A Positive Right to Abortion: Rethinking *Roe v. Wade* in the Context of Medication Abortion

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Abstract

The abortion right articulated in Roe v. Wade has become more unstable and uncertain ever since the landmark decision in 1973. Yet, Roe has never allowed a person absolute autonomy in to deciding to terminate their pregnancy. Rather, the Supreme Court's articulation of the abortion right was limited by the role of the state, the relational nature of the right, and the contexts in which it could be exercised. This Note argues that the restrictions on the abortion right apparent in Roe have undermined the decision's efficacy by enabling limitations such as restrictions on access to medication abortion and the criminalization of self-managed abortion. To eliminate these barriers to reproductive freedom and justice, this Note presents a new vision of the abortion right as a positive, civil right to access abortion care.

I. Introduction: Abortion as a Privacy Right and the Limits of *Roe v. Wade*

As President Donald Trump fulfills his promise to nominate more conservative federal judges,[1] the right to choose as established in *Roe v. Wade* is becoming

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1. Bridgette Amiri, *Brett Kavanaugh's One Abortion Case*, Am. Civ. Liberties Union (July 18, 2018), https://www.aclu.org/blog/reproductive-freedom/abortion/brett-kavanaughs-one-abortion-case; John Gramlich, *With another Supreme Court pick, Trump is leaving his mark on higher federal courts*, Pew Research Ctr. (July 16, 2018), http://www.pewresearch.org/fact-tank/2018/07/16/with-another-

more unstable and uncertain.[2] Of course, this right was never absolute. *Roe* does not allow a person "to terminate [their] pregnancy at whatever time, in whatever way, and for whatever reason [they] alone choose[]."[3] Rather, the Supreme Court's initial articulation of the abortion right was limited by the role of the state, the relational nature of the right, and the contexts in which it could be exercised. These restrictions have fundamentally undermined the efficacy and stability of the *Roe* decision and have created a significant barrier to achieving the vision of reproductive justice.

Roe does not grant a positive right to have an abortion, but creates a negative right against some state interference in the abortion decision. Specifically, *Roe* construes the right to abortion as a balance between the interests of the state and those of individuals.[4] The *Roe* Court located the right to abortion within the right to personal liberty, holding that the "right to privacy is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[5] Like other privacy rights stemming from personal liberty and bodily autonomy, abortion "must be considered against important state interests in regulation" of health care and in the safety of its citizens.[6] Yet *Roe* goes further, establishing a trimester framework as the method of balancing these interests in the context of abortion.[7] The decision even dictates the point at which "protection of health, medical standards, and prenatal life, become dominant."[8] It recognizes viability of the fetus as the time at which the state's interests become sufficiently compelling to outweigh any interests of the pregnant person and thus at which the prohibition of abortion is allowed.[9]

Additionally, the language of *Roe* creates a vision of who holds the abortion right that is both limited and ambiguous. The *Roe* Court did not unequivocally grant women alone the right to choose. The story of Jane Roe or Norma McCorvey, a single pregnant woman seeking to safely and legally abort an

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supreme-court-pick-trump-is-leaving-his-mark-on-higher-federal-courts/; Ronald Klain, *Conservatives have a breathtaking plan for Trump to pack the courts*, THE WASHINGTON POST (Nov. 21, 2017), https://www.washingtonpost.com/opinions/conservatives-have-a-breathtaking-plan-for-trump-to-pack-the-courts/2017/11/21/b7ce90d4-ce43-11e7-9d3a-bcbe2af58c3a_story.html?utm_term=.2d814311d598.

2. Roe v. Wade, 410 U.S. 113, 153 (1973); *see also* Robin West, *From Choice to Reproductive Justice*, 118 YALE L. J. 1394, 1400 (2009) (discussing the instability of the abortion right as constitutionalized in *Roe* due in part to its "perennial" status as a presidential campaign issue).

3. *Roe*, 410 U.S. at 153. In fact, *Roe* assumes that the only people who would need to exercise the right to abortion are women. *Id*. In recognition of the fact that women are not the only people who may become pregnant, this note will use the term pregnant person whenever possible. However, in order to reflect the full range of restrictions on the abortion right and the limitations of current scholarship, this note will refer to women when that exclusive language is used by the cases or data discussed as in *Roe*.

4. *Id*. at 153–55, 163.

5. *Id*. at 153.

6. *Id*. at 154.

7. *Id*. at 155, 163.

8. *Id*.

9. *Id*.

unintentional pregnancy, is now fairly well known.[10] Yet, Roe was not the only plaintiff in this foundational case; Dr. James Hallford, who was arrested for providing abortions, intervened in Roe's challenge to Texas' statute prohibiting abortions.[11] Perhaps because of a physician's appearance in the case, *Roe* is not clear about whose actions and decisions the abortion right includes or protects. When first articulating the right, the majority opinion focuses on women, their pregnancies, and their decision-making processes.[12] However, in the portion of the opinion establishing the trimester framework, the Court holds:

> for the period of pregnancy prior to this compelling point, *the attending physician*, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State (emphasis added).[13]

By assigning physicians an essential role in the decision-making process and the "effectuat[ion]" of abortion on top of allowing state intervention, the language of *Roe* further limits women's rights to bodily autonomy.[14]

The Court's ambiguity in the assignment of the abortion right also limits the contexts in which abortions are viewed as being constitutionally permissible. From the beginning, the Court's opinion emphasized that the women plaintiffs in *Roe* and its companion case[15] sought access to abortions performed by physicians in safe, clinical conditions.[16] In part because of the dangerous history of illegal abortions,[17] these women asked for abortion to be decriminalized specifically so that physicians like Dr. Hallford could terminate their pregnancies.[18] As a result, the *Roe* opinion only foresaw and discussed abortion care in the context of a clinic, hospital, or other medical facility.[19] Therefore, the abortion right as described in the language of *Roe* is arguably limited to abortions performed by

10. McCorvey's identity became known after *Roe*. She eventually became an anti-abortion activist. *See* Emily Langer, *Norma McCorvey, Jane Roe of Roe v. Wade decision legalizing abortion nationwide, dies at 69*, WASH. POST (Feb. 18, 2017), https://www.washingtonpost.com/national/norma-mccorvey-jane-roe-of-roe-v-wade-decision-legalizing-abortion-dies-at-69/2017/02/18/24b83108-396e-11e6-8f7c-d4c723a2becb_story.html?utm_term=.82a9c5f6f68e.

11. *Roe*, 410 U.S. at 120–23.

12. *Id.* at 153.

13. *Id.* at 163 (internal quotes omitted).

14. *Id.*

15. *See* Doe v. Bolton, 410 U.S. 179 (1973) (holding Georgia's abortion law unconstitutional following challenge by Mary and John Doe, a married couple).

16. *Roe*, 410 U.S. at 120–21.

17. *See id.* at 150 (noting the high mortality rate for illegal abortions).

18. *Id.* at 120–21.

19. *See id.* at 163 ("Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.").

doctors, which states are free to regulate further by confining the process to a clinic or hospital setting.[20]

The foundational limitations of *Roe* have been maintained and expanded in the Supreme Court's later abortion jurisprudence. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court more explicitly assigns women the exclusive right to choose abortion.[21] The plurality held that "[o]nly where state regulation imposes an undue burden on a *woman's* ability to make this [abortion] decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause."[22] The "undue burden" standard thus erodes *Roe's* strict trimester framework, but clarifies that the abortion right belongs to women and not their physicians.

Yet, in the same decision, the Court determined that informed consent and waiting period requirements were constitutional.[23] By upholding this legislation, the Court indicated that requiring a doctor to provide abortion care was not an impermissible burden on the abortion right. In so doing, the Court simultaneously preserved the central role of physicians and continued to confine abortion to clinic and hospital settings.[24] Thus, the *Casey* Court maintained the view that pregnant persons should not receive an abortion without consulting a physician, despite more definitely assigning them the right to make their own abortion decisions. In other words, the Court also reiterated the right's "relationality."

Roe's privacy framework for the abortion right has proven insufficient even to protect against government intrusions into abortion care provided by doctors in a clinic or hospital.[25] *Casey's* undue burden standard still used today maintains the states' role in regulating abortion, prohibiting only restrictions having "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[26] Between 2010 and 2016, states enacted 334 abortion restrictions that have undeniably limited access to the procedure.[27] In 2017, the United States House of Representatives voted to prohibit abortions after a fetus reaches a gestational

20. *Id*. at 150 ("The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.").

21. 505 U.S. 833 (1992).

22. *Id*. at 874 (emphasis added).

23. *Id*. at 884–86.

24. *Id*.

25. *See, e.g*., Jill E. Adams and Melissa Mikesell, *And Damned If They Don't: Prototype Theories to End Punitive Policies against Pregnant People Living in Poverty*, 18 GEO. J. GENDER & L. 283, 332 (2017) (discussing continued barriers to accessing abortion such as lack of public funding options).

26. *Casey*, 505 U.S. at 877.

27. *The 334 abortion restrictions enacted by states from 2011 to July 2016 account for 30% of all abortion restrictions since Roe v. Wade*, GUTTMACHER INST. (July 21, 2016), https://www.guttmacher.org/infographic/2016/334-abortion-restrictions-enacted-states-2011-july-2016-account-30-all-abortion.

age of twenty weeks.[28] Though the Supreme Court has struck down some types of restrictive legislation, states have also continued to defend these same laws on the grounds that their iterations actually protect women's health and promote a valid interest in regulating medical practice.[29]

This paper will argue that the negativity and relationality of the right articulated in *Roe* has enabled these limitations on abortion access. Reframing the right as a positive right to access abortion care would enable pregnant persons to choose abortion on their own terms. The difference between the right's current articulation and the proposed shift would be most profoundly felt in the arena of medication abortions. A positive right to access care would clearly protect decisions to end a pregnancy with medication, while the current articulation of the right leaves these procedures at best ambiguous or at worst entirely unprotected. The argument proceeds in two parts. Part I will look at medication abortion and the way in which the legal framework established in *Roe* and refined in subsequent Supreme Court decisions has allowed its restriction. Part II will explain how an expansion of the abortion right as a right to privacy in the medical relationship between a woman and her doctor is inherently limited and will argue that abortion should be reconstructed as a positive right necessary for full participation in society. Ultimately, this vision of the abortion right is more consistent with achieving reproductive justice for all people.

II. THE CONSTITUTIONALITY OF LIMITS ON MEDICATION ABORTION CARE: IMPACTS ON ACCESS AND HEALTH

There are two types of medication commonly used to terminate pregnancies in the United States: mifepristone and misoprostol.[30] The United States Food and Drug Administration (FDA) first approved the use of mifepristone to terminate pregnancy in 2000.[31] The FDA approved misoprostol in 1988 but only to treat ulcers.[32] The two medications are normally given in a combined

28. Pain Capable Unborn Child Protection Act, H.R. 36, 115th Cong. (2017); Jessie Hellman, *House passes 20-week abortion ban*, THE HILL (Oct. 3, 2017), http://thehill.com/policy/healthcare/353709-house-passes-20-week-abortion-ban.

29. *Compare* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (holding that Texas' admitting privilege requirement for physicians and ambulatory surgical center requirements for clinics were an unconstitutional burden on the right to abortion) *with* Comprehensive Health v. Hawley, No. 17-1996, 2018 WL 4288362 (8th Cir. April 4, 2017) (in which Missouri is arguing that their admitting privilege and ambulatory surgical center requirements are constitutional).

30. Heather Boonstra, *Medication Abortion Restrictions Burden Providers – and Threaten U.S. Trend Toward Very Early Abortion*, 18 GUTTMACHER POL'Y REV. 1, 18 (2013).

31. *Questions and Answers on Mifeprex*, FDA (Mar. 28, 2018), https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm492705.htm. Notably, Mifepristone had been approved for use in France since 1988. *Id.*

32. *See New Drug Application (NDA): 019268*, FDA, https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=019268 (last visited Sept. 7, 2018); *Cytotec (misoprostal): Information for Patients*, PFIZER (Jan. 2017), https://www.pfizermedicalinformation.com/en-us/patient/cytotec.

regimen.[33] Mifepristone is taken first and works by blocking the release of the hormone progesterone, causing the uterine lining to break down and starting bleeding.[34] Misoprostol is taken next, causing the uterus to contract, expelling the uterine lining and other products of conception, and completing the abortion.[35] This regimen is used to terminate early pregnancies up to seventy days from a person's last menstrual period (seventy days lmp).[36] The method is highly effective and results in successful termination of pregnancy ninety-five to ninety-nine percent of the time. This success rate is similar to that for surgical abortion.[37] Complications, including those requiring further medical intervention, are extremely rare.[38] Some studies have found that misoprostol alone can effectively terminate early pregnancies, though it is less likely to be successful than the combined mifepristone-misoprostol regimen.[39] However, unlike mifepristone, misoprostol can be obtained over-the-counter in pharmacies outside of the United States.[40]

Some people prefer medication abortion because it is less invasive than surgical abortion.[41] The procedure also allows pregnant persons more control over and privacy in the process because misoprostol can often be taken, and thus the abortion completed, at a person's home.[42] However, in the United States mifepristone is only accessible through providers registered with the manufacturer of the drug and cannot be dispensed at retail pharmacies or legally ordered online.[43] Thus, a physician or advanced practice clinician (such as a nurse practitioner) must initiate medication abortion at a hospital, clinic, or telemedicine site.[44]

Additionally, although the FDA, professional associations, and medical researchers indicate that misoprostol may be safely taken at home and that follow-up can be completed by phone, many states have restricted where medication abortion can be administered.[45] As of December 2015, eighteen states require a physician to be

33. *See Evidence You Can Use: Medication Abortion*, GUTTMACHER INST. (May 2017), https://www.guttmacher.org/evidence-you-can-use/medication-abortion (noting that the combined regimen was used in thirty-one percent of abortions in 2014).

34. Angel Foster, *Medication Abortion: A Guide for Health Professionals*, IBIS REPROD. HEALTH 1, 2, 5 (2005), https://ibisreproductivehealth.org/sites/default/files/files/publications/Telemedicine%20introductory%20brief%20Jan%202016.pdf.

35. *Id*. at 3, 5.

36. *See* FDA, *supra* note 31.

37. *See* Foster, *supra* note 34, at 26.

38. For example, severe bleeding occurs in only one to two percent of cases and severe bleeding requiring a transfusion only in one-tenth of one percent of cases. *Id*. at 10.

39. The misoprostol-only regimen is 75-90% effective at 9 weeks lmp. *See Instructions for Use: Abortion Induction with Misoprostol Alone in Pregnancies Through 9 Weeks' LMP*, 1 GYNUITY HEALTH PROJECTS (Oct. 2013), http://gynuity.org/downloads/resources/clinguide_ifu_abortion_en.pdf.

40. Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL'Y REV. 3, 72 (2015), https://www.guttmacher.org/gpr/2015/09/prosecuting-women-self-inducing-abortion-counterproductive-and-lacking-compassion.

41. *See* GUTTMACHER *supra* note 33.

42. *Id*.

43. *See* FDA, *supra* note 31.

44. *Id*.

45. *See* GUTTMACHER *supra* note 33.

physically present to administer an abortifacient, completely forbidding the use of telemedicine for medication abortions.[46] The vast majority of abortions in the United States occur before twelve weeks gestation.[47] Medication abortion could, therefore, provide an effective method to expand access to abortion care, particularly in areas with few providers.[48] However, *Roe*'s privacy and relationality framework has allowed states to restrict access to this type of abortion care and criminally prosecute people who violate the restrictions.

A. TEXAS: HB2 AND ACCESS TO MEDICATION ABORTION CARE

In 2013, the Texas legislature enacted House Bill 2 (HB2), an omnibus bill containing a ban on abortion after twenty weeks, a requirement that physicians preforming abortions have admitting privileges at nearby hospitals, ambulatory surgical center requirements for clinics, abortion reporting requirements, and restrictions on the administration of medication abortion.[49] The ambulatory surgical center and admitting privilege requirements were struck down in 2016, when the Supreme Court found that they imposed an undue burden on women seeking abortions without advancing Texas' legitimate interest in promoting women's health and safety.[50] Although the medication abortion restrictions were also challenged, the Supreme Court did not hear the issue and that part of the legislation remains in place.[51]

The medication abortion restrictions enacted through HB2 have three parts. First, they prohibit anyone but physicians from prescribing or administering medication abortion, preventing other qualified advanced-practice clinicians from providing this care.[52] Second, they limit the manner in which medication abortion can be provided by requiring physicians to follow the "on-label" protocol prescribed by the FDA.[53] At the time the Texas legislation was passed, the FDA's on-label protocol required a higher and therefore more expensive dosage of

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46. *Telemedicine provision of medication abortion*, IBIS REPRODUCTIVE HEALTH (Jan. 2016), https://ibisreproductivehealth.org/sites/default/files/files/publications/Telemedicine%20introductory%20brief%20Jan%202016.pdf.

47. In 2013, 89% of abortions occurred in the first twelve weeks of pregnancy. *See Induced Abortion in the United States*, GUTTMACHER INST. (Oct. 2017), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states (hereinafter *Induced Abortion*).

48. *See Medication Abortion*, KAISER FAM. FOUND., 5–6 (Oct. 2017), http://files.kff.org/attachment/Fact-Sheet-Medication-Abortion.

49. H.B. 2, 83rd Leg., 2d Spec. Sess. (Tex. 2013); *see also* TEX. HEALTH & SAFETY CODE. ANN. § 171.063 (West 2013). The bill received national attention after State Senator Wendy Davis successfully filibustered an earlier version of the legislation, forcing then-Governor Rick Perry to call a special session focused only on enacting the restrictions. *See* Jessica Mason Pieklo, *Abortion Rights Under Fire: Why Wendy Davis' Filibuster Matters*, ROLLING STONE (June 26, 2013), http://www.rollingstone.com/politics/news/abortion-rights-under-fire-why-wendy-davis-filibuster-matters-20130626.

50. Whole Woman's Health v. Hellerstedt, 136 S.Ct. 2292, 2319 (2016).

51. *See* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583 (5th Cir. 2014); TEX. HEALTH & SAFETY CODE. ANN. § 171.063 (West 2013).

52. H.B. 2, 83rd Leg., 2d Spec. Sess. (Tex. 2013).

53. *Id*. The bill also allowed physicians to follow the guidelines established by the American College of Obstetricians and Gynecologists as of Jan. 1, 2013 which are similar to the FDA's before they were updated in 2016. *Id*.; Planned Parenthood of Greater Tex. Surgical Health Servs., 748 F.3d at 600–01.

mifepristone.[54] Further, requiring adherence to the FDA's contemporary protocol limited the use of medication abortion to up to forty-nine days lmp.[55] However, at the time the legislation was passed, many providers had begun to use mifepristone at a lower dose and later in pregnancy (up to sixty-three days lmp) in accordance with evidence-based guidelines developed by researchers and professional associations.[56] Lastly, the legislation requires physicians to be in the physical presence of their patients when providing abortion care, thus prohibiting the use of telemedicine.[57] Not only do many advanced practice clinicians safely and effectively provide medication abortion care, researchers and professional organizations agree medication abortion can be initiated through telemedicine and that at least the second part of the regimen can be effectively taken at home.[58]

The conditions created by HB2 made it significantly more difficult for people in Texas to access abortion care. Over half of the abortion clinics in Texas closed because they or their physicians were unable to comply with the HB2 requirements.[59] The mean distance travelled by women seeking to obtain an abortion increased by twenty miles and it took them longer to get an appointment at the clinics that remained open.[60] The restrictions in HB2 also increased the frustrated demand for medication abortion by approximately fourteen percent between 2013 and 2014.[61] Due to the direct restrictions on medication abortion and the fact people were forced to seek abortions later in pregnancy when surgical abortion becomes necessary, HB2 decreased the total number of medication abortions provided by seventy percent.[62]

Though HB2 created real obstacles to obtaining a medication abortion, *Roe*'s articulation of the right to choose allows state regulation of abortion methods. In *Gonzales v. Carhart*, the Supreme Court addressed the federal Partial Birth Abortion Ban,[63] which prohibited a method of abortion used in the second trimester of pregnancy called intact dilation and evacuation (intact D&E).[64] The Court

54. *See* Planned Parenthood of Greater Tex. Surgical Health Servs., 748 F.3d at 600–01.

55. *Id*.

56. The FDA on-label protocol now states that mifepristone can be used at a lower dose up to seventy days lmp. *See* FDA, *supra* note 31; *see also Planned Parenthood of Greater Tex. Surgical Health Servs*., 748 F.3d at 600–01.

57. H.B. 2, 83rd Leg., 2d Spec. Sess. (Tex. 2013).

58. *See* Thoai Ngo et. al., *Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review*, WHO (March 4, 2011), https://www.who.int/bulletin/volumes/89/5/10-084046/en/; *see also* Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (striking down Iowa's ban on telemedicine abortion).

59. *See* Gerdts et. al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas*, 106 APJH 5, 857 (May 2016).

60. *Id*. at 861.

61. *Id*. at 862.

62. *Texas women's experiences attempting self-induced abortion in the face of dwindling options*, IBIS REPRODUCTIVE HEALTH 1 (Nov. 17, 2015), https://ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP_Texas%20womens%20experiences%20self%20induction_ResearchBrief_17Nov2015.pdf.

63. 18 U.S.C. § 1531.

64. 550 U.S. 124, 134–38 (2007).

upheld the ban under *Casey*, finding that a legislature may regulate abortion methods as long as the restrictions do not create an undue burden for those seeking an abortion.[65] Since there were and are methods other than D&E to terminate a pregnancy in the second trimester, the Court did not find that the ban presented a substantial obstacle to obtaining abortion care.[66] Further, the Court emphasized that this type of legislation may be enacted even in the face of medical disagreement about the procedure's effectiveness and the necessity of a particular procedure to maintain a person's health.[67]

Given this precedent, when abortion providers brought a case against HB2's medication abortion restrictions, it logically did not include a challenge on behalf of persons who simply preferred medication abortion to surgical abortion beyond forty-nine days lmp.[68] Rather, in *Planned Parenthood of Greater Texas v. Abbott*, the Fifth Circuit was asked to address whether the lack of a life or health exception in the medication abortion statute imposed an undue burden on people seeking an abortion between fifty days lmp and sixty-three days lmp for whom surgical abortion would pose a substantial health risk.[69] In *Abbott*, the Court refused to limit the restrictions even to include a health exception because of conflicting evidence as to the necessity of medication abortion in those cases where continuing a pregnancy would place a person's health at risk.[70] Therefore, the protocols allowed by the Texas statute must be followed unless a pregnant person's life is in danger, as required by *Casey*.[71]

The many provisions of HB2 created a need for increased access to safe and flexible abortion care in the state of Texas. Given the safety of medication abortion in general and of telemedicine in particular, both of these options could have ameliorated the problems caused by the implementation of the parts of HB2 later struck down by the Supreme Court.[72] However, instead of protecting the right to choose, the *Roe* and *Casey* frameworks prevented a broad and effective challenge to medication abortion restrictions. As a result, these regulations remain in place even as their limited medical justifications have been eliminated.[73]

B. THE CRIMINALIZATION OF SELF-MANAGED MEDICATION ABORTION

Further, *Roe* has allowed people to be prosecuted when they seek to circumvent state-imposed restrictions and induce their own abortions. People are more likely to attempt self-induced abortion when access to safe, legal, and clinic-

65. *Id*. at 161.
66. *Id*.
67. *Id*. at 163.
68. *See* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 603–04 (5th Cir. 2014).
69. *Id*. at 601.
70. *Id*. at 603–04.
71. *Id*. at 604.
72. *See generally* Whole Woman's Health v. Hellerstedt, 136 S.Ct. 2292 (2016).
73. *See* FDA, *supra* note 31 (describing the FDA's change in on-label protocol for mifepristone).

based abortion care is restricted.[74] A study conducted in 2015 after the enactment of HB2 found that between 100,000 and 240,000 thousand Texas women, or between just over one percent and four percent of the female population, had attempted to self-induce an abortion.[75] Qualitative interviews with women in Texas conducted after the implementation of HB2 found that clinic closures caused by the bill made women more likely to self-induce an abortion.[76] These Texas women identified travel, procedure costs, and the closure of a local clinic as some of the reasons why they chose or felt forced to try to self-induce.[77]

In addition to economic and geographic barriers, people choose to self-induce abortion to avoid the shame and stigma associated with going to an abortion clinic and to maintain control over the abortion process.[78] They may also elect to self-induce because of the recommendation of a friend or family member or because its similarity to menstrual regulation makes the process seem easier and more natural than abortion at a clinic.[79] Common self-induction methods include medication, herbs or supplements, physical manipulation, and illicit substances; they vary greatly in safety and effectiveness.[80] In Texas, the vast majority of women surveyed chose to self-induce using misoprostol, but achieved mixed results due to variance in ingestion and dosage methods from those normally recommended for medication abortion.[81] Most of these women purchased misoprostol on the black market or from pharmacies in Mexico, where misoprostol is available over-the-counter.[82] Additionally, a recent study has indicated that people in the United State can order effective mifepristone and misoprostol online.[83]

Research has shown that when provided with information and education on medication abortion, self-management of abortion using this method can be both safe and effective. Most pregnant people can remember the date of their last menstrual period and determine whether there are circumstances that contraindicate the use of medication to abort a pregnancy.[84] They can also follow instructions

74. Daniel Grossman, et al., *Self-induction of abortion among women in the United States*, 18 REPROD. HEALTH MATTERS 36, 136 (2010).

75. Daniel Grossman et. al, *Knowledge, opinion and experience related to abortion self-induction in Texas*, TEX. POL'Y EVALUATION PROJECT 2 (Nov. 14, 2015) https://utexas.app.box.com/v/koeselfinductionresearchbrief.

76. *See Texas women's experiences attempting self-induced abortion in the face of dwindling options*, TEX. POL'Y EVALUATION PROJECT 1 (Nov. 17, 2015), https://ibisreproductivehealth.org/publications/texas-women%E2%80%99s-experiences-attempting-self-induced-abortion-face-dwindling-options (hereinafter Texas women's experiences); Olga Khazan, *Texas Women Are Inducing Their Own Abortions*, THE ATLANTIC (Nov. 17, 2015), https://www.theatlantic.com/health/archive/2015/11/texas-self-abort/416229/.

77. *See id*., at 2.

78. *See id*.; Grossman, *supra* note 75, at 142.

79. *See Texas women's experiences*, *supra* note 76, at 2; Grossman, *supra* note 75, at 142.

80. Grossman, *supra* note 75, at 138–39.

81. *See Texas women's experiences*, *supra* note 76, at 3–4.

82. *Id*.

83. Chloe Murtagh et al., *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, CONTRACEPTION (Accepted June 2017).

84. Adams and Mikesell, *supra* note 25, at 329.

given to them and decide whether medication abortion is right for them without directly meeting with a physician.[85] Additional studies have demonstrated that an in-person follow-up visit for medication abortion is not usually necessary, as most people can manage side effects on their own and recognize if their situation is serious enough to require a trip to a medical provider.[86]

In fact, there are a number of abortion care models outside of the United States that provide pregnant persons with medication abortion and information on how to take it, without requiring a visit to a healthcare provider. For example, the organization Women on Web distributes mifepristone and misoprostol to persons seeking to terminate their pregnancies in countries where "access to safe abortion is restricted."[87] The group requires people to have an online conversation with a physician to determine if medication abortion is appropriate, and provides extensive information about the process on their website.[88] People in the areas reached by Women on Web can receive pills at a low cost and are able to manage their own medication abortion process and care.[89] Research has suggested that the complication rates for people receiving medication abortion from Women on Web are comparable to medication abortion in more traditional clinical settings.[90]

Yet, though abortion restrictions have created a demand for safe self-managed medication abortion care, prosecutors have used these same restrictions to arrest and charge people who choose or are forced by personal, social, or economic circumstances to pursue this option.[91] In a study of forced legal interventions on pregnant women, Lynn Paltrow and Jean Flavin identified eight cases in which women were charged under a state's abortion laws after allegedly self-inducing an abortion between 1973 and 2005.[92] Since that study, at least three other people have been prosecuted for terminating their own pregnancies.[93] Other research has

85. *Id*. at 330.

86. *Is it difficult to do a medical abortion by yourself?*, WOMEN ON WEB, https://www.womenonweb.org/en/page/482/in-collection/6901/is-it-difficult-to-do-a-medical-abortion-by-yourself (last visited Oct. 6, 2018).

87. *I need an abortion with pills*, WOMEN ON WEB, https://www.womenonweb.org/en/i-need-an-abortion (last visited Oct. 6, 2018).

88. *Id*.

89. *Id*.

90. *About Women on Web*, WOMEN ON WEB, https://www.womenonweb.org/en/page/521/about-women-on-web (last visited Oct. 6, 2018).

91. Lynn Paltrow and Jeanne Flavin, *Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 DUKE J. OF HEALTH POL., POL'Y AND L. 2, 317 (2013).

92. *Id*.

93. This includes two Asian American women from Indiana and a woman from Idaho. *See* Cleve Wootson Jr., *Court overturns feticide conviction of Indiana woman who had self-induced abortion*, WASH. POST (July 22, 2016), https://www.washingtonpost.com/news/post-nation/wp/2016/07/22/court-overturns-feticide-conviction-of-indiana-woman-who-had-self-induced-abortion/?utm_term=.38d32724da77; Mark Stern, *A Quiet Victory*, SLATE (June 5, 2015), http://www.slate.com/articles/double_x/doublex/2015/06/jennie_linn_mccormack_case_court_strikes_down_idaho_s_abortion_laws.html (discussing prosecution of

identified a total of eighteen cases in which people were arrested for terminating their own pregnancies in the United States.[94]

One case is exemplary. Idaho resident Jennie McCormack was arrested and charged for the use of abortion medication to successfully terminate her pregnancy. McCormack lived 140 miles away from the nearest abortion clinic in Salt Lake City, Utah. When she found out she was pregnant despite using birth control, she already had three children, no income other than some child support, and no car.[95] Since Utah has a mandatory seventy-two hour waiting period, having an abortion at a clinic would have meant two trips to the clinic and could have cost between $400 and $2,000 depending on the gestational age of the fetus.[96] Looking for a less expensive and time consuming method to terminate her pregnancy, McCormack got enough money to buy $200 "abortion pills" prescribed by an online provider.[97] Two months later, McCormack received the pills in the mail. Although her pregnancy was farther along than recommended for medication abortion, McCormack successfully terminated her pregnancy using the pills she received.[98]

When she told a neighbor what she had done, she was arrested and charged with felony violation under Idaho Code § 18-606.[99] This statute renders Idaho women criminally liable for violations of § 18-608, prohibiting anyone but a physician from performing an abortion and requiring abortions to take place in a hospital or licensed clinic.[100] The prosecutor was unable to develop enough evidence to make a case against McCormack, and the charges were dismissed without prejudice.[101] However, since the prosecutor threatened to bring further charges against McCormack if more evidence came to light, McCormack and her attorney decided to bring a constitutional challenge to § 18-606.[102] In *McCormack v. Hiedeman*, the United States Court of Appeals for the Ninth Circuit upheld the Idaho District Court's order enjoining enforcement of § 18-606.[103]

Though significant for McCormack, the Ninth Circuit's decision leaves the legal status of self-induced abortion ambiguous. The Ninth Circuit narrowed the District Court's preliminary injunction such that it only bars enforcement of the statute against McCormack and not other similarly

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Jennie McCormack); Katha Pollitt, *Protect pregnant women: Free Bei Bei Shaui*, THE NATION (March 26, 2012), https://www.thenation.com/article/protect-pregnant-women-free-bei-bei-shuai/.

94. *Making Abortion a Crime (Again): How Extreme Prosecutors Attempt to Punish People for Abortions in the U.S.*, THE SIA LEGAL TEAM 2, available at https://docs.wixstatic.com/ugd/aa251a_09c00144ac5b4bb997637bc3ac2c7259.pdf (last visited Oct. 6, 2018).

95. Ada Calhoun, *The Rise of DIY Abortions*, NEW REPUBLIC (Dec. 21, 2012), https://newrepublic.com/article/111368/the-rise-diy-abortions.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*; *see also* IDAHO CODE ANN. § 18-606 (1973).

101. Calhoun, *supra* note 95.

102. *Id.*; McCormack v. Hiedeman, No. cv-2011-397, 2011 WL 4436548 (D. Idaho 2011).

103. McCormack v. Hiedeman, 694 F.3d 1004, 1025 (9th Cir. 2012).

situated persons.[104] Neither the District Court nor the Ninth Circuit declared Idaho Code § 18-606 to be unconstitutional.[105] Further, the decision does not state that McCormack or any pregnant person has a right to self-manage their abortion care or to be free from prosecution for doing so.[106] Rather, the Court merely held that requiring patients to police the behavior of abortion providers or face criminal liability for their provider's behavior likely constitutes an unconstitutional undue burden on those seeking abortion care.[107] The opinion does not establish that requiring physicians to provide abortion care in a hospital or clinic is unconstitutional.[108] Thus, *McCormack* maintains the framework established in *Roe* and *Casey*, and in doing so, continues to center the role of health care providers in the abortion process.

For these reasons, *McCormack* sets an incredibly limited precedent. It does not construe self-managed abortion care as a part of the abortion right, but instead continues to allow the state to mandate where and by whom abortion is provided. Though the decision speaks against the criminalization of women's reproductive health care choices, it perpetuates barriers to accessing care by allowing Idaho to require that patients interact with providers exclusively in a formal health care setting in order to obtain an abortion.[109] In light of unprecedented abortion restrictions passed in the last decade, [110] the legal treatment of Idaho Code § 18-606 in *McCormack* and HB2 in *Abbott* demonstrates that the abortion right, as construed in *Roe* and its progeny, is unable to fully protect comprehensive access to medication abortion or self-managed abortion care.

III. REFRAMING THE RIGHT TO ABORTION

A. STRENGTHENING THE RIGHT TO CHOOSE

Many scholars have recognized the limits of *Roe* and have called for a reconsideration of the decision's foundational assumptions.[111] Yet, some of *Roe*'s more recent critics have proposed that to fully protect access to medication abortion and prevent the criminalization of self-induced abortion, the basic construction of abortion as a privacy right must simply be expanded. For example, Jill Adams, Melissa Mikesell, and Yvonne Lindgren argue that people already have a

104. *Id.* at 1019.

105. *See McCormack*, 694 F.3d at 1025; McCormack v. Hiedeman, 900 F. Supp. 1128, 1133–34 (D. Idaho 2013); McCormack v. Hiedeman, No. cv-2011-397, 2011 WL 4436548 (D. Idaho 2011).

106. *McCormack*, 694 F.3d at 1018, 1025.

107. *Id.*

108. *Id.*

109. *See, e.g.*, IDAHO CODE ANN. § 18-608 (1973).

110. Elizabeth Nash et. al., *Laws Affecting Reproductive Health and Rights: State Policy Trends at Midyear, 2017*, GUTMMACHER INST. (July 2017), https://www.guttmacher.org/article/2017/07/laws-affecting-reproductive-health-and-rights-state-policy-trends-midyear-2017?gclid=EAIaIQobChMInLGxoqW1wIVg0wNCh3ANQd0EAAYASAAEgJOLvD_BwE.

111. *See, e.g.*, Robin West, *From Choice to Reproductive Justice*, 118 YALE L. J. 1394, 1415 (2009); CATHERINE MACKINNON, FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW (1988).

privacy right to complete medication abortions in their own homes free from government intrusion.[112] They suggest that medication abortion completed at home, with or without the supervision of a health care provider, is protected by the Fourth Amendment's zonal protection of the home and the associated right "to be left alone" in that space.[113] Alternatively, Lindgren argues that choosing to have an abortion at home is a decision of "personal significance related to procreation" and an essential element of intimate association.[114] Like the right to contraception described in *Griswold v. Connecticut*,[115] it is thus protected by the Fourteenth Amendment's guarantee of decisional autonomy in intimate relationships free from government influence.[116] According to analysis of these scholars, the legal system must merely recognize that additional home-based privacy rights apply to abortion to overturn or prevent legislation requiring medication abortion to be completed in a formal health care setting with the direct supervision of a medical professional.[117]

Another approach to ensuring that medication abortion is protected under the *Roe* framework is the "cumulative burdens" standard. Under *Casey's* articulation of the undue burden standard, a state may only legitimately regulate abortion where such regulation does not place a substantial obstacle in the path of a woman seeking pre-viability abortion care.[118] In *Whole Woman's Health*, the Court indicated for the first time that *Casey* and *Roe* may require consideration of the impact of *all* burdens in the path to an abortion, not just those caused by the law challenged in a given case.[119] Adams and Mikesell suggest expanding the *Casey* and *Whole Woman's Health* approach to require examination of the cumulative impact of cumulative burdens preventing people from accessing abortion. This would include consideration of economic and demographic variables.[120] For example, a court considering a case similar to McCormack's challenge to the Idaho statute would be required to evaluate how the geographic distribution of clinics, the economic status of people like McCormack, and Idaho's abortion restrictions compound to make accessing care more difficult. Theoretically, the cumulative impact of burdens on people seeking an abortion would outweigh any baseless state regulation of medication abortion or criminalization of a person's decision to terminate their own pregnancy.[121]

By recognizing that abortion is a private decision that may be made and completed entirely at home without state intervention, Adams, Lindgren, and

112. Adams and Mikesell, *supra* note 25, at 324–24; Yvonne Lindgren, The *Doctor Requirement: Grisworld, Privacy, and at-Home Reproductive Care*, 32 CONST. COMMENT 341, 357–58 (2017).
113. Adams and Mikesell, *supra* note 25, at 324–24; Lindgren, *supra* note 111, at 357–58.
114. Lindgren, *supra* note 112, at 369.
115. 381 U.S. 479 (1965).
116. Lindgren, *supra* note 112, at 367.
117. Adams and Mikesell, *supra* note 25, at 324–25; Lindgren, *supra* note 112, at 357–58.
118. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874 (1992).
119. Adams and Mikesell, *supra* note 25, at 322.
120. *Id.* at 323.
121. *Id.* at 324.

Mikesell identify the right to abortion as one belonging solely to pregnant persons and not to their health care providers. Yet, a closer examination of these two approaches reveals that they do little to support people's *access* to medication abortion in any setting. First, as Lindgren herself points out, the home is not a place of safety or equality for many people, such as those experiencing domestic violence.[122] For low-income people whose lives are constantly monitored by police and other government agents the home is not a truly private space.[123] As such, even an expanded vision of abortion as a privacy right fails to protect against the many ways private or government actions might impact the legitimate exercise of a person's privacy right to abortion. In other words, allowing people to make their own decisions within the home without government interference does not mean that they will actually be able to do so.[124]

Additionally, though the pragmatic reading of *Whole Woman's Health* as put forth by Adams and Mikesell has already been visible in some reproductive rights impact litigation,[125] the approach maintains one of the most problematic elements of *Roe's* framework. Though requiring the examination of the cumulative impact of cumulative burdens might allow accommodation of social and economic inequalities, these burdens must still be weighed against the interests of the state that could include a preference for childbirth over abortion.[126] Thus, Adams and Mikesell's expanded undue burden standard maintains the position that some burden is acceptable and that the state may play a role in imposing such a burden on the grounds that they are protecting people's health or promoting potential life.

These approaches perpetuate the problems of *Roe* because framing abortion as a part of the right to privacy or a private decision in which the state may not interfere removes any obligation for the state to support access to abortion care. In fact, the characterization of abortion as a personal, private, and moral decision has repeatedly been mobilized to restrict access to funding for abortion care.[127] Further, relegating discussions about and the practice of abortion to the private sphere has increased stigma and allowed dangerous myths about the procedure to be perpetuated by its opponents.[128] Ultimately, Adams, Lindgren, and Mikesell's proposals preserve a right to choose for pregnant persons without ensuring meaningful access to accomplish that choice. For example, even if it would have

122. Lindgren, *supra* note 112, at 371–72.

123. *Id*. at 359–60 (recognizing that though the home is a space of relative safety, government surveillance is a constant presence in the lives of low-income persons and immigrants); *see also* Adams and Mikesell, *supra* note 25, at 323–24; Nathan Freed Wessler, *ICE Using Powerful Stingray Surveillance Devices In Deportation Searches*, ACLU (May 23, 2017), https://www.aclu.org/blog/privacy-technology/surveillance-technologies/ice-using-powerful-stingray-surveillance-devices.

124. Lindgren, *supra* note 112, at 369–74.

125. Adams and Mikesell, *supra* note 25, at 322.

126. *Id*. at 323; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874 (1992).

127. *See* Harris v. McRae, 448 U.S. 297 (1980) (upholding ban on the use of public funds for abortions because a person's inability to afford the procedure is not a state-imposed obstacle).

128. *See generally* A. Kumar et al., *Conceptualising Abortion Stigma*, 11 CULT, HEALTH, & SEXUALITY 6 (Jul. 2009) (describing the phenomenon of abortion stigma).

prevented her prosecution, a more robust right to privacy or court analysis of the cumulative burdens caused by Idaho's abortion restrictions would not have helped McCormick pay for an abortion or access information on how to safely self-manage her abortion care. The current legal treatment of medication abortion and self-induced abortion therefore demonstrates the necessity of moving further beyond *Roe* to assign the abortion right to pregnant persons alone, prevent state obstruction of abortion care, and achieve meaningful access to comprehensive reproductive health care.

B. ABORTION AS A RIGHT TO ACCESS

The current understanding of the United States Constitution, and hence the current understanding of "rights," is that our rights are negative rights against government intrusion into private life.[129] Yet, at various times in our legal history we have also recognized the need for some positive civil rights, which are necessary for full civic participation in the public spheres of work, education, and political life. For example, as explained by Robin West, many of the civil rights of which people may not be deprived on the basis of race, class, or gender are positive rights *to* something or to behave in some manner.[130] These are the positive rights necessary to promote individual flourishing and achieve some level of human welfare and are owed to everyone on the basis of their humanity.[131] Without these underlying rights, people are unable to fully participate in or "enter" society.[132] However, individuals are unable to realize these rights without state institutions and support.[133] For example, the right to be free from discrimination in education ensures that people can fully participate in their communities through work and civic engagement, but requires institutions to provide and protect access to quality schools.[134] In other words, there are certain civil rights that must include the ability to access the thing protected or they become meaningless.[135]

Though *Roe* frames abortion as a constitutionally protected right separate from civil society and state intervention,[136] abortion is actually necessary for persons who can become pregnant to participate fully in society. First, abortion is a part of reproductive healthcare, and West herself specifically recognizes the ability to

129. *See, e.g.* U.S. Const., amend. I (prohibiting Congress from enacting laws restricting freedom of speech or the free exercise of religion).

130. ROBIN WEST, *Toward a Jurisprudence of the Civil Rights Act*s, *in* A NATION OF WIDENING OPPORTUNITIES? THE CIVIL RIGHTS ACT AT FIFTY 2–3 (2014).

131. West describes these rights as those that "facilitate forms of individual participation in the civic community that promote fundamental individual capabilities, such as our capabilities for intimacy, work, physical security, health, engagement in mental and cultural life, and neighborliness, and they do so through guaranteeing access to the laws that structure the civic institutions that promote or protect them." *Id.* at 18.

132. For this reason, West refers to such rights as "rights to enter." *Id.* at 20.

133. *Id.* at 10.

134. *Id.* at 14–16.

135. *Id.*

136. West describes these types of rights as constitutionally protected "exit rights" because they protect individuals' right to live outside of society and be free from civic engagement. *Id.* at 21–22.

access healthcare as a right necessary for full participation in society that requires laws and structures to support it.[137] Abortion restrictions not only impact how health care is received, but also the ability of people like McCormack to make personal decisions and to fully participate in intimate relationships.[138] Currently, one in four women in the United States will have an abortion before the age of forty-five.[139] In 2014, fifty-nine percent of abortion patients had already had at least one birth and seventy-five percent were low-income.[140] The reasons patients give for seeking an abortion are often related to their ability to manage their current obligations and to continue fully participating in society. Seventy-five percent of abortion patients cite the need to take care of others, the cost of raising a child, and the belief that having a baby would interfere with their work or school as reasons for seeking abortion care.[141] Finally, even the Supreme Court in *Casey* recognized the importance and centrality of the procedure in the lives of persons who may become pregnant.[142] This vision of abortion access as necessary to ensure equal participation is consistent with the movement for abortion rights that existed before *Roe* and can be seen in a number of Supreme Court opinions and dissents.[143]

The experiences of pregnant persons clearly indicate that abortion is much more than a private exercise of individual autonomy as envisioned by *Roe*. Rather, in a country where only fourteen percent of civilian workers had access to paid family leave in 2016[144] and funding for safety net programs is perpetually at risk,[145] the ability to access abortion can determine the social, civil, and economic role a person will be able to hold in society. As such, a true right to abortion must be construed as a positive right to access the procedure, as opposed to a negative right against certain levels of state intervention in pregnant person's private rights. Like the approaches suggested by Adams, Lindgren, and Mikesell, a positive right to access abortion would belong to pregnant persons alone and not their health care providers. However, it would also fundamentally reframe the role and interests of the state.

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137. *Id*. at 9, 13.

138. Lindgren, *supra* note 112, at 369.

139. *Induced Abortion*, *supra* note 47.

140. *Id*.

141. *Id*.

142. *See Casey*, 505 U.S. 833, 856 (1992).

143. *See* Reva B. Siegel, *Roe's Roots: The Women's Rights Claims that Engendered Roe*, 90 B.U. L. REV. 1875, 1879–86 (2010); *see also* Gonzales v. Carhart, 550 U.S. 124 (2007) (Ginsburg, J. dissenting); *Casey*, 505 U.S. at 856.

144. Drew Desilver, *Access to paid family leave*, PEW RESEARCH CTR. (March 23, 2017), http://www.pewresearch.org/fact-tank/2017/03/23/access-to-paid-family-leave-varies-widely-across-employers-industries/ (last visited Oct. 1, 2018).

145. *See, e.g. President Trump's 2018 Budget Proposal Reduces Federal Funding for Coverage of Children in Medicaid and CHIP*, KAISER FAM. FOUND. (May 23, 2017), https://www.kff.org/medicaid/fact-sheet/presidents-2018-budget-proposal-reduces-federal-funding-for-coverage-of-children-in-medicaid-and-chip/ (last visited Oct. 1, 2018).

For example, a positive right to abortion would be inconsistent with the Supreme Court's decision in *Harris v. McRae*.[146] In *Harris*, the Court considered whether the Hyde Amendment, which prohibits federal funding of abortion except where a pregnant person's life is at risk or the pregnancy is the result of rape or incest, was constitutional under *Roe*.[147] The Court held that there is a fundamental difference between taking actions to obstruct access to abortion, such as the criminal penalties imposed on doctors challenged in *Roe*, and promoting childbirth by refusing to "subsidize" abortion.[148] The government did not push the women challenging the Hyde Amendment into poverty.[149] Thus, the Court determined that, despite their desperate financial situation, the state did not need to ensure that these women had the same access to medically necessary abortions as they would for their other health care needs.[150]

A positive right to abortion would necessarily eliminate the significance of this distinction and the legitimacy of government restrictions on abortion funding. Just as a positive civil right to education requires the government to create schools and institutions to prevent discrimination within them,[151] a reframed right to abortion would require the state to facilitate access to care regardless of a person's race or class. This could require public financing for the procedure and the development of other institutional supports for abortion, such as training programs for abortion providers, increased access to medication abortion at home, and the prohibition of prosecuting people for terminating their own pregnancies. At the very least, a positive right would require public funding of the procedure where an abortion is medically necessary and a person qualifies for a program like Medicaid or where funds are available for costs related to carrying a pregnancy to term.[152]

Overall, a positive right to abortion avoids the limitations of *Roe* by granting the right directly to pregnant persons and reframing the role of the state, allowing individuals to take full control of their abortion decision and ensuring they have the ability to access the type of abortion care they prefer. However, reframing the right to abortion in this way would not prohibit all state-imposed regulations meant to further pregnant people's health and safety. Like other positive rights, it would simply require courts to analyze these regulations through a different lens

146. 448 U.S. 297 (1980); *See also* Alina Salganicoff, Adara Beamesderfer, Nisha Kurani, and Laurie Sobel, *Coverage for Abortion Services and the ACA*, KAISER FAM. FOUND. (Sept. 19, 2014), https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca/ (explaining the current impact of the Hyde Amendment on insurance in the United States) (last visited Oct. 1, 2018).

147. *Harris*, 448 U.S. at 311.

148. *Id.* at 314–15.

149. *Id.* at 316.

150. *Id.*

151. ROBIN WEST, *Toward a Jurisprudence of the Civil Rights Acts*, *in* A NATION OF WIDENING OPPORTUNITIES? THE CIVIL RIGHTS ACT AT FIFTY 16–18 (Samuel Bagenstos and Ellen Katz, eds., 2014).

152. *See* Women of the State of Minn. v. Gomez, 542 N.W. 2d 17, 31 (Minn. 1995) (holding that because the Minnesota Constitution protects people's *decision* to have an abortion, the state could not choose to fund health care for low income people's pregnancies and not medically necessary abortion).

and to impose a higher standard in judging the legitimacy of state actions. For example, courts could apply strict scrutiny to abortion regulations, requiring abortion-related laws to be the least restrictive means to further a state's compelling interest in facilitating safe and affordable access to abortion.[153] Under this standard, requiring a trip to a pharmacy or a screening conversation with a provider such as that conducted by Women on the Web would likely be permissible because it helps ensure that people like McCormack are able to access the necessary information to safely and effectively terminate their pregnancies. However, this operationalization of the positive right to abortion would not allow states to restrict access to care that the medical community has determined is safe and that could expand access to abortion, such as the medication abortion provisions of Texas HB2. Thus, a positive right provides a more comprehensive solution to problems in the context of medication abortion than merely expanding *Roe's* privacy framework.

IV. CONCLUSION: MEDICATION ABORTION AND REPRODUCTIVE JUSTICE

Reproductive Justice is a theoretical framework based on the idea that people should be able to decide if, when, and how to have children and to raise them.[154] The theory was created by women of color, who felt that reproductive rights, civil rights, and racial justice movements failed to reflect on the intersectional experiences of women of color.[155] Specifically, reproductive justice advocates critiqued the reproductive rights movement for a failure to look beyond the mere right to choose to the issue of accessing these choices.[156] Achieving reproductive justice involves far more than merely securing access to abortion.[157] However, reframing the right to abortion as a positive "right to enter" is more consistent with this intersectional vision of reproductive freedom because it allows a range of choices for reproductive care, empowers people to access the choice they prefer, and ensures that these choices will not result in state-driven consequences.

Medication abortion provides one example of the significant impact of reframing the abortion right. Were the abortion right to include a right to access care, restrictions contradicting standard medical practice and limiting people's choices such as Texas and Idaho's medication abortion laws would no longer be a constitutional exercise of state power.[158] Rather, the state would have to take steps to

153. *See, e.g.* Fisher v. Uni. of Tex. at Austin, 136 S.Ct. 2198, 2202–09 (2016) (noting that alleged violations of equal protection are subject to strict scrutiny).

154. *See* Loretta Ross, *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*, 4–5, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051 (last visited Oct. 1, 2018); *What is Reproductive Justice*, IF, WHEN, HOW (last visited Oct. 1, 2017), https://www.ifwhenhow.org/about/what-is-rj/.

155. *Id.*

156. *Id.*

157. *See generally* Loretta Ross, *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051 (last visited Oct. 1, 2018).

158. *See supra* § I for discussion of these regulations.

facilitate pregnant people's access to abortion through funding and institutional support. As a result, McCormack might have been able to get access to a clinic where she would have had support in deciding to have an abortion and information on how to obtain care. Had she still decided to self-manage her abortion, she would have been provided with the information and support to do so earlier on in her pregnancy when the risks of medication abortion are lower and the process more likely to be safe and effective.

Maintaining the abortion right as a part of the right to privacy allows states to over-regulate abortion care, foster abortion stigma, and ignore the other social and economic issues connected to the exercise of this constitutional right. Ultimately, the current legal treatment of medication abortion demonstrates a need to reframe and redefine abortion as a positive right necessary to ensure the full participation of those who can bear children in civil society. Positive rights are necessarily aspirational;[159] it is unlikely that changes in law alone will be sufficient to completely ensure that persons are able to control if, when, and how to have and raise children. However, changing the current construction of a constitutional right to abortion in this manner will contribute to preventing prosecution of pregnant persons, ensuring access to care for all people, and beginning to realize the vision of reproductive justice.

159. Robin West, *Toward a Jurisprudence of the Civil Rights Acts*, *in* A NATION OF WIDENING OPPORTUNITIES? THE CIVIL RIGHTS ACT AT FIFTY 18 (Samuel Bagenstos and Ellen Katz, eds., 2014).