this moment to ban or dramatically limit women’s reproductive health care, labeling procedures as ‘non-urgent.’” (Harris). Harris expressed support for maintaining the centrality of physician-patient relationships to decision-making regarding procedures that are urgent and time-sensitive or can be delayed. In the statement, Harris said that the AMA will “fight government intrusion in medical care,” (Harris). These statements highlight the disconnect between government

policy and the reality facing medical practitioners on the ground interacting with and treating patients. The “urgent-emergent” necessity of reproductive health procedures, including abortion, cannot be planned for and require immediate care, complicated by the executive orders (Harris). Despite the advice from top practitioners in their field, not all abortion bans were lifted.

Additionally, Texas as a case study forces us to ask questions about how the framing of essential versus elective healthcare informs how we understand abortion care, pointing towards the politicization of pregnancy termination and its rhetorical distancing from its essential placement in “comprehensive health care” as the ACOG states (“Joint Statement”). Framing abortion as an elective procedure downplays the severity of delayed care. By forcing pregnant individuals to delay their abortion procedures, especially in states like Texas, choices become further constrained based on administrative regulations that have increasingly limited access to abortion access before the outbreak of COVID-19. Through various mechanisms, such as mandated waiting times, multiple visit requirements, limitations on time post gestation that abortions are legally available, and policies that restrict who can administer abortions and under what circumstances, access to abortion procedures have been curbed in ways that restrict the choices available for pregnancy termination.

In Texas specifically, abortion is banned after 20 weeks gestation, and after 16 weeks gestation, it must be performed at an ambulatory surgical center or hospital (“Abortion”). Delaying access to abortion care during the pandemic with no clear end could erase the window entirely of seeking a legal abortion in Texas. Various

administrative regulations already exist to curtail abortion access, yet none ban all abortions in Texas. However, the emergency order did ban them under the cover of elective services. In doing so, they do not have to directly contest the laws protecting abortion and can instead continue to push back access to service by extending the emergency order deadlines. These restrictions highlight the need to consider the administrative violence imposed by the state towards those seeking pregnancy termination.

These actions continue a long legacy of government intervention at the point of reproductive health care and medicine. While such a holistic account is beyond the scope of this paper, it is important to note that the action to ban abortion utilizing another crisis or justification was not new and unique to the pandemic moment. States have been opportunistic in attempting to ban abortion and curb reproductive health access nationwide, especially in states that saw the executive order ban like Texas.

Rhetorical integration is necessary for reimagining what is possible during a public health crisis in order to maintain access to abortion, what should be considered an essential, time-sensitive procedure. But the pandemic has also served to illuminate how precarious access is during ordinary times, thus rhetorical integration of abortion into healthcare more generally is important beyond the times of public health crisis as access to abortion is also a public health issue. The weaponizing of “pro-choice” rhetoric in defense of the abortion bans highlights some of the limitations of the framing of pro-choice vs. pro-life as it fails to capture the nuance and reality of the situation. The use of choice is seen plainly in the words of Attorney General Paxton himself. In a press release

tellingly titled “AG Paxton: Governor’s Order Halting Unnecessary Medical Procedures, Including Abortion, Must be Enforced,” abortion providers are singled out for their questioning of compliance. He takes an antagonistic tone to decree that “Abortion facilities want special treatment not available to any other health care provider in Texas” (“AG Paxton”). In response to their defiance, he twists the rhetoric of abortion as a choice to buttress the ban. “For years, abortion has been touted as a ‘choice’ by the same groups now attempting to claim that it is an essential procedure,” (“AG Paxton”). The use of choice does not contain a consideration of the different choices afforded to different people based on class, race, and gender. Nor does it consider the shifting circumstances of a pandemic. The use of choice rhetoric is especially limiting considering it was originally intended as a framework for liberation from oppression, rather than as a justification for oppression through healthcare restrictions. The designation of choice as the protection for the right to abortion is limiting in both scope and practically when considering the essential nature of access.

Alternatives to Texas' Response

In contrast to states like Texas, other states provide a different rubric for what shape future legislation protecting abortion procedures might take. Instead of banning the procedure, some states explicitly mentioned protecting abortion procedures in their executive orders when deciding upon what procedures would be temporarily halted under non-essential. This had direct consequences on access, whether protected or prohibited. While a few states specifically protected abortion, it more often resulted in immediate cessation which dramatically decreased access. In addition, while many states did not mention abortion specifically in their executive orders one way or another, access may still be limited due to limited travel and prohibitions like that of South Dakota where physicians who provide abortions are not able to drive in from out of state and thus are not able to perform abortions (Sobel et al.). Despite the lack of intervention on the part of state governments in abortion access directly, other policies such as travel bans had a negative effect on access.

Kentucky provides an example of a hands-off approach that did protect against an abortion ban. Following the executive order from Governor Andy Beshear, non-essential procedures were suspended but left the decision up to health care professionals to specify which procedures are included under essential (Yetter). Kentucky provides an example of how less government intervention may function as a protection for abortion access, given the alternatives. Following the executive order by Democratic Governor Andy Beshear, essential procedures were suspended, but Gov. Beshear left the decision up to health care professionals to determine which procedures

were included under essential (Yetter). However, Republican Attorney General Daniel Cameron was unhappy with this decision and called on Governor Beshear to suspend abortion saying that the procedures violated the order. AG Cameron argued "Abortion providers should join the thousands of other medical professionals across the state in ceasing elective procedures, unless the life of the mother is at risk, to protect the health of their patients and slow the spread of the coronavirus," (Yetter "Kentucky Attorney"). He pursued the challenge of the executive order at the same time as Republican legislators introduced a new bill in the state senate to expand the power of the Attorney General over abortions (Yetter "Bill"). The bill was approved in a revised version granting the AG power to enforce any of the emergency orders issued by the governor (Yetter "Bill"). Ultimately the bill was vetoed by Governor Beshear, prohibiting the expansion of the attorney general power over abortion clinics and allowing the one abortion clinic in Kentucky to continue operating during the pandemic (Yetter "Gov. Beshear"). Kentucky illustrates one example where political party lines inform the approach state leaders take to prohibiting or allowing abortion access during pandemic responses. Beshear noted that he had more important matters to attend to insure the state's safety commenting, "I'm just not doing divisive issues right now... We've got to defeat this coronavirus" (qtd. in Yetter "Gov. Beshear"). The focus for him is solely on the COVID-19 crisis rather than restricting the power of health care professionals to determine essential and non-essential healthcare in the state.

Additionally, other states like Virginia, Washington, and New Jersey specifically protected access to reproductive procedures like abortion. In Virginia, the Order of

Public Health Emergency Two released from the Office of the Governor and State Health Commissioner on March 25, 2020, prohibited “procedures and surgeries that require PPE, which if delayed, are not anticipated to cause harm to the patient by negatively affecting the patient's health outcomes, or leading to disability or death.”

(Commonwealth of Virginia). While this executive order is pretty standard compared to other states, its statement stands out for its specific inclusion of note that this Order

“does not apply to the full suite of family planning services and procedures nor to treatment for patients with emergency or urgent needs,” (Commonwealth of Virginia).

They note that a variety of centers and health care offices “may perform any procedure or surgery that if delayed or canceled would result in the patient's condition worsening,”

which covers procedures like surgical and medication abortion (Commonwealth of Virginia). Abortion services also remained accessible in Illinois where reproductive

health care centers were included in the essential businesses and operations category

(“Read the Governor’s”). Likewise, Washington state also included specific language

similar to Virginia’s that note in the exceptions category the full suite of family planning procedures with specific provisions with patients with emergency and urgent needs

(Washington). Inclusions such as Virginia’s and Washington’s protect access specifically without compromising state objectives in meeting the surge in need within the

healthcare system of the state.

This call for protection of abortion procedures is stated more explicitly in the New Jersey state response to COVID-19, providing an example of tweaks in regulations that can serve to protect reproductive healthcare. In a press release from the

Governor's office on March 23, 2020, Governor Murphy moved to suspend all elective surgeries and invasive procedures. This order moved to address the shortage of PPE in the state to meet growing demand, as Governor Murphy explained that the state is working "with our partners in health care to strategically preserve supplies and equipment for emergency purposes only" ("Governor Murphy"). While Executive Order 109 signed by Governor Murphy addresses these equipment shortage issues, it also calls for the "[e]xplicit exemption for family planning and termination of pregnancies," ("Governor Murphy"). The press release notes "[t]he order provides that it shall not be interpreted in any way to limit access to family planning services, including termination of pregnancies." ("Governor Murphy"). This direct reference serves to protect access to abortion in the state and maintaining reproductive justice in the state. Choosing to limit or protect abortion specifically is a political decision, not a health-focused one and these examples highlight the potential for safeguarding abortion access even in the midst of an unprecedented public health emergency. Reliance on an argument of PPE conservation to safeguard the health of health care providers ignores the reality of care necessary for pregnant individuals and creates obstacles for providers by assigning fines and criminal punishments to those who violate the orders. The commitment to maintaining the health of their state residents via access to time-sensitive procedures is not a priority in these orders that seek to postpone access to surgical, and especially medication, abortion.

The contrast in state responses to halting and suspending specific healthcare procedures is most contested in the realm of reproductive care. The explicit decision to

include abortion in essential or elective, or deliberate confusion created by refusing to distinctly name abortion in either category, highlights an essential singling out of abortion as different to other healthcare procedures. However, all of the responses point towards “abortion exceptionalism” in that utilizing a public health crisis state leaders were able to utilize executive orders to thwart constitutional protection of access to abortion procedures despite its time-sensitive and essential health nature.

As Howard notes, the collusion of the criminal justice system and health care systems, both formally and informally, create the conditions for exceptionalism for pregnancy that have a disproportionate effect on marginalized communities directly along lines of race and class, placing a higher burden on Black, low-income women (Howard 402). While part of this utilizes the framework of rights of individual against each other (maternal-fetal conflict), the regulations restricting rights with regard to abortion fall under what she highlights as the rights of individuals against a concept of a societal good (Howard 403). State leaders justify their bans on abortion because of a concept of greater societal good in supposedly reducing PPE usage and physician-patient contact to reduce the spread of COVID-19. Attorney General Paxton of Texas said, “We must work together as Texans to stop the spread... no one is exempt” (“Health Care Professionals”). Kim Reynolds, Governor of Iowa, said “Everyone is making sacrifices. Everyone.” in response to the criticism she got in relation to the executive order banning abortions (Rodriguez). In Ohio, Attorney General Fulkerson said, “This is an unprecedented time in the state’s history, and everyone must do their part to help stop the spread of this disease” (Knowles). All of these statements point toward the

utilization of a public health crisis to forward and reproduce the notion that pregnant individuals would need to forgo access to abortion care to support the greater good in combatting the spread of COVID-19. This rhetoric was produced and used against the reproductive rights of pregnant individuals, curtailing the ability to terminate pregnancy.

CHAPTER 3: Risk Displacement and Abortion Bans

The state executive orders in the spring of 2020 represent a risk management strategy on the part of individual states in curtailing and addressing the rising cases of COVID-19 in the United States. As numbers of confirmed cases continued to increase, and the federal government recommended suspending elective healthcare operations in an effort to curtail the spread, the individual states enacted their own orders which created a piecemeal approach to the management of the pandemic. Given the ongoing nature of the pandemic and the uncertainty of the future of abortion access in the United States, it becomes ever more imperative that we consider the impact of the abortion bans that were attempted through state executive orders. As these orders included nearly 25% of states, the actions of Alabama, Alaska, Arkansas, Kentucky, Iowa, Indiana, Mississippi, Ohio, Oklahoma, Tennessee, and Texas - whether they succeeded in banning abortion procedures or not - cannot be ignored.

Despite the expiration of immediate bans, the impact of the spring abortion bans is far-reaching. The reproductive justice framework necessitates that we consider the disproportionate impact of these decisions on low-income and women of color, despite their being couched as generalized restrictions. In the United States, the abortion rate for Black women is nearly five times that of white women and the rate for Latina women is twice that of white women (Cohen). Additionally, according to a Guttmacher Institute study in 2014, “three-fourths of abortion patients were low income—49% living at less than the federal poverty level, and 26% living at 100–199% of the poverty level” (Jerman). Despite the broad language of restrictions, the risk is disproportionately

shouldered by Black, Latina, and low-income women.⁴ We see this specifically with the Texas case where the intent versus the impact of the policies highlight that inclusion of abortion procedures in elective surgery designations resulted in the displacement of risk for responsibility from state officials to individuals, practitioners, and the public more generally. Following is a consideration of the various risks taken on by pregnant individuals, abortion practitioners, and abortion clinics nationally and a consideration of who was ultimately protected by the bans. What is of concern here is that in an effort to minimize risk and combat a pandemic, the executive orders that ban abortion compromise the health of the people they ostensibly purport to protect: both healthcare practitioners and pregnant individuals.

⁴ While the Guttmacher Institutes studies break out demographics, this does not mean that the identities of Black, Latina, and low-income do not overlap to create intersectional identities and thus the data suggests that Black low-income women are the hardest hit when restrictions such as the Texas abortion bans take effect.

Risk to Pregnant Patients

A consideration of risk is multifold. There is a consideration of the immediate and direct consequences on patients seeking, and indeed already scheduled for, abortion procedures. With the bans and shifting legality of abortion access, many in Texas were forced to wait to attain an abortion. However, the physical ramifications of canceled appointments are great and go against the recommendations of leading healthcare professionals. As stated by the American College of Obstetrics and Gynecologists, alongside other leading groups of reproductive healthcare providers, “It [abortion] is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being” (“Joint Statement”). The recommendation from the ACOG comes from research into the mortality rates of legal induced abortions. Bartlett, et al., studied data from 1988-1997 on the mortality rates for women who received a legal induced abortion procedure. While they note that the overall death rate was low at 0.7 per 100,000 legal induced abortions, the number one risk factor for death was gestational age (Bartlett). Their findings note that the “risk of death increased exponentially by 38% for each additional week of gestation” (Bartlett). While deaths from legal-induced abortion are rare, the authors’ findings indicate that “[i]f women who terminated their pregnancies after 8 weeks of gestation had accessed abortion services during the first 8 weeks of gestation, up to 87% of deaths might have been avoided” (Barlett). Beyond preventing unintended pregnancy, this study highlights the

importance of early access to termination procedures to minimize the risk of mortality after a legal induced abortion procedure. Time remains critical in the risk assessment of the procedure.

With changes in abortion methods, including the legalization of mifepristone - the primary drug for medication abortions - in 2000, and shifting ages of women becoming pregnant, Zane, et al., were interested in expanding upon the work provided in the report from Bartlett et al. Their data looks at legal induced abortion mortality rates from 1998-2010 (Zane). The study echoes previous findings that while “[a]bortion-related deaths are clinically and statistically rare events.... [g]estational age at the time of the abortion remains the strongest risk factor for abortion-related mortality” (Zane.) Zane, et al., are also able to provide more context for the risk factors across race noting that “[b]lack women have a risk of abortion-related death that is three times greater than that for white women. This is similar to the black:white risk ratio for all pregnancy outcomes of 3.2,” (Zane). The risk of mortality remains critically attached to gestational age as a defining characteristic, but Zane et al.’s study indicates that race places an important consideration for risk assessment as well and that marginalized populations remain higher at risk for mortality from complications of abortion.

Thus, for Texans and others the later an abortion is performed, the higher the risk of complication which merits concern about the ban on all abortion procedures. Delaying surgical abortions can also carry an increased risk of health complications for the pregnant individual, while also jeopardizing access due to state-imposed gestational limits of abortion. Additionally, access is restricted due to the fact that fewer physicians

are trained to provide the procedure for late-term abortions (Turret). However, the lack of providers is less of a concern for Texas where access to abortions is only permitted through 20 weeks post-fertilization in “cases of life endangerment, severely compromised physical health or lethal fetal anomaly,” (“State Facts”). The narrow period of availability for the procedure is of concern due to the indefinite ban on abortion in Texas that caused the out-of-state flight initially.

Beyond the risks associated with a delay in receiving care, there is also an increased risk due to expanding the period of pregnancy. This partly stems from the increased risk of exposure to COVID-19 and other airborne diseases from repeated health visits necessitated by prenatal care (Villavicencio). It also stems from the increased risks of morbidity and mortality associated with pregnancy in general as a condition. In a comparative study by Raymond and Grimes that assessed the safety of abortion compared with that of childbirth, they found that “[l]egal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion. Similarly, the overall morbidity associated with childbirth exceeds that with abortion” (Raymond). Part of this distinction might be due to the fact that pregnancies ending in abortion are much shorter than those ending in childbirth, thus limiting the time for pregnancy-related issues to happen (Raymond). Additionally, the authors note the changing procedures in the medical field, in particular the use of cesarean deliveries, that may impact the risk of mortality associated with childbirth (Raymond). In 2008 in the United States, as many as “one third of births occurred by cesarean delivery, an abdominal operation with

substantial morbidity” (Raymond). Overall, their work contributes a better understanding of the risks of terminating a pregnancy versus carrying a fetus through childbirth.⁵

While mortality and pregnancy is most often studied, the risk of morbidity is also present in pregnancy. A study by Bruce, et al., fills a gap in research by providing an epidemiological study of individuals as part of a specific health maintenance organization (HMO) to consider the development of diseases and conditions that affect health that may not necessarily land one in the hospital, as the use of hospitalization data only would fail to account for these conditions (Bruce). Overall, they found that “[a]lthough prevalence and type of morbidity varied by pregnancy outcome, overall, 50% of women had at least one complication. The most common complications were anemia (9.3%), urinary tract infections (9.0%), mental health conditions (9.0%), hypertensive disorders (8.5%), and pelvic and perineal trauma (7.0%)” (Bruce). These findings indicate that individuals were likely to develop some range of mild to severe complications over the course of pregnancy which is another consideration of the health risks posed by continuing to carry a fetus to term.

Moreover, pregnancy itself carries a unique risk during a pandemic due to changes in the immune system. By delaying or restricting access to abortion and

⁵ An important note here is that this article does place abortion in a binary with childbirth as the other outcome. The authors make the conscious choice to limit their study to live births. They note: “our comparison was limited to live births; we omitted other pregnancy outcomes: spontaneous abortion, stillbirths, ectopic pregnancies, and gestational trophoblastic disease. The number of pregnancies ending in these outcomes was not available. Stillbirths and ectopic pregnancies are associated with higher risks of death than is live birth. We likely therefore underestimated the mortality associated with opting for pregnancy continuation.” (Raymond)

requiring pregnancy to continue, it is possible that those individuals face a higher risk of mortality or morbidity during a pandemic. Kourtis, et al., explain that while pregnancy may not render a woman more susceptible than nonpregnant women to disease, the “immunologic alterations with advancing pregnancy may impair pathogen clearance, resulting in an increased severity of disease caused by some pathogens” (Kourtis). Increased severity of disease is noted in the case of other pathogens including influenza, HEV infection, HSV infection, malaria, coccidioidomycosis, and varicella (Kourtis). “Increased disease severity may also be due to other physiological changes of pregnancy (e.g., decreased lung capacity, urinary stasis, and changes in blood flow)” which heightens the body's vulnerability to infection (Kourtis). In general, this is much left to be understood about immunologic changes the body undergoes during pregnancy and “the interplay of infection, pregnancy, and the fetus and placenta” (Kourtis). And with all that was unknown about COVID-19 in March 2020, it was not unreasonable to consider these individuals more immuno-compromised than they otherwise would be when not in the condition of pregnancy.

With the recent release of updated information on the impact of COVID-19 on pregnant individuals, it is increasingly alarming that state policies prevented women from deciding to terminate their pregnancies during the pandemic. A study published in November 2020 used data of symptomatic pregnant women with confirmed COVID-19 infection to investigate the impact (Zambrano). “In an analysis of approximately 400,000 women aged 15–44 years with symptomatic COVID-19, intensive care unit admission, invasive ventilation, extracorporeal membrane oxygenation, and death were more likely

in pregnant women than in nonpregnant women” (Zambrano). It is important to note that these findings only apply to symptomatic women as not all individuals who contract COVID-19 display symptoms. The CDC estimates asymptomatic carriers constitute upwards of 40% of the total cases of COVID-19 (“Pandemic Planning”). A study conducted in Washington notes a similar trend of pregnant individuals with confirmed COVID-19 infection were more likely than similarly-aged, non-pregnant adults to experience “severe or critical disease and mortality” (Lokken). The study of symptomatic pregnant women highlights how the risks for severe outcomes from contracting COVID-19 were low in general, “pregnant women were at significantly higher risk for severe outcomes compared with nonpregnant women” (Zambrano). Both of these studies highlight the disproportionate rate of risk for pregnant individuals over the general population for severe complications due to contracting COVID-19.

Pregnant individuals also face differing presentation of symptoms and more persistent symptoms than other individuals. In one study, data on an outpatient pregnant population was used to consider the less severe side effects of contracting COVID-19 while pregnant. The research fills a gap in knowledge as presentation of pregnancy symptoms can overlap with the presentation of known common symptoms of COVID-19. This study “demonstrate[s] that the presenting symptoms in this primarily outpatient cohort of pregnant patients differ from those in nonpregnant populations, with a lower prevalence of fever and higher rates of fatigue, body aches, and headaches. Pregnancy also confers a prolonged course of disease for patients with COVID-19, where 25% of patients have persistent symptoms 8 weeks or more after disease onset”

(Afshar). While only one study, the cohort of outpatient pregnant individuals points toward the complications of contracting the virus while pregnant including the persistence of symptoms long after the general population usually gets better. Mild cases of COVID-19 often see symptoms dissipate after one or two weeks (Shammas). The persistence of symptoms for 8 or more weeks in 25% of mild cases in pregnant women is a stark divergence in disease experience indicating a longer experience of disease and complication.

Additionally, the risk for mortality and morbidity is increased for non-white pregnant women. Non-Hispanic Black women and Hispanic women experienced a disproportionately higher number of deaths than White women (Zambrano). Additionally, Asian and Native Hawaiian/Pacific Islander women had a greater risk for ICU admission (Zambrano). It is also important to note the differences of risk across race. While Raymond and Grimes briefly mentions race indicating that “[w]omen who had abortions were more likely to be African American or unmarried, demographic characteristics strongly associated with increased mortality,” the authors do not provide more analysis on the context of race, pregnancy, and mortality. However, despite the lack of attention to race as a factor for increased mortality, other researchers have noted the influence of race on pregnancy mortality more generally. One study on racial and ethnic disparities found that “Black women are three to four times more likely to die due to pregnancy-related complications than white women” (Louis). Additionally, comorbid conditions have a higher prevalence among black women (Louis). Both findings point towards the increased risk Black women face from pregnancy over white

women. A consideration of temporal trends by Gopal Singh finds that “[a]s maternal mortality rates have risen in the US during the past two decades, Black women, women in lower socioeconomic groups, and women in rural communities continue to experience unacceptably high risks of maternal mortality” (Singh). Pregnancy represents a much higher risk for maternal mortality for Black women, highlighting how pregnancy risk varies across different identities despite the legality of abortion “choice.”

Racial disparities matter in data analysis as they indicate risk is not equally distributed across the population, but instead more acutely affects marginalized individuals and necessitates a consideration for the disparate impact of risk of mortality and morbidity among pregnant women who contract COVID-19 and are symptomatic. These trends are seen more broadly in comparisons of racial and ethnic groups and mortality rate from COVID-19 as well. A study on racial and ethnic disparities noted inequity in COVID-19 mortality as both Black and Latinx populations indicated a higher mortality rate than White populations, even when the data was adjusted for age differences across population groups (Gross). Thus, the risk of carrying a pregnancy to term is even greater during an unprecedented pandemic, but especially for those already marginalized and left uncared for within the United States healthcare system more broadly.

All of these risks matter because the numbers reflect the reality that many individuals were forced to carry a pregnancy longer than necessary. A study by Kari White et al. compared data of abortion procedures performed at Texas clinics from January to May 2020 to the same time period of 2019. They noted a stark difference in

the procedural abortions. While the total number of medication abortions for the month increased from April 2019 compared to April 2020, medication abortions reflected 80% of all abortions, up from 39% (White). Additionally, when “[c]ompared with April 2019, there were fewer procedural abortions less than 12 weeks’ GA (2318 vs 317) and at 12 weeks’ GA or more (482 vs 242) in April 2020,” (White). In contrast, after the order was lifted in May 2020, procedural abortions were once again offered and the numbers increased from previous years. In May 2020, “815 procedural abortions at 12 weeks’ GA or more were provided vs 507 in May 2019” which reflects an increase of 82.6% over the expected number based on linear trends (White). The study suggests that rather than preventing abortions, the procedures were merely delayed. The decision to ban abortions did not have the intended consequence of actually decreasing abortion procedures, they just happened later or out of the state. Thus, the argument for preserving supplies, staff, and space would not be realized if individuals still sought out care out-of-state, placing strain on bordering state’s healthcare systems instead and impacting their facilities.

Additional unnecessary wait time was also reflected for Texas residents and out-of-state residents in neighboring states. Discussed more in depth below, Texas clinic closures funneled some Texans to other state facilities in search of procedures. The shutting down of operations in some neighboring states such as Oklahoma and increase in patients seeking care ended up leading to longer wait times for procedures. Thus, “clinics that are still accessible are now booked through mid-April because of the influx of patients they’re receiving from out of state. This has led to significantly increased

wait times for a procedure that's time-sensitive" (Avila). The temporary bans plus increased demand on open clinics both forced longer wait times, ultimately leading to a longer window of increased mortality and morbidity based on pregnancy condition during COVID-19 as well as increasing the risk of mortality and morbidity experienced due to delayed surgical abortion procedures.

The Risks and Burdens of Travel

Beyond the physical risks involved by continuing to carry a pregnancy to term during a pandemic, the shifting policy coupled with a changing pandemic landscape resulted in emotional and physical tolls for patients. Uncertainty and frustration of canceled appointments with no definitive end to these “unprecedented” times coupled with Texas’ already strict 20-week post-fertilization limit, lead many to seek care outside the state. As Kathy Kleinfeld of Houston Women’s Reproductive Services notes that patients are still calling clinics and looking for alternatives to care in the state: “Not a single woman has said then I’ll just go ahead and continue this pregnancy,” (qtd. in Avila). To meet the continued need, clinics began recommending patients to clinics in other states that were still legally allowing abortion procedures to continue contributing to the risk to patients and physicians. As a time-sensitive procedure related to the inevitable progressing condition of pregnancy, access was still necessary for patients seeking termination during the time of heightened closures at the beginning of the pandemic.

The increase in patients seeking travel to access care is seen clearly in the case of Texas as during the ban in Texas cases surged in neighboring spaces (McCammon “After Texas”). NPR reports a “more than sevenfold increase in patients traveling from Texas” to other clinics in neighboring states based on data given by Planned Parenthood (McCammon “After Texas”). A study on Texas abortion trends by White et al. compiled data about Texas residents seeking abortion care from 30 of 37 open clinics in Arkansas, Colorado, Kansas, Louisiana, Oklahoma, and New Mexico - all neighboring states

(White). Their data notes a dramatic increase as “Texas residents receiving care at out-of-state facilities increased from 157 in February 2020 to 947 in April 2020; monthly totals ranged from 107 to 165 in 2017” (White). Their findings are consistent with some Planned Parenthood data that suggests clinics in Colorado, New Mexico, and Nevada saw a 706% increase of Texas patients from March 23 - April 14 compared with the entirety of February 2020 (McCammon “After Texas”). Overall, hundreds of individuals left the state of Texas to travel during a pandemic to receive the care they were unable to receive in their home state increasing their risk of contracting and/or spreading COVID-19 during the pandemic.

The dramatic increase in Texas residents seeking care in bordering states leads us to a consideration of the increased risk due to travel. Firstly, there is the COVID-19 contraction and transfer risk to the individuals, the ones they may come into contact with on the road, and their family bubbles. We see the tension of the mental and physical tolls in the reflection of Sahra Harvin from Clinic Access Support Network. She said, “It puts callers in a difficult situation where they’re having to choose between their reproductive health needs to be met immediately and their health or safety from coronavirus. ...And I think it’s been really stressful and scary for our callers having to choose between endangering their health in one way and endangering their health in another way” (qtd. in Avila). Referring patients out of state to receive care also drives individuals from Texas into neighboring states which put those communities at increased risk during a time of travel restrictions, including the increased risk for

healthcare providers as patients seeking care elsewhere push the risk from providers in Texas to providers in other states.

The issue of travel is also one of privilege. Under ordinary circumstances, travel can pose a substantial barrier to accessing abortion care. “Such burdens include time away from work, lost wages, and the added costs and challenges of securing child care, lodging, and adequate and accessible transportation, to name just a few” (Bearak). All of these burdens are exacerbated from pandemic conditions “by unprecedented financial constraints, school closures and limited child-care options” (Bearak). And this does not account for the multifold of ways this increases even more for individuals who already face financial precarity and lack of adequate healthcare (Bearak). But with multiple states banning abortions and restricting travel it becomes even more difficult to attain care. “Extended travel, or any travel, during the COVID-19 crisis flies in the face of basic public health recommendations and, in some cases, legal orders” (Bearak). The Guttmacher Institute undertook an analysis of how state abortion bans would contribute to significant increases in drive time finding that state bans would increase the average drive time anywhere from 58% (Kentucky) to 1,925% (Texas) longer than without the closures (Bearak). Additionally, the impact of state clusters could compound that further. For example, not only did Texas ban abortion, but neighboring state attempts in Oklahoma, Arkansas, and Louisiana to ban abortion could impact the already high increase in drive time. If all states were successful in banning abortion, Guttmacher Institute estimates an increase from an average of 12 miles to 447 miles or approximately 3,635% longer driving distance (Bearak). In ordinary circumstances, drive

times could present a large obstacle to care, but the issue is increasingly complex when factoring in all the changed social conditions of the pandemic.

With general instability compounded by the swift economic downturn and widespread layoffs and furloughs, financials are an even larger consideration for placing abortion care out of reach than ordinary times. *Texas Monthly* reports that “Practical support organizations that help with the costs associated with getting an abortion—such as transportation, childcare, lodging, and other fees that aren’t for the abortion itself—report they are receiving an overwhelming volume of calls from clinics in Texas” (Avila). The increase in calls was reported during April 2020, the height of the ban. The newspaper reports that Clinic Access Support Network in Houston was helping to pay for individuals to travel out of state to receive care. Additionally, “Fund Texas Choice, which receives all of its funds from private donors, has doubled its typical weekly spending limit of \$1,000 since the executive order took effect, and it has been blowing past it, according to Rebecca Dreke, the treasurer” (Avila). The increased financial burdens are also linked directly to the policy of banning care. The report notes that 27 of the 40 women Fund Texas Choice assisted in March would have been eligible for medication abortion in the state of Texas, but instead traveled to neighboring states in order to access their care during the ban (Avila). The decision to travel out of the state increases the cost associated with achieving care. The *Texas Monthly* article profiles one couple that chose to travel to New Mexico instead of waiting for the procedure to become available again in Texas. The couple noted that their particular clinic in New Mexico was offering a \$50 discount on the procedure to individuals traveling from

abortion ban states such as Texas and Ohio (Avila). Even so, for the couple the abortion itself was \$450, but after adding in gas, the Airbnb, and groceries, the trip ended up costing upwards of \$2,500” (Avila). While only one particular example, the couple’s story highlights the increased financial burden of additional travel and accommodations.

More importantly, this personal anecdote points towards the privilege of accessing travel accommodations and being able to work remotely in order to travel early to access the out-of-state appointment, as the couple in the news story did (Avila). The impact on individuals without disposable income or ability to take time off from low-paying, essential work (such as grocery store workers) may limit the ability to access care with the state-wide ban. Only those with the financial means necessary, often white, middle- to upper-class individuals, would be able to travel and incur the high costs. It also does not even touch on the privilege of having a partner in the process to add both financial and emotional support. Additionally, if a surgical abortion requires sedation, individuals must have someone pick them up from the appointment, which could cause issues for those who do not have a partner to travel with (“Surgical Abortion”). The impact of the abortion care and travel restrictions could only be more severe on marginalized communities whose experiences are not frequently represented in news stories such as this one, and who do not have the out-of-state travel narrative to share. It stands to reason that individuals who did not successfully obtain an abortion would be less likely to be profiled in narratives considering the out-of-state flight of patients seeking abortion care. The financial costs for individuals seeking care and the

organizations interested in helping meet their needs both felt strain due to the conditions of the pandemic and the results of the abortion ban.

Financial Burdens on Abortion Clinics

There is also the risk to providers at clinics, including financial factors in closing down clinics. As Abigail Abrams reports, “Abortion providers say these new restrictions will likely have lasting impacts, not only on the patients in search of abortions, but also on independent abortion clinics’ ability to survive financially in the months ahead” (Abrams “COVID-19”). Abortion clinics face a financial burden that will continue to have an impact on care as the pandemic continues to unfold. The financial burden from weathering the pandemic is multifaceted. First, abortion providers, depending upon state requirements, must not take on and file paperwork for justification for all abortions provided adding time and costs to each appointment (Abrams “Abortion Clinics”). Additionally, “[k]eeping clinic doors open during COVID-19 has required spending much more money—on cleaning and personal protective equipment, and on hiring more staff to facilitate social distancing rules that also reduced the number of patients who could be seen” which also decreases their ability for revenue from services provided (Abrams “Abortion Clinics”). In order to help meet rising needs, the Abortion Care Network did launch a campaign to help support independent abortion clinics entitled Keep Our Clinics, raising nearly \$220,000 to help clinics (Abrams “Abortion Clinics”). However, this amount is small compared to need clinics face as a survey of Abortion Care Network member anticipated losing about \$50,000 per month due to the pandemic (Abrams “Abortion Clinics”). The issue of funding was seen nationally when providers were unsure if they would be able to access government relief funding that was available for other medical providers and nonprofits (Abrams “COVID-19”). “The

CARES Act stimulus package gives President Trump's Small Business Administration the leeway to deny funding to Planned Parenthood, and the final law also includes Hyde Amendment-like language, which experts say prevents state and local governments from using COVID-19 funds to help abortion services" (Abrams "COVID-19"). The Act was to provide federal relief through forgivable loans for eligible small businesses and nonprofits. "Planned Parenthood officials say local member organizations that fall within those limitations — not the larger, national group — applied for and received the funds" (McCammon "Trump Administration"). Despite being initially approved for the funds, things got messy in May after the Trump Administration sent letters requesting the money back. Letters sent from the Small Business Administration, the agency that oversaw the Paycheck Protection Program, said the local affiliates were not eligible and needed to return the funds or provide documentation of eligibility, despite already applying for and receiving approval for the funds from the agency (McCammon "Trump Administration"). The letters threaten legal action, stating that if the Small Business Administration can determine if the borrower "made a knowingly false certification" in their application, they "may refer the borrower for appropriate civil or criminal penalties." (McCammon "Trump Administration"). Altogether, Planned Parenthood affiliates applied for and received over \$80 million through the program (McCammon "Trump Administration"). These funds helped struggling clinics pay for their employees to stay on payroll and maintain operations. Requesting the money back from the loans was complicated as many clinics had already used the money to address pressing funding concerns.

Following the letters, some Republican Senators called for Planned Parenthood to give back the money like other large businesses and organizations did, including the Los Angeles Lakers, Shake Shack, and Ruth's Chris Steak House, as Senator James Lankford of Oklahoma suggested (McCammon "Trump Administration"). The Senator's comments speak to a larger issue about the whole program, namely the shifting eligibility and rampant fraud associated with the program. Jessica Abrahams of Faegre Drinker Biddle & Reath note the changing eligibility requirements make it unclear about who is actually eligible. "They keep changing the rules. ...So entities that qualified three weeks ago may not qualify today. There's a lot of confusion, a lot of concern" (McCammon "Trump Administration"). Additionally, fraud abuse totaling upwards of \$341 million have been reported from the PPP program (Campbell). As of January 2021, fraud cases have been filed against 140 defendants recovering a large amount of the misused money but millions remain unaccounted for (Campbell). The whole process of approval seems to be unclear and constantly shifting, creating a legal gray area that complicated the legality of eligibility under the program.

The legality of shifting eligibility and threats of legal consequences sparked concern. While Planned Parenthood of San Antonio and Houston refused to return the loans, Planned Parenthood of Greater Texas did elect to return its \$2 million to \$5 million loan ("Two Texas"). The two clinics opting to keep their loans had not heard of any consequences via the Small Business Administration as of August 2020 ("Two Texas"). It seems that ultimately the affiliates were not required to return the funds or

ended up facing legal consequences as no additional news stories or court procedures detailing updates or legal action have been found.

The question around funding is not yet out of the agenda and does not seem to be leaving the national conversation anytime soon. On January 27, 2021, a new bill with the intention of prohibiting funding for COVID-19 relief to be used for abortion services was introduced by newly elected Republican Senator Roger Marshall, an OB-GYN from Great Bend, Kansas (Lowry). It states “for the purpose of preventing, preparing for, or responding to the COVID–19 pandemic, domestically or internationally... shall be expended for any abortion” but includes exceptions for cases of pregnancy resulting from rape or incest and cases that put the individual’s life at risk (Lowry). Part of the success of senate race was his strong anti-abortion stance. “Being pro-life is just part of who I am and there is no other alternative. As an obstetrician, it’s been a thrill of my life to get to bring thousands of babies into the world and now it’s a thrill of my life to be in the U.S. Senate and continue the fight for pro-life policies,” Marshall said of the legislation (qtd. in Lowry). It is unclear whether this legislation will gain support, but signals the ongoing debate regarding federal funding and abortion providers. It also highlights the pervasive aspect of pro-life political affiliation as an identifying factor in policy creation.

Abortion clinics are already few and far between, and the financial burden that comes with shutting down procedures may prove to be too big of a burden to bear, forcing the closure of additional clinics and creating doubt about whether they will be able to return under ordinary conditions in the future. Dr. Robin Wallace of

Southwestern Women's Surgery Center in Dallas used the case of Texas' HB 2 law as an example of how legal victory does not necessitate a return to prior conditions of access. Texas instituted the HB 2 law requiring "all abortion providers to have admitting privileges at local hospitals and clinics to be equipped with hospital-level surgical centers" (Abrams COVID-19"). Dr. Wallace remarked that "We certainly saw after HB 2, when half the clinics closed, we went from 42 clinics to 21 virtually overnight," (qtd. in Abrams "COVID-19"). Ultimately the HB 2 law was struck down in the Supreme Court decision in *Whole Women's Health v. Hellerstedt*, but even "then with the favorable Supreme Court ruling in 2016, only a handful of clinics reopened. We did not see a rebound in terms of access" Dr. Wallace said (qtd. in Abrams "COVID-19"). There are a lot of obstacles facing clinics that close in considering to reopen. "Once abortion clinics close, they rarely reopen. The startup costs and hurdles, including applying for credit, finding a space that will rent to an abortion clinic and complying with many state's strict abortion laws, are particularly difficult for independent abortion clinics to overcome" (Abrams "Abortion Clinics"). Since 2015, 127 independent abortion clinics have closed across the United States, 14 of those closing during 2020 ("2020 Report" 8). This leaves only 337 open across the country as of November 2020 ("2020 Report" 8). While larger operations like Planned Parenthood are able to weather the storm of financial insecurity easier, ultimately all clinics are impacted by the financial constraints brought on by the pandemic.

Additionally, the closing of abortion clinics impacts more than just abortion access. These clinics provide necessary care that was also suspended under the essential

only services policy. Dr. Wallace reflects on the impact of the COVID-19 pandemic:

“We’re a healthcare clinic. We do trans care and contraception care and well visits, and all of those kinds of visits we definitely can’t do right now because they need to be delayed in order to allow people to stay home and to conserve our resources” (qtd. in Abrams “COVID-19”). While the closure of clinics drastically reduces access to abortion care, it also decreases access for healthcare more generally impacting access to resources in the future. Emergency measures coupled with funding issues will severely impact the future of abortion care access in the United States, which makes the abortion bans and subsequent challenges in court an important case study in considering the future public health law implications of such measures on the health of communities.

Impact versus Intent

Almost a year into the pandemic, what would we conclude if we asked whether the abortion bans achieved the goals they set out to: preserve PPE and hospital space and while protecting healthcare workers from unnecessary risk exposure? Arguably, no. Part of the answer comes from considerations of surges later in the pandemic from late summer and the winter holiday season. As the number of COVID-19 cases soared higher than the early days of the pandemic, there were no bans placed again on procedures. As Travis Bubenik, a reporter for *Courthouse News* reflects, “Ultimately, the fears from state leaders that somehow abortions would hinder hospitals’ ability to care for Covid-19 patients never came to pass, even with much higher surges in Covid-19 hospitalizations in Texas over the summer, months after the ban expired, and more recently around the holiday season” (Bubenik). Even in the midst of more cases, offering access to abortion did not hinder the ability to treat those patients. The ability to treat patients is due to the fact that offering abortion procedures does little to affect the goal of PPE and space preservation. Kari White, a researcher from Texas Policy Evaluation Project that led the Texas trends study, notes “It [abortion] rarely results in a complication that would require hospitalization,” (qtd. in Bubenik).

The state officials claiming that prohibiting abortion would somehow free up PPE and hospital capacity was just unsubstantiated by the evidence around how abortion care is safe overall, and out of step with the professional guidelines around how abortion care could be provided safely while still maintaining a low risk of exposure during a pandemic. (qtd. in Bubenik).

Considering the later surges in numbers of COVID-19 cases and hospitalizations in the late summer and during the winter from Thanksgiving to the end of the year, abortion

procedures continuing has not impacted or hindered the care of these individuals. And as access continues, abortion procedures rarely result in complications that require hospitalization. The strain on resources is trivial comparatively.

Taken all together, the impact of suspending abortion procedures did little to actually protect state residents, both patients and physicians - the very people the state voiced a desire to protect. Instead, the risk was shouldered by the marginalized and vulnerable in a myriad of ways, which created excess uncertainty during an already precarious and shifting time of public health crisis. In particular, the suspension of care directly affects Black and low-income women the most, indicating a disproportionate impact despite the broad policies resulting in abortion procedure restrictions. Health of pregnant individuals is also a public health issue and deserves attention. The high rate of risk of mortality and morbidity associated with pregnancy is a huge risk to undertake due to restrictions on termination during shifting social circumstances. It is important to examine this moment in public health history with respect to abortion policy as it can give us some perspective on the future. While the attempted and successful abortion bans called attention to the precarity of abortion access in the United States, the conditions of the ongoing pandemic have also given a glimpse into the possibility for expansion of access. The social distancing necessitated by the pandemic forced large structural changes for how Americans conduct everyday interactions, including doctor appointments. Illuminated and drastically expanded, telehealth options have become a norm in the healthcare infrastructure. Telehealth has made healthcare viable without

the use of PPE or risk of travel and patient-physician exposure, lessening the strain on hospital resources and contributing to appropriate social-distancing policies.

CHAPTER 4: On Pandemic Possibilities and Policy Obstacles

Considering alternatives to current care structures may strengthen access to abortion in the future. Looking from the Texas case study of *Planned Parenthood v. Abbott* towards the later pandemic response gives us an opportunity to rethink how we deliver healthcare and alternatives to current infrastructure that prioritizes a wider access. An example of this is the response of some attorneys general calling for eased restrictions on prescribing mifepristone for medicine-induced abortion through about 70 days post gestation. In an open letter written to Secretary Alex Azar of the U.S. Department of Health & Human Services and Commissioner Stephen Hahn of U.S. Food & Drug Administration on March 30, 2020, 21 attorneys general from across the United States, responding to an increase in telehealth options, requested the removal of restrictions in place in order to allow medical providers to use telehealth protocols for prescribing mifepristone for early, medicine-induced abortions (California). They voiced a need for improving safety and access to mifepristone via telehealth as the federal government encouraged states to adopt and expand telehealth capacities in response to the rise of COVID-19 cases in the US.

Since 2000 when it was approved, mifepristone remains the only drug approved for pregnancy termination in the US but is subject to a Risk Evaluation and Mitigation Strategy (REMS) which the open attorneys general letter calls “outdated, inconsistent with medical evidence, and limits healthcare providers’ ability to use telehealth and provide this necessary drug” which impacts access to care (California 2). The letter calls for the repeal of the REMS designation because it “create[s] unnecessary barriers

between women and abortion care, not only making it harder to find—for example, by prohibiting sale by retail or mail-order pharmacies—but also making it unappealing to prescribe” (California 1). Currently, in order to attain mifepristone under the current REMS designation, “the FDA requires that (1) a patient be handed the Mifepristone at a clinic, medical office, or hospital under the supervision of a healthcare provider; (2) the healthcare provider must be registered with the drug manufacturer; and, (3) the patient must sign a ‘Patient Agreement’ form confirming that she has received counseling on the risks associated with Mifepristone” (California 3). The FDA requirements then necessitate at least one in-person visit for the initial pill to be prescribed regardless of where it is taken and requires contact with a healthcare provider via dispensing requirements.

The in-person appointment and travel to arrive at the in-person appointment creates a considerable increase in risk for contracting COVID-19 versus a telehealth visit and potential pharmacy visit. The letter names the harm facing women in requiring travel as they seek early pregnancy termination via medication when telehealth would eliminate the in-person risk to both patient and provider, as well as the individuals women may come into contact on their journey via public transportation, waiting rooms, hallways, among other public and shared locations (California). The attorneys general urge a reclassification of the REMS designation as “[t]he FDA should not mandate this medically unnecessary travel, particularly during the COVID-19 crisis where not only are women being advised to stay home, but families are faced with additional childcare and financial constraints” (California 3). The attorneys general note

the obstacles facing women because of the pandemic that also impact their ability to access and gain the abortion care they need. It may also complicate their desire to continue a pregnancy due to pandemic conditions. They recognize the uniqueness of the public health emergency and seek to eliminate barriers to care in order to provide both providers and patients with expanded telehealth options.

What is also important to note in this letter is the outdated designation of REMS for mifepristone that the attorneys general highlight. The letter addresses the risk posed by medicine-induced abortion from mifepristone considering that “Mifepristone is *four times* safer than Viagra and *fourteen times* safer than carrying a pregnancy to term” (California 3, emphasis in original). Mifepristone is shown by many medical studies to be a safe drug and the letter cites FDA research noting there have been rare severe adverse health effects and the “safety profile” of the drug has not changed in 15 years (California 3). These notes on the safety of ingesting mifepristone for medicine-induced abortion highlight the undue burdens surrounding access to mifepristone that exist even outside of the pandemic conditions as the outdated safety designation attached to mifepristone access creates obstacles to attaining care.

The REMS requirement is outdated and unnecessary. Instead of access via telehealth and a local pharmacy, the REMS designation requirement of in-person protocols requires access to a physical space where a provider can and will prescribe mifepristone and oversee the initial dosage. But the burdens are heightened when travel access is discouraged and restricted and health visits pose a high risk of exposure to COVID-19 to both provider and patient, as much about the virus and its effects are

still unknown. As a document signed by 21 attorneys general across the US with a vested interest in the health of women across the country independent of region, the letter sheds light on the obstacles facing women seeking a medicine-induced abortion at a time where expanded telehealth options and eased restrictions via a change in REMS designation could increase access to care. The letter presents an alternative way of considering care utilizing increased telehealth options that have been more fully utilized during the pandemic.

Abortion Access and Physical Obstacles

As a legitimate form of accessing care, telehealth represents an option for future health interactions in the continuation of the pandemic, as well as a post-pandemic world. Telehealth options with eased restrictions on supervision for first dosage requirements would be useful now as access is curbed by social distancing requirements and travel remains risky. In addition, a consideration of an expansion of telehealth with regards to accessing medication abortions would dramatically increase the availability of care. This would be especially true for states where clinics are few and far between. An analysis published in 2017 set out to quantify how long it takes for patients from urban areas to travel to their nearest abortion clinic utilizing data from, which notes that travel distances will be affected by the duration of weeks already pregnant given that some clinics only provide certain abortion procedures up to certain gestation period (Goldenberg). This difference in care is noted drastically in the example of Boise, ID where a patient that is 12 weeks pregnant can make the round-trip travel to a clinic in under an hour versus a round-trip travel time of nearly nine hours if they wait till they are 16 weeks along to pursue an abortion (Goldenberg). The study indicates that many urban areas lack access to a close clinic that provides abortions, and that 151 urban areas⁶ in the U.S. have no accessible abortion clinics within a 1-hour round trip drive (Goldenberg). Various metropolitan areas in Texas, South Dakota, Wyoming, and Idaho are the least accessible with round-trips ranging from 8-10 hours depending upon the

⁶ Note: The authors define an “urban area” as a city that has a population of 50,000+ according to 2015 estimates.

stage of pregnancy, noted in increments of 8, 12, 16, and 20 weeks pregnant (Goldenberg). The worst offender is the city of Bismarck, ND with a whopping 11-hour drive to receive an abortion at 20 weeks pregnant (Goldenberg). The only clinic for the state, Red River Women's Clinic, is located in Fargo, ND, and only performs abortions up to 16 weeks pregnant ("Choosing"). As a study by the Guttmacher Institute indicates, approximately $\frac{1}{3}$ of abortion patients in the U.S. traveled more than 50 miles to receive care citing that the clinic chosen was based on the closest distance (Fuentes and Jerman). Their study results conclude that travel distance remains one of the most important factors about accessing abortion care.

These studies say nothing about the states that have requirements for multiple clinic visits with mandatory waiting periods that may double travel times or necessitate overnight stays. As of January 1, 2021, Guttmacher Institute reported that 25 states require a mandatory waiting period of 24 hours, although some states like Utah require 72 hours or three full days, between counseling and abortion procedures ("Counseling and Waiting"). Of those states, 12 require the counseling be provided in-person which would necessitate two separate trips to the clinic ("Counseling and Waiting"). With the waiver of in-person counseling for medication abortion as suggested by the open Attorneys General letter, access could radically be expanded for those who may otherwise have to travel once or twice to a clinic. Instead, this travel would be reduced to a trip to their local pharmacy. These policies also do not address the social concerns that can impact access, such as lack of access to reliable transportation, inability to take time off work, difficulty attaining childcare, among other factors that make travel

difficult. An expansion of telehealth would decrease the strain and resources necessary by these individuals, facilitating an expansion of access to care. It would also prevent the excuse of banning access based on PPE as was the case in Texas. Despite the ruling that still prevented access to medication for abortions, telehealth and eased access on doctor presence would prevent the invoking of PPE as an excuse. In turn, access could be preserved in future circumstances if a public health emergency similar to the COVID-19 pandemic were to arise again. Expanding what access could look like in the future is one step to safeguarding abortion care as we work to more fully integrate abortion into the general healthcare narrative.

Supreme Court Decisions and FDA Regulations: *ACOG v. FDA*

As abortion procedures have been able to carry on, the disruption in care and the subsequent legal battle should still give us pause when we consider both the personal and institutional ramifications of the decision. Individual lives were affected, as well as the stability of abortion clinics in a physical operation sense. What is also of concern is the impact such a case may have on future situations. American law is based on a principle known as *stare decisis*, “the idea that like cases should be decided alike” (Walker). When a case is brought before the court, a judge selects prior cases upon which to rely and no external authority designates which cases are utilized (Walker). This sort of system is why we can see disparate responses to the same case between Judge Yeakel and the judges at the 5th Circuit Court. However, under the principle of *stare decisis*, “every case has the potential of being a precedent in some sense” (Walker). As scientists have warned that future public health crises are more than possible and the COVID-19 pandemic ““is not the last pandemic we are going to face,”” a consideration of the precedent the Texas decision may have is crucial for protecting access in similar situations (Gill). These issues are possible to surface if the situation of the pandemic worsens - although given current surging numbers of cases and hesitancy to reinstate spring lockdown policies, this situation seems less likely now, but may however still prove to be an issue - or future public health emergencies emerge. This sentiment is echoed by professor of law Dr. Elizabeth Sepper. She notes, “The litigation raises questions about how courts will treat claims that the pandemic efforts of states violate constitutional rights,” (Méndez). Additionally, she notes that as ““some scientists

say there's going to be future pandemics that will line up right behind COVID, so determining where the line of permissible activity matters quite a bit'" (Méndez). The fight over Texas illuminated a tense legal battle over the preservation of constitutionally protected access in an era of public health uncertainty.

With the recent passing of Supreme Court Justice Ruth Bader Ginsburg (Totenberg) and the subsequent appointment and confirmation of Amy Coney Barrett, the nine seated judges reflect a 6-3, conservative-liberal majority (Wise and Bravin). The line of what is permissible is considerably more concerning now if cases are elevated to the Supreme Court. While this reflects a mere one vote shift from the previous era of Supreme Court 5-4 conservatism, the significance is crucial. As Joan Biskupic, CNN legal analyst and Supreme Court biographer notes, "[f]or decades, a quartet of liberal justices has sometimes been able to secure -- often through tense negotiations -- a crucial fifth vote from the conservative wing (Biskupic). That has meant even though America's highest bench was shifting rightward, it preserved abortion rights and narrowly declared a right to same-sex marriage," (Biskupic). This establishes a "broad conservative majority for the first time since the 1930s" which may have a radical impact given that the struggle with a conservative bench is the potential ramifications in judicial review (Wise and Bravin).

As of spring 2021, we have already witnessed that this shift in bench composition will affect how the law around abortion is interpreted. While overturning precedent is difficult, this does not mean that the Supreme Court will not have an impact in other areas, including administrative law. Texas is symptomatic of a larger

conservative national narrative with regards to abortion access. The narrative is played out in the national court system in the case of *ACOG v. FDA*. In March 2020, part of the United States response to the surge in COVID-19 cases included the Federal Drug Administration relaxing in-person dispensing requirements for most drugs and widely encouraging the use of telehealth in order to reduce the spread of the novel virus (Bravin “Supreme Court Restores”). Despite the open letter from the attorneys general and other calls from the AMA and ACOG to relax those same regulations for mifepristone, the Trump administration left in place the in-person dispensing regulations.

Thus in May 2020, the American Civil Liberties Union filed a federal lawsuit on behalf of the American College of Obstetrics and Gynecology, the Council of University Chairs of Obstetrics and Gynecology, New York State Academy of Family Physicians, SisterSong Women of Color Reproductive Justice Collective, and Dr. Honor MacNaughton, MD, an independent family medicine doctor (“American College”). They asserted that the FDA requirements caused an extra burden during the pandemic due to REMS “that mandates unnecessary travel and personal interactions, jeopardizing the health and lives of patients and clinicians,” (*ACOG v. FDA*). This is a unique burden specifically placed on those requiring mifepristone, a drug known for treating abortion and early miscarriage. The FDA requires that mifepristone can only be obtained in a clinical setting, despite the fact that the FDA then permits them to swallow the pill later at home without any clinical supervision. The lawsuit notes this differential treatment. “Of the more than 20,000 drugs regulated by the FDA, mifepristone is the only one that

patients must receive in person at a hospital, clinic, or medical office, yet may self-administer, unsupervised, at a location of their choosing” (*ACOG v. FDA*). While this in and of itself would present a case of abortion exceptionalism due to the singled out nature of the drug, the restrictions are even more targeted. “Moreover, when not used for abortion or miscarriage, the FDA authorizes mailing the identical chemical compound to patients’ homes in higher doses and much larger quantities,” (*ACOG v. FDA*). The challenge posed by the *ACOG* highlights not only the differential treatment of mifepristone as an abortion drug, but specifically due to its use in cases of abortion and early miscarriage care, that the extra burdens have not been eased despite the ongoing pandemic situation. These designations have stayed in place despite the fact that it has indeed been proven “safe and effective when prescribed through telemedicine and can be safely taken in the comfort of a patient’s home” (“*ACOG Suit*”). This puts healthcare providers and patients at greater risk arbitrarily compared to other procedures.

A statement from the President of *ACOG*, Eva Chalas, M.D., F.A.C.O.G., F.A.C.S., sums up the tension of the case:

Our request in this case is simple: The federal government should permit patients seeking safe and effective reproductive health care, which includes care for miscarriage and termination of pregnancy, the same ability to access care and protect themselves from exposure as patients in other contexts are afforded. During the COVID-19 pandemic, the health care community — from individual physicians to government agencies — has come together to identify safe, effective ways to provide patients with the care that they need, including through telemedicine. The FDA’s decision to maintain medically unnecessary restrictions on mifepristone is a glaring exception, which results in discrimination in access and threatens to harm patients and their clinicians during a time of national crisis. Lifting the barriers to mifepristone will allow women, including those from underserved communities that are disproportionately affected by both COVID-19 and the ongoing maternal health crisis, the ability to obtain

necessary and essential evidence-based care without having to risk potential life-threatening exposure. (“New Lawsuit”).

The issue is complex in that the in-person dispensing requirements are relegated strictly to mifepristone, despite the FDA easing restrictions for other drugs during the pandemic. They are also holding on to outdated scientific knowledge to maintain the restrictions as mifepristone has been safe and effective via telemedicine. Additionally, the decision most adversely affects marginalized communities, namely low-income, women of color, who are hit hardest by the conditions of the pandemic and face the largest existing inequalities and structural barriers to care. It also creates additional burdens to travel that may be relaxed when patients can access care via telemedicine. In addition, despite the widespread encouragement to adopt telemedicine to protect both healthcare workers and patients, the in-person dispensing policy requires that interaction during a time of heightened risk of contracting and spreading COVID-19.

Based on the arguments presented, on July 13, 2020, a federal district court ruled that the FDA must temporarily suspend the in-person dispensing requirements (“Federal Court”). The court issued a preliminary injunction that prevents the FDA from enforcing the requirement specifically for mifepristone, however, this was limited to cases for early abortion care and was not lifted when utilized as a part of early miscarriage treatment (“Federal Court”). The U.S. District Judge Theodore Chuang suspended the rule noting that it “imposed a ‘substantial obstacle in the path of women seeking an abortion’” (Bravin “Supreme Court Restores”). The injunction is to remain in effect until a minimum of 30 days after the federal government declares an end for the public health emergency, which is to be determined by the U.S. Department of Health

and Human Services (“Federal Court”). The 4th Circuit Court of Appeals denied the Trump administration’s appeal of the case.

While the decision was decidedly a victory for the expansion of abortion care, it is important to note that existing state policies could prohibit the usefulness of easing REMS requirements because of existing policy. While the initial compromise lifted the FDA restrictions, some state laws in existence may be relevant in determining what that means practically for different clinics, the ACOG notes. They explain laws such as “state laws that might prevent the mailing of mifepristone include laws explicitly restricting medication abortion via telemedicine, laws requiring in-person administration of mifepristone, as well as laws applying more generally to the dispensing of medications by mail. We reiterate that clinicians seeking to take advantage of the court’s ruling should consult with a lawyer about any state law restrictions” (“Court’s Order”). These types of laws would render mute this eased restriction for physicians affected by those state rulings.

However, despite the denial of the appeal at the 4th Circuit Court, the Trump administration appealed the case to the Supreme Court in August 2020. During this time the composition of the Court changed dramatically with the passing of Supreme Court Justice Ruth Bader Ginsburg in September, as mentioned above (Totenberg). In the interim of a replacement, the Supreme Court put off the Trump administration’s appeal, instead deciding to send the decision back to the lower courts in early October, which left in place Judge Chuang’s original decision to suspend the in-person dispensing requirements (Bravin “Supreme Court Puts Off”). Despite the dissent of two

conservative justices, the unsigned order noted that it would be beneficial for the court if there was “‘a more comprehensive record’ on the issue” (Bravin “Supreme Court Puts Off”). Instead, the responsibility was sent back down the courts with a request that Judge Chuang “promptly consider a motion by the government to dissolve, modify, or stay the injunction, including on the ground that relevant circumstances have changed,” in effect asking for a compromise to be met at the lower level (Bravin “Supreme Court Puts Off”). A few days later, Amy Coney Barrett was sworn in and filled the vacant seat on the Supreme Court bench and was thus part of the decision when the case returned back to the Supreme Court in December 2020 (Litman). *ACOG v. FDA* is now the first case on abortion policy heard with the addition of Justice Barrett, which may signal the verdict for future cases heard on abortion care issues.

The Supreme Court released their decision to reinstate requirements for in-person visits to pick up mifepristone for women seeking medication abortions (Bravin “Supreme Court Restores”). The conservative majority published no explanation for the decision, but it is important to note that Chief Justice John Roberts issued his own brief statement justifying his vote with the logic that government officials, rather than the courts, should determine public-health measures. He believes the question before them is not one concerning the undue burden standard on a woman’s right to abortion: “The question is instead whether the District Court properly ordered the Food and Drug Administration to lift those established requirements because of the court’s own evaluation of the impact of the COVID-19 pandemic.” In considering government responses, Roberts finds that “courts owe significant deference to the politically

accountable entities with the ‘background, competence, and expertise to assess public health’” citing *South Bay United Pentecostal Church v. Newsom* (*ACOG v. FDA*). What I find of concern here is that the case of *ACOG v. FDA* effectively pitted medical expertise against a governmental organization and their regulations. Additionally, Justice Stephen Breyer voted against the reinstatement of the in-person requirements, but did not join or issue a separate opinion. Despite the concern of health care professionals and attorneys general, the REMS designation and burdensome requirements continue to be in place for accessing mifepristone despite the ongoing nature of the pandemic. With the most prominent reproductive healthcare professionals calling for relaxed policies to aid their patients, why do the judges endorsing this opinion rely on the justification that puts politicians back into the driver’s seat of women’s reproductive health policy?

In response to the decision, Justice Sonia Sotomayor’s dissent, joined by Justice Elena Kagan, argues that the decision to reinstate the in-person dispensing requirements do not center the patient’s care and effectively “the FDA’s policy imposes an unnecessary, unjustifiable, irrational, and undue burden on women seeking an abortion during the pandemic,” (*ACOG v. FDA*). She notes that the FDA allows patients to receive all consultation for a medication abortion virtually and the allowance to take both drugs, mifepristone and misoprostol, which together induce the medication abortion similar to that of an early miscarriage. However, as the lawsuit notes, it is the *only* drug of over 20,000 FDA-approved drugs with such a pick-up requirement. As such, Justice Sotomayor notes that the pandemic has drastically highlighted the “unique treatment of mifepristone” as the FDA and Health and Human Services (HHS) waived

the in-person requirements for other drugs, which permits patients to now receive prescriptions for “powerful opioids without leaving home, yet still requires women to travel to a doctor’s office to pick up mifepristone, only to turn around, go home, and ingest it without supervision” (*ACOG v. FDA*). Her dissenting arguments echo many of the ones brought up in the initial lawsuit, going on to point out the hypocrisy of encouraging telemedicine and waiving other in-person dispensing requirements, but retaining the one for mifepristone putting both patients and physicians at risk of needless exposure during a pandemic (*ACOG v. FDA*).

Beyond the failure of the government to demonstrate irreparable harm, Justice Sotomayor dissents from the decision due to the race and class disparities exacerbated by requiring in-person dispensing requirements due to the risks involved for women of color and low-income women. She writes:

Pregnancy itself puts a woman at increased risk for severe consequences from COVID–19. In addition, more than half of women who have abortions are women of color, and COVID–19’s mortality rate is three times higher for Black and Hispanic individuals than non-Hispanic White individuals. On top of that, three-quarters of abortion patients have low incomes, making them more likely to rely on public transportation to get to a clinic to pick up their medication. Such patients must bear further risk of exposure while they travel, sometimes for several hours each way, to clinics often located far from their homes. Finally, minority and low-income populations are more likely to live in intergenerational housing, so patients risk infecting not just themselves, but also elderly parents and grandparents. These risks alone are significant deterrents for women seeking a medication abortion that requires in-person pickup. (*ACOG v. FDA* 6-7).

Justice Sotomayor points out the intersecting risks and concerns facing women of color and low-income women in requiring in-person pick-up requirements for mifepristone.

The risks are not only disproportionately high with regards to pregnant individuals’ morbidity and mortality, but also high for their exposure to COVID-19, a risk that

extends to their extended family members and surrounding communities. The issue of picking up mifepristone is not merely one of unnecessary, outdated bureaucratic policy, but also one of severe health ramifications for requiring increased correspondence during a pandemic in which the CDC has explicitly called for the reduction of in-person interactions, which Justice Sotomayor also references (*ACOG v. FDA* 2-3). The risks are disproportionately borne by marginalized communities facing even greater precarity during the pandemic.

FDA Policy as Administrative Violence

The policy of denying the suspension of burdensome regulations regarding abortion care via mifepristone is an example of administrative violence. This concept is taken up in the work of Dean Spade in *Normal Life: Administrative Violence, Critical Trans Politics, & the Limits of Law*. Spade argues for a reconceptualization of the role of law in social justice movements while writing from a critical trans perspective. He argues that instead of a focus on law reform through discrimination law and hate crime law, movements would be better served by addressing administrative law that governs the life chances of individuals and distributes security and vulnerability across the population (Spade 3). His attention to the specific violence of administrative regulations towards regulating and mediating the life and health changes of trans individuals can be expanded to consider the particular violence that regulations create surrounding abortion access via the FDA policies. The specific REMS designation and requirements for dispensing are part of agency-created administrative law and, as demonstrated above, contribute to the health risk associated with accessing pregnancy during a pandemic for both patients and physicians. It also serves to curtail access to rural areas or to individuals who live far from a clinic. Expansion of telemedicine, including the removal of the in-person dispensing requirement, would open access to people who need it and reduce the risk associated with contact.

Agencies like the FDA are able to revisit their own law and policies because of, or even in spite of, a specific court case. While this revising process is still long and difficult, it provides an avenue of change not reliant on changing precedent. Focusing on these

sites of violence for change could impact the way that reproductive rights are accessed. When a consideration of the obstacles that agency law creates, strategies to address those can be formulated such as the case in the open letter from the attorneys general calling for change. The pandemic served merely as a disruption great enough to highlight the outdated policies, but what other restrictions are outdated and unhelpful? Additionally, why must they be maintained? Addressing these issues provides an avenue for strengthening and expanding access is one way to utilize law reform in a positive way for protecting the right to abortion of pregnant individuals.

Beyond addressing the policy through the court system, Jess Bravin's reporting on the case indicates that despite the Supreme Court ruling in *ACOG v. FDA*, the Biden administration may choose to use a federal statute as a way to maintain access to abortion rights (Bravin "Supreme Court Restores"). This would make abortion part of federal rule of law, potentially stating who can access care and who cannot prohibit care. Additionally, the change in leadership due to the Biden administration may place a qualified individual in position to make decisions regarding public healthcare. With a change in administration, there is also a change in leadership of the FDA, which may reflect a different set of priorities. As of February 2021, an FDA commissioner had not yet been appointed by President Joe Biden. Janet Woodcock, who headed the Center for Drug Evaluation and Research for nearly 25 years, is currently the acting commissioner (Scott). It seems to be that his choice for commissioner boils down to two different candidates, Woodcock who would likely take a more traditional approach to leading the agency, or Joshua Sharfstein, the "reformer candidate" (Scott). These two top

contenders offer two divergent approaches to leading the agency and it is still up in the air as to what may happen with the direction of the FDA under Biden's presidency.

While Dean Spade's work provides a place to consider the potential ramifications of administrative law on abortion care and access, his work intersects with that of other scholars calling for a reconceptualization of justice for all bodies. Spade's understanding of justice is another way to potentially think alongside other activists' work toward the possibilities of the future rather than merely a reflection on the present. His work gives shape to the possibilities of movements beyond a rights-based approach, which he argues often fails to address the harms faced by marginalized populations through administrative and bureaucratic avenues. Considering alternatives to a right-based approach for justice and access to care can also be useful in considering how pregnant persons also face increased administrative violence through state and federal regulations, specifically abortion access. Through Spade's attention to how administrative policy places disproportionate risks on marginalized populations, the significance of the administrative process whereby abortions were banned during the pandemic becomes clear as a site of administrative violence due to the harm it perpetuates.

CHAPTER 5: Conclusion

The COVID-19 pandemic exposed needless structural barriers to abortion procedures, specifically with regards to abortion access, that continue a long legacy of disruption to care that most significantly impacts low-income and Black women. Centering the experiences of marginalized communities highlights how a disruption of care disproportionately affects their care as they face more significant barriers to abortion healthcare and incur the greatest risks of increased morbidity and mortality by continuing to carry a pregnancy to term. The difference in treatment of the medication mifepristone stems from the difference in application, signaling a bias towards abortion practitioners and patients. We see this in both *Planned Parenthood v. Abbott* and *ACOG v. FDA* where mifepristone is treated differently from all other oral medications, even given the unprecedented risk of in-person contact the COVID-19 pandemic creates.

This project focuses on two court cases, *Planned Parenthood v. Abbott* and *ACOG v. FDA*, that both arose from the conditions of the pandemic and the inequalities of access around abortion, specifically medication-based abortion procedures, that these cases exposed. Documented in this paper is the use of state violence to regulate and control pregnant individuals for the sake of perpetuating patriarchal power. State legislatures utilized a public health crisis and weaponized the rhetoric of choice to ban abortion under “non-essential” and “elective” procedures. The banning of abortion created a case of abortion exceptionalism where abortion access was treated different from other healthcare procedures, most notably in the treatment of mifepristone. Politicians were able to push their anti-abortion agenda under the guise that everyone

must sacrifice and come together to combat the spread of COVID-19 and the risk it poses to the health of the whole community.

Considerations of state violence during the pandemic are necessary. While it may seem easy to brush off Texas as an extreme example of over governance during the early crisis days of the pandemic, it is important to consider the impact it had and the support that it garnered. Beyond the states that acted to ban abortion, “18 state attorneys general signed an amicus brief supporting Texas’ COVID-19 abortion ban—including Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah and West Virginia” (Baker). The top legal officer of 18 states, the person who is to “act as the ‘People’s Lawyer’ for the citizens,” openly supported Texas’ decision to ban abortion (“State Attorneys”). This block of attorneys general represents just over one-third of all states.

It also set a precedent for other states. While it is hinted at in the timelines of other states choosing to include abortion in non-essential procedures, Mississippi is a textbook example of Texas’ influence. In April, following the passing of executive order GA-09 from Governor Abbott, Governor Tate Reeves of Mississippi mentioned on a right-wing radio show that he was finalizing an executive order that would ban abortions during the pandemic based specifically on Texas (Pittman). He noted the 5th U.S. Circuit Court of Appeals ruling that upheld the Texas ban could act as an example for how he could pass his own temporary ban without getting blocked by the same court (Pittman). He is quoted as saying of the Texas order that “As soon as we got it, our

lawyers have been reviewing it, looking at it, because we want to make sure we have a similar order that meets the guidelines as set forth by the court” (qtd. in Pittman). He touted the goal of making Mississippi “the safest place in America for an unborn child” using the order as “guidance” (qtd. in Pittman). Not only were the lawyers reviewing the document, but Reeves noted he was “copying and pasting” elements from Texas in his Mississippi order, and approximately 25% of the wording in his order, Executive Order 1470, is identical (Pittman). Texas literally became the example to use for governors interested in utilizing the pandemic with the explicit opportunistic agenda of banning abortion. While ultimately after the 5th Circuit Court ruled to allow medication abortion to continue Governor Tate neglected to utilize state power to shut down the state’s only abortion clinic, the example of Mississippi provides compelling evidence of the influence of Texas and its original ban. Texas’ response and subsequent legal battle in *Planned Parenthood v. Abbott* is an important case to study for its immediate and potential for future impact on abortion access during a public health crisis and the limits of state power.

Shifting the narrative around abortion, both within and outside medical terminology is important. The pandemic highlighted the ease with which abortion was rendered elective/non-essential care and will continue to have damage on the way abortion may be incorporated in the future. This is likely not the last public health emergency we will face so considering how to approach these things. One consideration is the approach that Illinois, New Jersey, Virginia, and Washington took towards intentional integration into the category of “essential” regardless of the circumstance.

However, it is imperative to note in the analysis of these two decisions the displacement of risk that politicians control that disproportionately affects marginalized groups. The folks that bore that cost of the decisions are those who already face systematic and structural barriers to healthcare in general, facing even greater obstacles brought on by the pandemic. The cost of limiting abortion access comes at a cost stratified by race, class, and gender during a time of heightened vulnerability.

These cases point to some serious issues with the current regulations and may have serious consequences in the future. Considering alternatives to a rights-based approach, as proposed by Dean Spade, may provide one answer for achieving reproductive justice. Addressing the obstacles present to “choice” in abortion access necessitates a consideration of the role that administrative law plays in curtailing and regulating access. The case of *ACOG v. FDA* has already highlighted that the Supreme Court’s conservative majority leans towards opposing over protecting rights of access and other avenues may be prudent in considering how to maintain and sustain access to abortion in the future. It also broadens the conversation from protecting the decision in *Roe v. Wade*, to a consideration of policies that prevent the expansion of telemedicine, The ACOG points towards some “state laws that might prevent the mailing of mifepristone include laws explicitly restricting medication abortion via telemedicine, laws requiring in-person administration of mifepristone, as well as laws applying more generally to the dispensing of medications by mail” (“Court’s Order”). Addressing the burden of the REMS designation is another. When these sorts of policies are addressed,

it opens up possibilities for expansion of access to medication abortion beyond the physical space of the clinic.

These changes in policy are catalyzed by the pandemic in order to expand availability, but may have the possibility of retaining that expansion of access even after the specific urgency required by the pandemic conditions dissipates. The possibilities of future research are important as the pandemic is still ongoing. Scientists agree that “normal” life may not resume for some time, so the gravity of current decisions is important when considering the impact for the future. The pandemic has also clearly shown that large structural change is possible and that resistance to rise up and radically restructure how we live does not stem from an inability to do so. Of course, this is not to say that the ramifications have been equally felt across the nation or that where the infrastructure was non-existent sufficient resources were available. The uneven investment in different communities based on race and class are more than apparent during this pandemic. What might it look like for government intervention in the form of protection and access to resources during a pandemic? The ability to dramatically restructure how we are able to conduct work, life, and play points toward the possibility of shifting in other areas of our lives.

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