



Abortion and Telemedicine: Looking Beyond COVID-19 and the Shadow Docket

Jareb A. Gleckel[†] & Sheryl L. Wulkan^{**}

This Article examines the Supreme Court’s recent shadow docket opinion in FDA v. American College of Obstetricians and Gynecologists (“ACOG”) — not just its present effects, but its bigger-picture implications for the future of abortion jurisprudence. In FDA v. ACOG, the Court, without full briefing or argument, stayed a Maryland court’s injunction against the Food and Drug Administration (“FDA”). In doing so, it allowed the FDA to continue enforcing its “in-person requirement,” forcing women to travel to pick up abortion medication during the COVID-19 pandemic. Parts I and II of this Article review the Court’s abortion jurisprudence and the opinion in FDA v. ACOG. Part II also suggests that FDA v. ACOG is inconsistent with the Court’s contemporaneous “shadow docket” opinions — summary opinions that enjoined states’ restrictions on church gatherings during the pandemic. Part III then explores the impact that FDA v. ACOG could have on abortion jurisprudence in a post-pandemic world. We first speculate about a post-pandemic United States where the Court continues to recognize abortion as a constitutionally-protected right. We argue that,

[†] Copyright © 2021 Jareb A. Gleckel & Sheryl L. Wulkan.

^{*} Jareb A. Gleckel, J.D., Cornell Law School, Class of 2020.

^{**} Sheryl L. Wulkan, M.D., internal medicine (Board Certified), sports medicine, and health care physician.

while “in-person requirements” impede women seeking abortions, they also, ironically, make it harder for states to pass laws restricting access to abortion under contemporary case law. We then contemplate a parallel post-pandemic universe in which the Court overturns *Roe v. Wade* and stops recognizing the right to abortion. If the Court decides that abortion is not a fundamental right, as pro-choice liberals fear, it will be the in-person mifepristone requirements, or lack thereof, that determine the severity of that decision for many women in the United States. In a world without *Roe*, in-person requirements would maximally restrict women’s access to abortion.

TABLE OF CONTENTS

INTRODUCTION	107
I. THE UNDUE BURDEN TEST	109
II. <i>FDA v. AMERICAN COLLEGE OF OBSTETRICIANS AND</i> <i>GYNECOLOGISTS AND THE SHADOW DOCKET</i>	111
III. THE IMPACT OF <i>FDA v. ACOG BEYOND THE PANDEMIC</i>	116
A. <i>Telabortions and the Undue Burden Test</i>	116
B. <i>Telabortions in a World Without Roe</i>	119
IV. A BRIEF CONCLUSION (WITH APOLOGIES)	120

“For now, I respectfully dissent.”¹

INTRODUCTION

On January 12, 2021, the Supreme Court quietly stayed a Maryland district court’s preliminary injunction.² The injunction would have enabled women who are eligible for medication abortions³ during the COVID-19 pandemic⁴ to receive the two necessary medications without visiting a clinic, hospital, or other healthcare facility.⁵ But in *FDA v. American College of Obstetricians and Gynecologists*,⁶ the Supreme Court intervened without hearing argument or issuing a written opinion.⁷ By issuing a stay, the Court allowed the FDA to continue imposing its “in-person requirement,” forcing women to travel to obtain abortion medication.

Unsurprisingly, this decision spurred criticism — most immediately from Justice Sotomayor, who wrote in dissent with Justice Kagan

¹ *Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 585 (2021) (Sotomayor, J., dissenting).

² *Id.* at 578.

³ Medication abortions are non-surgical procedures. Patients take two medications, mifepristone and misoprostol, to induce early termination of an intrauterine pregnancy. Patients may take these medications at any location of their choosing. *See infra* Part II, note 32 and accompanying text.

⁴ *Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin.*, 472 F. Supp. 3d 183, 232 (D. Md. 2020) (holding that the injunction will last “during the pendency of the public health emergency based on COVID-19 declared by the Secretary of HHS pursuant to the Public Health Service Act”).

⁵ *Id.* (“[T]he preliminary injunction will apply to bar FDA enforcement of the In-Person Requirements against Plaintiffs, their members, and other similarly situated individuals, without geographic limitation.”).

⁶ *See generally Food & Drug Admin.*, 141 S. Ct. at 578.

⁷ *FDA v. ACOG* is part of a “growing category of emergency appeals that are decided without the full-dress treatment of thorough briefing and oral argument.” Stephen Wermiel, *On the Supreme Court’s Shadow Docket, the Steady Volume of Pandemic Cases Continues*, SCOTUSBLOG (Dec. 23, 2020, 3:16 PM), <https://www.scotusblog.com/2020/12/on-the-supreme-courts-shadow-docket-the-steady-volume-of-pandemic-cases-continues/> [<https://perma.cc/7BYG-CZZE>]. In recent years, scholars have called increasing attention to these orders and summary decisions, which they refer to as the “shadow docket.” *See* William Baude, *Foreword: The Supreme Court’s Shadow Docket*, 9 N.Y.U. J.L. & LIBERTY 1, 3-5 (2015); *see also* Stephen I. Vladeck, *The Solicitor General and the Shadow Docket*, 133 HARV. L. REV. 123, 157 (2019) (explaining that the shadow docket “leaves a fog of uncertainty as to exactly what the standards are in different categories of cases — a muddle that is as unhelpful to lower courts as it is to the parties”).

joining.⁸ Since *Roe v. Wade*,⁹ the Supreme Court has recognized that women have a constitutional right to get an abortion. In more recent cases, the Court has determined that the government violates this constitutional right if it places an “undue burden” on women seeking to exercise the right.¹⁰ In *FDA v. ACOG*, Justice Sotomayor wrote that the in-person requirement is unconstitutional because it fails the “undue burden” test.¹¹

Part I of this Article traces the “undue burden” test through the Supreme Court’s recent abortion cases, namely *Planned Parenthood of Southeastern Pennsylvania v. Casey*,¹² *Whole Woman’s Health v. Hellerstedt*,¹³ and *June Medical Services v. Russo*.¹⁴ Part II turns to *FDA v. ACOG*. It discusses the lower court’s decision, the Supreme Court’s shadow docket reversal, and Justice Sotomayor’s dissent. Part II also provides a new insight into the opinion. Specifically, this Part observes the inconsistency between *FDA v. ACOG* and the Court’s contemporaneous shadow docket opinions — opinions enjoining state limitations on the number of people who can attend houses of worship during the pandemic.

Part III delves into new territory. It argues that, while *FDA v. ACOG* has (properly) garnered attention for its immediate impact on women during the pandemic, interested parties should also pay attention to what the case signifies for abortion jurisprudence beyond the pandemic. Subpart A examines what impact *FDA v. ACOG*, and specifically the in-person requirement, would have on a post-pandemic world where the undue burden test remains the law. It suggests that, while retaining in-person requirements would predictably decrease access to abortions, eliminating these requirements and allowing telabortions¹⁵ could,

⁸ See *Food & Drug Admin.*, 141 S. Ct. at 579 (Sotomayor, J. dissenting). When the Supreme Court decides cases on the shadow docket, the justices may nonetheless write separately, which has led to a “substantial body of work that has taken place on the shadow docket.” Wermiel, *supra* note 7 (“In three of the seven cases decided in November and December, the justices produced 51 pages of opinions. Add that number to the 45 pages produced in COVID-related prison and religion cases from May through October, and the total is just short of 100 pages . . .”).

⁹ 410 U.S. 113 (1973).

¹⁰ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992).

¹¹ *Food & Drug Admin.*, 141 S. Ct. at 579 (Sotomayor, J. dissenting).

¹² 505 U.S. 833 (1992).

¹³ 136 S. Ct. 2292 (2016).

¹⁴ 140 S. Ct. 2103 (2020).

¹⁵ We define “telabortion” to refer to abortions that are provided entirely by telemedicine: in other words, abortions that do not require a woman to ever leave her home. According to the main provider’s website, “TelAbortion involves all the same steps and procedures as an in-person medical abortion, but you do not have to travel to

ironically, make it easier for states to pass laws restricting abortion access for women. Subpart B explores what impact *FDA v. ACOG* would have in a parallel post-pandemic universe where the Court overturns *Roe v. Wade*. It argues that *FDA v. ACOG* is such an important opinion because, if the conservative supermajority on the Roberts Court does overturn *Roe*, then in-person requirements will maximally prevent women from accessing abortions.

I. THE UNDUE BURDEN TEST

In reaching its decision in *FDA v. ACOG*, the Maryland court waded its way through the mess of recent abortion cases to interpret the “undue burden” standard.¹⁶ The Supreme Court introduced the “undue burden” test in 1996, when a plurality in *Casey* wrote that a law is unconstitutional if it places an undue burden on a woman’s right to an abortion.¹⁷ The plurality explained, “[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”¹⁸

In 2016, in *Whole Woman’s Health v. Hellerstedt*,¹⁹ the Court employed this standard to strike down a Texas law. The law required abortion providers to have hospital admitting privileges within thirty miles of where they perform abortions and required abortion clinics to meet the standards for ambulatory surgical centers.²⁰ Applying the undue burden test to this law, the *Whole Woman’s Health* Court examined “the burdens [the] law impose[d] on abortion access together with the benefits th[e] law[] confer[red]” and concluded that the burdens outweighed the benefits.²¹

Just four years later, in *June Medical Services*, the Court revisited the “admitting privileges” requirement.²² Louisiana passed a law that was virtually identical to the Texas statute at issue in *Whole Woman’s Health*,

an abortion clinic. Instead, an abortion provider conducts a video evaluation over the internet. Any tests that may be needed are done at medical facilities close to your home. The abortion pills are then sent to you by mail.” *How Does it Work?*, TELABORTION, www.telabortion.org (last visited Feb. 28, 2021) [https://perma.cc/C98W-5WC5].

¹⁶ Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin., 472 F. Supp. 3d 183, 208-10 (D. Md. 2020).

¹⁷ See *Casey*, 505 U.S. at 877.

¹⁸ *Id.*

¹⁹ 136 S. Ct. 2292 (2016).

²⁰ See *id.* at 2310.

²¹ See *id.* at 2298.

²² See *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2112 (2020).

and once again, the Court struck down the requirement as unconstitutional.²³ The separate *June Medical* opinions, however, left confusion about the status of the undue burden test.²⁴ Writing for a four-justice plurality, Justice Breyer applied *Whole Woman's Health* balancing to find the law unconstitutional.²⁵ Chief Justice Roberts, whose separate concurrence provided the fifth vote, wrote that the statute in *June Medical Services* was so similar to that in *Whole Woman's Health* that *stare decisis* compelled the Court to strike down the law — but he rejected the plurality's balancing approach.²⁶ Offering a different interpretation of *Casey's* test, the Chief Justice wrote that, in order for courts to strike down a law as unconstitutional, the law must create a substantial obstacle to a woman's right to seek an abortion.²⁷ According to the Chief, courts merely take the benefits of an abortion regulation into account when determining, as a threshold matter, whether a regulation is rationally related to the government's interest.²⁸ Therefore, in a *Marbury v. Madison*-like fashion,²⁹ the Chief Justice handed a win to pro-choice liberals while creating a path forward for pro-life, conservative states to restrict abortion access.³⁰

²³ See *id.* at 2133 (Roberts, C.J., concurring).

²⁴ See *id.* at 2152 (Thomas, J., dissenting) (“[T]he fact that no five Justices can agree on the proper interpretation of our precedents today evinces that our abortion jurisprudence remains in a state of utter entropy.”).

²⁵ See *id.* at 2112.

²⁶ See *id.* at 2139 (Roberts, C.J., concurring).

²⁷ See *id.* at 2136 (Roberts, C.J., concurring) (“*Casey* instead focuses on the existence of a substantial obstacle, the sort of inquiry familiar to judges across a variety of contexts.”).

²⁸ See *id.* at 2135 (Roberts, C.J., concurring) (“Laws that do not pose a substantial obstacle to abortion access are permissible, so long as they are ‘reasonably related’ to a legitimate state interest.”).

²⁹ In *Marbury v. Madison*, 5 U.S. 137 (1803), Chief Justice John Marshall, a Federalist, famously ruled in favor of Thomas Jefferson to appease the Republican executive branch. However, he used the opinion to achieve his own goal of establishing the central role of courts in interpreting the Constitution. See *id.* at 180.

³⁰ One of us has written elsewhere critiquing Chief Justice Roberts' approach to the undue burden test — specifically the problems that will arise if courts do not examine benefits of abortion regulations as part of the analysis. The *Verdict* column suggests that focusing on the size of an obstacle encourages pro-life states to pass numerous laws that place small obstacles in the path of women seeking abortions. The additive effect of such laws will be the same as a single law that creates a substantial obstacle. The column considers, for example, a law that requires women to recite their ABCs before getting an abortion — a law that clearly does not create a *substantial* obstacle, as the Chief would construe the word “substantial,” but that common sense dictates must be unconstitutional. To the extent that rational-basis review would filter out the most absurd of such laws, pro-life states merely have to find a happy medium.

II. *FDA v. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE SHADOW DOCKET*

In *FDA v. ACOG*, physicians challenged the FDA's enforcement of two regulations pertaining to the abortion drug mifepristone.³¹ Mifepristone is a medication that patients take in combination with a second drug, misoprostol, to terminate an intrauterine pregnancy.³² To assess whether patients qualify for this non-surgical procedure, healthcare providers ensure, in most pertinent part, that the patient has been pregnant for less than ten weeks and does not have an ectopic pregnancy.³³ The provider can conduct the assessment either in person or virtually,³⁴ and patients can take these drugs at any location of their choosing.³⁵

Unlike misoprostol,³⁶ mifepristone is subject to Elements to Assure Safe Use ("ETASU") requirements.³⁷ Of relevance here, one requirement specifies "that the drug be dispensed to patients only in

On a 0–100 scale, a statute with benefits in the 0–5 range would be unconstitutional under the threshold rational basis test. A statute with burdens > 50 (or perhaps even higher) would be unconstitutional under the substantial obstacle test. But statutes with a benefit in the 5–10, and a burden in the 40–50 range will slip through. Over time, under the Chief's approach, such statutes will create far more burdens than benefits and achieve what the Court would not allow a single statute to accomplish.

Jareb Gleckel, *What Chief Justice Roberts's June Medical Concurrence Tells Us About the Future of Abortion*, VERDICT (Jun. 30, 2020), <https://verdict.justia.com/2020/06/30/what-chief-justice-robertss-june-medical-concurrence-tells-us-about-the-future-of-abortion> [https://perma.cc/N22H-AREP].

³¹ See *Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin.*, 472 F. Supp. 3d 183, 189 (D. Md. 2020).

³² *Id.* at 189-90 (describing the "Mifepristone-Misoprostol Regimen").

³³ *Id.* at 192. An ectopic pregnancy is a disqualifying condition characterized by the fertilized egg growing outside the uterus. *Id.*

³⁴ *Id.* ("In recent times, the assessment has also occurred entirely through remote technologies such as a video connection over the internet, referred to as telemedicine, through which the healthcare provider makes the necessary determinations based on the patient's reported medical history, last menstrual period, results of over-the-counter pregnancy tests, and symptoms.")

³⁵ *Id.*

³⁶ Patients take misoprostol twenty-four through forty-eight hours after taking mifepristone; they can obtain the misoprostol from a retail or mail-order pharmacy, in addition to a healthcare facility. *Id.*

³⁷ *Id.* at 190 ("An ETASU can be imposed on a drug that has been 'shown to be effective' but is 'associated with a serious adverse drug experience' such that it can be approved only on the condition that the designated elements are satisfied.") (citing 21 U.S.C. § 355-1(f)(3) (2018)).

certain health care settings,”³⁸ and a second stipulates that the drug “be dispensed to patients with evidence or other documentation of safe-use conditions.”³⁹ To comply with the second requirement, the certified healthcare provider must give each patient a copy of a Patient Agreement Form — and the form “can be read as requiring that the prescriber and patient be in the same location when this paperwork is completed.”⁴⁰ In short, to acquire mifepristone, a patient must attend a healthcare facility (1) to receive mifepristone and (2) to sign a form.

In light of the ongoing COVID-19 pandemic, physicians sued the FDA, arguing that by enforcing these regulations and requiring women to pick up mifepristone in person, the FDA is unconstitutionally placing an “undue burden” on a woman’s right to an abortion. The Maryland district court agreed.⁴¹ First, in applying the undue burden standard, the court adopted the balancing approach rather than the Chief’s approach in his *June Medical Services* concurrence.⁴² Citing *Marks v. United States*,⁴³ the court recognized that “[w]here the Chief Justice’s concurrence in the judgment was necessary to reach a majority, the holding of *June Medical Services* is fairly limited to the reasoning that represents a ‘common denominator’ that he shared with the plurality.”⁴⁴ However, the court found that the Chief’s reasoning was neither “predicated . . . on an overruling of *Whole Woman’s Health*” nor shared by the plurality.⁴⁵ Therefore, the district court concluded that the Supreme Court had decided *June Medical Services* “without the need to apply or reaffirm the balancing test of *Whole Woman’s Health*,” and that the test from *Whole Woman’s Health* remains binding.⁴⁶

After deciding that its role was to balance benefits and burdens, the Maryland court recognized the severe burdens that in-person requirements place on women seeking abortions:

the difficulty of traveling to medical offices . . . , the challenges caused by medical office closures and limited capacity, the heightened health risk that many abortion patients face due to

³⁸ 21 U.S.C. § 355–1(f)(3)(C).

³⁹ 21 U.S.C. § 355–1(f)(3)(D).

⁴⁰ *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 191-92.

⁴¹ *Id.* at 224.

⁴² *Id.* at 209 (“Where *Whole Woman’s Health* remains the most recent majority opinion delineating the full parameters of the undue burden test, the Court finds that its balancing test remains binding on this Court.”).

⁴³ 430 U.S. 188 (1977).

⁴⁴ *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 209.

⁴⁵ *Id.*

⁴⁶ *Id.*

demographic characteristics, the particularized risk and challenges associated with transportation to get to such offices, the greater difficulty of securing childcare under present conditions, and the impact of the economic downturn on the ability of patients to secure transportation and childcare.⁴⁷

Regarding benefits, the district court concluded that the in-person requirements were “unnecessary health regulations” that “do not advance general interests of patient safety.”⁴⁸ Relying on medical experts, it explained that telemedicine allows doctors to provide all necessary information to patients. Moreover, the location where the patient picks up the medicine is not relevant to monitoring the patient for complications since the regulations do not require in-person administration of mifepristone.⁴⁹ Overall then, the Maryland court found that the FDA was creating a “substantial obstacle” for “a large fraction of the women for whom it is relevant.”⁵⁰

Because of the nature of shadow docket rulings, there is no way to know with certainty why five of the justices vacated the Maryland court’s stay (or why Justice Breyer dissented).⁵¹ We do, however, know the basis of the Chief Justice’s concurrence and why Justice Sotomayor, joined by Justice Kagan, dissented. First, concurring with the stay, Chief Justice Roberts wrote that he did not believe the case called for reaching the undue burden analysis.⁵² Rather, he cited his opinion in *South Bay United Pentecostal Church v. Newsom* (*South Bay I*) and relied on the proposition that courts should defer to politically accountable branches in matters of public health.⁵³

⁴⁷ *Id.* at 216.

⁴⁸ *Id.* at 217.

⁴⁹ *See id.*

⁵⁰ *Id.* at 224; *see also id.* at 211 (finding that the law creates a substantial obstacle for the relevant population, which is women “who do not, based on their healthcare provider’s medical judgment, actually require an in-person visit with their healthcare provider in order to be properly assessed and counseled”).

⁵¹ *See supra* note 7.

⁵² *Food & Drug Admin v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 578-79 (2021) (Roberts, C.J., concurring) (“The question before us is not whether the requirements for dispensing mifepristone impose an undue burden on a woman’s right to an abortion as a general matter. 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.”)

⁵³ *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613 (2020) (Roberts, C.J., concurring). Arguably, while Chief Justice Roberts favors such deference in principle, his rulings are inconsistent. *Compare Am. Coll. of Obstetricians &*

Justice Sotomayor would have found that the FDA is placing an undue burden on women.⁵⁴ In a powerful opinion, she argued that it does not make sense to unnecessarily put women — and everyone with whom they live or come in contact, including grandparents — at risk of exposure to COVID-19. She emphasized the absurdity of requiring women to travel to a doctor’s office during a pandemic to pick up medication “only to turn around, go home, and ingest it without supervision.”⁵⁵ She underscored the disproportionate impact of in-person requirements on women with low incomes and women of color — both because women of color comprise more than half of women who have abortions, and because COVID-19 has killed three times more Black and Hispanic individuals than non-Hispanic White individuals.⁵⁶ And she responded to Chief Justice Roberts’ call for deference, arguing that, although courts must show deference to policymakers’ reasoned decision-making, the record is “bereft of any reasoning.”⁵⁷

One thing, however, that Justice Sotomayor did not address in her dissent — at least not explicitly — is that *FDA v. ACOG* is inconsistent with the Supreme Court’s contemporaneous shadow docket cases addressing the pandemic. In a slew of recent cases, including, most famously, *Roman Catholic Diocese of Brooklyn v. Cuomo*, the Court has enjoined state regulations that limited people’s access to worship services during the pandemic.⁵⁸ In doing so, the justices who voted to enjoin these regulations have insisted that the regulations discriminate on the basis of religion.⁵⁹ For example, in *Roman Catholic Diocese of Brooklyn*, Justice Kavanaugh noted that in the strictest regulatory zones, “a church or synagogue must adhere to a 10-person attendance cap, while a grocery store, pet store, or big-box store down the street does not face the same restriction.”⁶⁰ It is doubtful that such regulations do, in fact, discriminate against religion — for all practical purposes, the

Gynecologists, 141 S. Ct. at 578 (Roberts, C.J., concurring) (deferring to the FDA’s enforcement of in-person abortion requirements), with *S. Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716, 717 (2021) (Roberts, C.J., concurring) (rejecting the state’s determination that it is unsafe for people to attend church to worship).

⁵⁴ *Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. at 579 (Sotomayor, J., dissenting).

⁵⁵ *Id.*

⁵⁶ *Id.* at 582.

⁵⁷ *Id.* at 584.

⁵⁸ See *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 63 (2020).

⁵⁹ See *id.* at 73 (Kavanaugh, J., concurring).

⁶⁰ *Id.*

Court seems to be striking down neutral and generally applicable laws.⁶¹ But the legal premise that states cannot discriminate against religion is sound.⁶²

With this premise in mind, we return to *FDA v. ACOG*. Access to abortion remains a constitutionally protected interest.⁶³ Nevertheless, women have to risk exposure to COVID-19 to get abortion medication — and at the same time, “[g]overnment policy now permits patients to receive prescriptions for powerful opioids without leaving home.”⁶⁴ It should not be more difficult for patients to access mifepristone than to access other drugs — especially highly addictive drugs — that are not tied to constitutionally protected interests. If making it easier for people to access grocery stores than churches discriminates against one constitutionally protected interest, religion, then making it easier for people to access opioids than mifepristone certainly discriminates against another constitutionally protected interest, abortion.⁶⁵

⁶¹ The premise that the regulations are not neutral and generally applicable is largely inauthentic. See *id.* at 79 (Sotomayor, J., dissenting) (“New York applies ‘[s]imilar or more severe restrictions . . . to comparable secular gatherings, including lectures, concerts, movie showings, spectator sports, and theatrical performances, where large groups of people gather in close proximity for extended periods of time.’ Likewise, New York ‘treats more leniently only dissimilar activities, such as operating grocery stores, banks, and laundromats, in which people neither congregate in large groups nor remain in close proximity for extended periods.’”); see also Michael C. Dorf, *The Upside-Down Treatment of Religious Exceptions Cases in the Supreme Court*, VERDICT (Feb. 17, 2021), <https://verdict.justia.com/2021/02/17/the-upside-down-treatment-of-religious-exceptions-cases-in-the-supreme-court> [<https://perma.cc/MH82-6US7>] (“The Court might or might not formally overrule [*Employment Division v. Smith* in *Fulton v. City of Philadelphia*] or some future case, but it has informally abandoned *Smith* already.”); Leah Litman, *Covid at the Court: South Bay United Pentecostal*, TAKE CARE (Feb. 6, 2021), <https://takecareblog.com/blog/covid-at-the-court-south-bay-united-pentecostal> [<https://perma.cc/H9WB-W6ES>] (explaining that “the new supermajority conservative Court is already changing the law on religious liberty” by “provid[ing] religious institutions with an exemption from some facially neutral generally applicable regulations — those that courts deem too burdensome”).

⁶² See, e.g., *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 532 (1993) (“At a minimum, the protections of the Free Exercise Clause pertain if the law at issue discriminates against some or all religious beliefs or regulates or prohibits conduct because it is undertaken for religious reasons.”).

⁶³ See *Roe v. Wade*, 410 U.S. 113, 166 (1973).

⁶⁴ *Food & Drug Admin v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 579 (2021) (Sotomayor, J., dissenting).

⁶⁵ See *id.* at 585 (“[M]aintaining the FDA’s in-person requirements for mifepristone during the pandemic . . . treats abortion exceptionally.”).

III. THE IMPACT OF *FDA v. ACOG* BEYOND THE PANDEMIC

In Part III, we examine the implications that the Court's opinion in *FDA v. ACOG* will have beyond the pandemic. We begin with the following observation: by allowing the FDA to enforce in-person requirements for mifepristone during the pandemic, the Court heavily-handedly insinuates that these same requirements would be acceptable in a non-pandemic world. Consider a child, who is grounded, and asks her parents if she can run down the block to see her grandmother. Her parents tell her, "You can go see your grandma, but you're still grounded, so come right home after." If the girl can go to see her grandma despite being grounded, it just about goes without saying that the girl can see her grandma under normal circumstances when she is not grounded. Like the girl in the example, the FDA should feel safe to assume that its actions are acceptable under normal circumstances.

It is not clear to us that the in-person mifepristone requirement should be constitutional — irrespective of an ongoing pandemic. Delving into that analysis is beyond the scope of this Article, but we highlight a sentence from Justice Sotomayor's dissent that explained, "[o]f the over 20,000 FDA-approved drugs, mifepristone is the only one that the FDA requires to be picked up in person for patients to take at home."⁶⁶ In-person requirements are (at least arguably) one more instance of how "[t]his country's laws have long singled out abortions for more onerous treatment than other medical procedures that carry similar or greater risks."⁶⁷

But the battle over the in-person requirement, irrespective of the merits, begs the question: what impact would in-person requirements have on women beyond the pandemic? The answer to that question depends starkly on whether the Court continues to apply the "undue burden" test or overturns *Roe v. Wade*.

A. *Telabortions and the Undue Burden Test*

As an initial matter, eliminating in-person requirements for mifepristone would have the direct effect of making it easier for women to access abortions. Eradicating any level of inconvenience increases the likelihood that a person will act⁶⁸ — just ask the microwave dinner

⁶⁶ *Id.* at 579.

⁶⁷ *Id.* at 585 (citing Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 *YALE L.J.* 1428, 1430 (2016)).

⁶⁸ See generally Lynn Silipigni Connaway, Timothy J. Dickey & Marie L. Radford, "If It Is Too Inconvenient I'm not Going After It:" Convenience as a Critical Factor in Information-Seeking Behaviors, 33 *LIBR. & INFO. SCI. RES.* 179 (2011) (describing that

industry. Of course, going to a clinic for abortion medication is far more than just an inconvenience; women may not want to face protesters outside of a clinic, run into acquaintances, explain to a boss why they need time off from work, or explain to a family member where they are.⁶⁹ By eliminating these hindrances, telabortions provide major benefits to women. And, as discussed above, there is no evidence (or reason to believe) that telabortions would create negative health risks.⁷⁰ Therefore, in some respects, the obvious conclusion is the correct one — telabortions would help women in a post-pandemic world just as they would during the pandemic.

Ironically, however, under the current undue burden analysis, telabortions could also make it easier for states to limit abortion access. To understand why, we return to *Whole Woman's Health* and *June Medical Services*, which we discussed at length in Part I. Recall that, in both of those cases, the Court struck down laws requiring abortion providers to have hospital admitting privileges within thirty miles of their clinics.⁷¹ In *Whole Woman's Health*, the Court held that the burdens of the regulation outweighed the benefits,⁷² and in *June Medical Services*, the plurality found the same.⁷³ Chief Justice Roberts, concurring in *June Medical Services*, agreed (at least as a matter of precedent) that the admitting-privileges requirement created a substantial obstacle for women seeking abortions.⁷⁴

“convenience is a factor for making choices in a variety of situations, including both academic information seeking and everyday-life information seeking”); Erin Schumaker, *The Psychology Behind Why People Don't Recycle*, HUFFPOST (Aug. 3, 2016, 8:14 AM), https://www.huffpost.com/entry/psychology-of-why-people-dont-recycle_n_57697a7be4b087b70be605b3 [<https://perma.cc/3YGN-A943>] (finding that many people do not recycle because it is not convenient or takes up too much time).

⁶⁹ See *Singleton v. Wulff*, 428 U.S. 106, 117 (1976) (discussing that women may wish to protect the privacy of their decision to have an abortion); Maya Oppenheim, *Anti-Abortion Protesters Deter Women from Going 'into Clinics as Well as Entering Services to Find Staff'*, INDEPENDENT (Sept. 30, 2020), <https://www.independent.co.uk/news/uk/home-news/antiabortion-protesters-clinics-40-days-life-b721336.html> [<https://perma.cc/76A9-KQXR>].

⁷⁰ See *supra* text accompanying note 48.

⁷¹ See *supra* Part I.

⁷² See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2298-99 (2016).

⁷³ See *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2112-13 (2020).

⁷⁴ *Id.* at 2138 (Roberts, C.J., concurring) (“*Whole Woman's Health* held that Texas’s admitting privileges requirement placed ‘a substantial obstacle in the path of women seeking a previability abortion,’ . . . Because Louisiana’s admitting privileges requirement would restrict women’s access to abortion to the same degree as Texas’s law, it also cannot stand under our precedent.”).

We now take a closer look at why, on the facts, the admitting-privileges requirement in both cases created an undue burden. In *Whole Woman's Health*, the admitting-privileges requirement caused approximately half of all facilities providing abortions to close; after the requirement went into effect, the number of clinics in Texas dropped from about forty to about twenty.⁷⁵ But it wasn't just the closures in and of themselves that created a substantial obstacle. As the Court noted, "[t]hose closures meant fewer doctors, longer waiting times, and increased crowding."⁷⁶ It also meant that women of reproductive age were significantly farther from providers. After the closures, 400,000 women lived 150 miles or more from a provider, and 290,000 lived more than 200 miles (as compared to 86,000 and 10,000 prior).⁷⁷

In *June Medical Services*, the Louisiana law at issue would have reduced women's access to abortion "to the same degree or worse."⁷⁸ In his concurrence, the Chief Justice noted the particular burden that clinic closures would have had on women in northern Louisiana, who would have needed to travel 320 miles to New Orleans for an abortion rather than having local access to care.⁷⁹ In short, when states impose abortion restrictions, the restrictions create substantial obstacles if they close down clinics, causing women to have to travel farther and wait longer.

Now imagine a world with telabortions. Also recall that Chief Justice Roberts only concurred in *June Medical Services* because of the *Whole Woman's Health* precedent, and that since deciding *June Medical Services*, the Court has gained one more conservative, pro-life justice and lost one liberal justice. It is not difficult to imagine the Court ruling that, even if a state law shuts down almost every non-surgical abortion clinic in a state, the law does not create an undue burden because women will still have access to telabortions. Being 320 miles from a clinic does not matter if women do not have to drive.

With this in mind, we conclude this Part with a warning about the following possible scenario: (1) under a liberal, pro-choice administration, the FDA waives the in-person requirements for mifepristone;⁸⁰ (2) states pass abortion laws that cause clinics to shut

⁷⁵ See *Whole Woman's Health*, 136 S. Ct. at 2312.

⁷⁶ *Id.* at 2313.

⁷⁷ *Id.*

⁷⁸ *June Med. Servs.*, 140 S. Ct. at 2140 (Roberts, C.J., concurring).

⁷⁹ *Id.*

⁸⁰ Since we wrote this Article, the FDA under the Biden Administration has, in fact, declared its intent to exercise enforcement discretion with respect to the in-person mifepristone requirements for the remainder of the COVID-19 public health emergency.

down, and the Court upholds these laws because women have access to care through telabortions; (3) under a conservative administration, the FDA reinstates the in-person requirements for mifepristone; (4) the Supreme Court upholds the FDA's policy change. Women would then be unable to access either telabortion or in-person care at clinics. The warning, in summary, is that while telabortion appears to be a fantastic option for patients, pro-choice advocates should pay attention to the possible negative externalities.

B. *Telabortions in a World Without Roe*

Roe v. Wade determined that women have a constitutionally protected right to abortion.⁸¹ Overturning *Roe* would mean that the right is no longer deemed fundamental and that states can pass laws making abortions illegal. In such a world, it is likely that blue states would continue to allow women abortion access, while many red states would not.⁸² In short, women in conservative states in the South and Midwest would likely have difficulty accessing abortions.

Enter telemedicine. If a woman does not have to attend a clinic to pick up abortion medication, but instead can have a telemedicine appointment and order the pill by mail, then telabortion would mitigate the impact of states banning abortions. How would this work? The practical and legal answers here differ. As a legal matter, a patient still would not be able to obtain abortion medication without traveling to a different state. If, for example, Arkansas made abortions illegal but New York did not, a doctor from New York would not be able to mail abortion medication to a patient in Arkansas. Rather, the patient would have to travel to attend the telemedicine appointment from a state where abortion is legal, the doctor would need to hold a license in that state or a license to practice across state lines, and the doctor would have to mail the pills to an address in the state where abortion is legal.⁸³

See Pam Belluck, *F.D.A. Will Allow Abortion Pills by Mail During the Pandemic*, N.Y. TIMES (Apr. 13, 2021) <https://www.nytimes.com/2021/04/13/health/covid-abortion-pills-mailed.html> [<https://perma.cc/CFW3-H2K6>].

⁸¹ See *Roe v. Wade*, 410 U.S. 113, 166 (1973).

⁸² See Amy Morona, *What are Trigger Laws? Examining States' Preemptive Legislative Bans on Abortion*, PBS (Mar. 26, 2019), <https://www.pbs.org/weta/washingtonweek/blog-post/what-are-trigger-laws-examining-states-preemptive-legislative-bans-abortion> [<https://perma.cc/CY9M-H2FP>] (discussing state laws expressing a legislative intent to ban abortion as soon as the Court deems it constitutionally permissible).

⁸³ See 21 U.S.C. §§ 802(21), 823(f) (2018) (permitting the Drug Enforcement Administration to register a practitioner to dispense controlled substances only if that practitioner's jurisdiction permits the same); see also *Do I Qualify?*, TELABORTION, <https://telabortion.org/do-i-qualify> (last visited Nov. 16, 2020) [<https://perma.cc/B8YX->

For practical purposes, however, it is not clear how (or why) an abortion clinic would ensure that patients attend their telemedicine appointments from the state in which they purport to be.⁸⁴ Then, as long as a patient has friends or family (or someone they could pay) in a state where abortion is legal, the clinic could mail the pills to that address. At that point, the patient could drive to pick up the pills at her convenience, such as over a weekend when she does not have to work. Alternatively, friends or family could drive the pills to a half-way point, deliver them on a visit, or even risk mailing the pills.⁸⁵ Therefore, eliminating in-person requirements for mifepristone would create a practical — if not legal — avenue for women seeking abortions in the event the Court overturns *Roe v. Wade*.

In light of this discussion, the Court's recent opinion in *FDA v. ACOG* has far-reaching implications. If the conservative supermajority on the Roberts Court decides that abortion is not a fundamental right, as many liberals fear, it will be the in-person mifepristone requirements, or lack thereof, that determine the severity of that decision for many women in the United States. Therefore, by validating the FDA's in-person requirements for mifepristone in *FDA v. ACOG*, the Court has taken a quiet but important step towards preventing women from accessing abortions in a United States without *Roe v. Wade*.

IV. A BRIEF CONCLUSION (WITH APOLOGIES)

To the extent this Article is cynical with respect to the future of abortion jurisprudence in the United States, we apologize to readers.

TKME] (informing patients that they must “live in a state where the project operates, or . . . live elsewhere but [be] able to have [a] consult and receive the package in a project state”); *State-Level Telehealth Regulations*, ALEDADE, <https://resources.aledade.com/guides/state-level-telehealth-regulations> (last revised Jan. 12, 2021) [<https://perma.cc/2SD3-SEE5>] (summarizing state telehealth laws).

⁸⁴ Typically, when performing telemedicine, doctors must obtain a patient's address and verify that the address is in the appropriate state. There is generally no way for a physician to know, however, if a patient has provided an accurate address. Telephone Interview with Confidential Source, Telemedicine Provider (Feb. 24, 2021).

⁸⁵ Mailing prescription drugs is illegal, of course, except for authorized dispensers. See 21 U.S.C. § 841(a) (2018) (prohibiting anyone from knowingly or intentionally distributing controlled substances); *id.* § 822(a) (2018) (requiring manufacturers, distributors, and dispensers of controlled substances to register with the Drug Enforcement Administration). But so are “back-alley abortions,” and those are also a lot more dangerous. See *Back-Alley Abortion*, CAMBRIDGE DICTIONARY, <https://dictionary.cambridge.org/us/dictionary/english/back-alley-abortion> (last visited Mar. 1, 2021) [<https://perma.cc/4764-3BKQ>] (defining a back-alley abortion as “an illegal and usually dangerous operation to end a pregnancy done by someone who is not medically trained”).

The goal of the Article is not to perpetuate the worries about abortion that have permeated society since the Trump administration and the shift to a conservative supermajority on the Supreme Court. Instead, we hope this Article helps readers to think about highly polarizing abortion cases in a new light, taking into account all of their different implications. It is important to track the moving pieces as the jurisprudence quietly inches forward — or backwards.