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Abortion Experts

Aziza Ahmed[†]

I. INTRODUCTION

The COVID-19 pandemic, and the overturning of *Roe v. Wade*,¹ has intensified the fight for access to medication abortion.² As state governors put emergency orders into place limiting health care provisions to essential services, some also limited access to abortion, designating it a nonessential service.³ In the face of these challenges, women’s health advocates, in keeping with prior advocacy, have called for greater access to medication abortion.⁴ The increased reliance on telemedicine during the COVID-19 pandemic provides new possibilities for the provision of abortion medication that do not rely on a patient engaging in-person at

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¹ 410 U.S. 113 (1973).

² *Dobbs v. Jackson Women’s Health*, 141 S. Ct. 2619 (2022).

³ See Laurie Sobel et al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, KAISER FAMILY FOUNDATION (Aug. 10, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/> [<https://perma.cc/9GLA-5AMU>].

⁴ The contemporary advocacy around medication abortion is part of a long history of feminist advocacy targeting the FDA. At least since the 1980s, feminists have viewed the FDA guidance and regulation as a central point of advocacy given the agency’s impact on the ability of women to make evidence-based decisions about their bodies or exercise bodily autonomy. In the abortion context and beyond, conservative advocates have also played a role in advocating that the agency place greater restrictions on medication abortion. In the 1990s, perhaps the most well-known feminist campaign targeting the agency, feminist advocates forced the Food and Drug Administration to issue new guidelines encouraging drug manufacturers to include women in clinical trials. Until this point, data that existed on drugs and medical treatments had excluded women due to concerns about fetal harm. Without adequate data, feminists felt that healthcare for women was lacking the appropriate evidence-base. Feminist advocacy forced the FDA and, in turn, researchers to include women in clinical trials. Though still today women are often excluded, the new guidance led to a windfall of data on how drugs interact with women’s bodies. See Aziza Ahmed, *Feminist Activism in the Context of Clinical Trials and Drug Roll-Out*, in *A JURISPRUDENCE OF THE BODY* 205, 209–12 (Chris Dietz et al. eds., 2020); for a detailed history of how the FDA and NIH were transformed by AIDS and women’s rights advocates see also STEVEN EPSTEIN, *INCLUSION: THE POLITICS OF DIFFERENCE IN MEDICAL RESEARCH* (2009).

a clinic for a physician's visit or to pick up medication.⁵ While feminist health advocates and physicians began to advocate for a change in FDA rules that would allow for the provision of medication abortion via telemedicine, conservatives demanded the opposite: that the FDA enforce existing and unnecessary regulations on medication abortion and pass laws to ban medication abortion via telemedicine.⁶

In tracking these recent fights, and in conversation with a growing literature on law and expertise,⁷ I argue that conservative and progressive advocacy over medication abortion are windows into how courts legitimize and delegitimize different types of expertise in the service of political goals. Courts deploy arguments about expertise to lay the groundwork for a separation of powers analysis and institutional arguments about when they should act vis-à-vis as administrative agencies. By relying on a tried and true mode of institutional reasoning, these arguments help the court retain the perception of neutrality.⁸ Yet, even as courts purport to act in a neutral manner, their decisions have the capacity to legitimate the claims of some experts over others and impact the ability of people to access abortions. I argue in this essay that, in the aggregate, like the law, these expert claims form the background norms and assumptions that shape how we believe abortion should be regulated. It is important to acknowledge the politics of expertise, how it is deployed for the sake of institutional preservation, and the way expertise and law are co-constitutive. Seeing expertise as situated and operationalized for political and distributional gains could allow reproductive rights advocates the ability to open up new doors for political

⁵ For developments on abortion and telemedicine, see Rachel Rebouché, *Assuring Access to Abortion*, in *ASSESSING LEGAL RESPONSES TO COVID-19* (Scott Burris et al. eds., 2020). There have been numerous studies on the safety and efficacy of medication abortion. See, e.g., Ushma D. Upadhyay et al., *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, JAMA NETWORK OPEN (Aug. 24, 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451> [<https://perma.cc/V6YH-JLCQ>]; Daniel Grossman et al., *Medication Abortion With Pharmacist Dispensing of Mifepristone*, OBSTET GYNECOL (Apr. 2021), <https://pubmed.ncbi.nlm.nih.gov/33706339/> [<https://perma.cc/4YEW-GFEV>].

⁶ Amrutha Ramaswamy et al., *Medication Abortion and Telemedicine: Innovations and Barriers During the COVID-19 Emergency*, KAISER FAM. FOUND. (June 16, 2021), <https://www.kff.org/policy-watch/medication-abortion-telemedicine-innovations-and-barriers-during-the-covid-19-emergency/> [<https://perma.cc/XQ6T-MPKR>]. On telemedicine and medication abortion, see Rebouché, *supra* note 5.

⁷ See DAVID KENNEDY, *A WORLD OF STRUGGLE: HOW POWER, LAW, AND EXPERTISE SHAPE GLOBAL POLITICAL ECONOMY* (2016); Sheila Jasanoff, *(No?) Accounting for Expertise*, 30 *SCIENCE AND PUBLIC POLICY* 157 (2003); SHEILA JASANOFF, *SCIENCE AT THE BAR: LAW, SCIENCE, AND TECHNOLOGY IN AMERICA* (1997); Benjamin Levin, *Criminal Justice Expertise*, 90 *FORDHAM L. REV.* 2777 (2022).

⁸ This essay draws inspiration from the critical take on separation-of-powers provided by Karl Klare. See Karl Klare, *Critical Perspectives on Social and Economic Rights, Democracy, and Separation of Powers*, in *SOCIAL AND ECONOMIC RIGHTS IN THEORY AND PRACTICE: CRITICAL INQUIRIES* (Helena Alviar et al. eds., 2015).

advocacy and help advocates remain agile to the use and deployment of legal arguments rooted in expertise.

This paper proceeds as follows. First it will set the stage for our cotemporary moment by telling the political history of medication abortion. Then the paper will turn to contemporary debates on medication abortion as they have played out in the courts in the context of COVID-19 with a focus on how expertise has been mobilized to advocate for and against access to mifepristone. Finally the paper will offer a new way to begin to think about the co-constitutive relationship between law and expertise in the medication abortion context. Understanding the interaction of law and expertise in the context of abortion is important for understanding how the court deploys expert ideas to arrive at holdings that have specific political and material distributional consequences.

A. Medication Abortion Comes to America

The history of medication abortion teaches us how politics have been infused into the regulation of medication abortion. Documentation of the approval process and the political furor surrounding it suggests that the Food and Drug Administration (FDA) approval of mifepristone, a medical abortion drug, was a case of abortion exceptionalism—treating a medical service associated with abortion as in need of unique regulation.⁹ Both the approval process and the outcome cemented tension between feminist advocates, who sought to expand access to medication abortion, and the anti-abortion movement, which attempted to increase its visibility and mobilize its influence to alter the regulatory environment to prevent access to abortion medication. Feminist health advocates argued that, in doing the cost-benefit analysis, the FDA erred on the side of considering costs at the expense of benefits.¹⁰ To be sure, there were very few adverse impacts to the use of mifepristone. In fact, by the time the drug was approved for use in the United States, it was being widely dispensed in Europe.¹¹

The story of medication abortion begins in the early 1980s when the French drug company Roussel Uclaf developed the drug RU-486 or Mifepristone.¹² Mifepristone was being widely used in France as an

⁹ Jaelyn J. Serpico, *Abortion Exceptionalism and the Mifepristone REMS*, 104 *CONTRACEPTION* 8, 8–9 (2021) (discussing abortion exceptionalism in the FDA approval process); see also DAVID S. COHEN & CAROLE JOFFE, *OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA* (2021) (discussing law and abortion exceptionalism).

¹⁰ Julie Dohm & Migham Ji, *An Introduction to Risk Evaluation and Mitigation Strategies*, 104 *CONTRACEPTION* 4 (2021).

¹¹ Rachel K. Jones & Stanley K. Henshaw, *Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden*, 34 *PERSPECTIVES ON SEXUAL REPRODUCTIVE HEALTH* 154 (2002).

¹² See MELISSA HAUSSMAN, *REPRODUCTIVE RIGHTS AND THE STATE: GETTING THE BIRTH*

abortifacient and often replaced the need for a surgical abortion.¹³ By the mid-1980s, Roussel Uclaf saw an opportunity for new profits: replacing the millions of surgical abortions performed each year with medication abortion. Roussel Uclaf set its sights on the United States to execute this strategy. Unlike in France, where the drug used to address what was perceived as a medical issue, in the United States it was moralized as a question of life and death.¹⁴ As documented by R. Alto Charo in a detailed case study on the drug, conservatives in the United States resisted the importation of RU-486.¹⁵ The approval process for the drug immediately became part of the abortion debates, with evangelical and Republican congressmen arguing that the drug should be denied approval by the FDA because it is an abortifacient.

The FDA, the agency that would approve mifepristone's use for abortion in the United States, and Roussel-Uclaf both became the focal points in the conservative push to have mifepristone banned for importation. A boycott targeting Roussel-Uclaf led its parent company Hoechst Celanese to give the patent to the Population Council, a non-governmental research organization, in 1994.¹⁶

The Population Council went to the FDA for approval in 1996.¹⁷ Against evidence that mifepristone was safe, the FDA only approved the drug under Subpart H, a set of restrictions designed for use with serious or life-threatening illnesses.¹⁸ Pregnancy, however, is not a serious or life-threatening illness. Over the protests of feminist health advocates, the FDA concluded that termination of unwanted pregnancy is

CONTROL, RU-486, AND MORNING-AFTER PILLS AND THE GARDASIL VACCINE TO THE U.S. MARKET 100–114 (2013) (outlining the history of medication abortion); *see also* R. Alto Charo, *A Political History of RU-486*, in *BIOMEDICAL POLITICS* 43 (Kathi E. Hanna ed., 1991).

¹³ For a detailed overview of the political and legal process for approval of mifepristone, *see* Charo, *supra* note 12; *see also* Eli Y. Adashi et al., *The Next Two Decades of Mifepristone at FDA: History as Destiny*, 109 *CONTRACEPTION* 1 (2022). For a consideration of burdens and benefits of mifepristone regulation, *see* Greer Donley, *Early Abortion Exceptionalism*, 107 *CORNELL L. REV.* 627 (2022). On the public health turn in abortion litigation, *see* Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 *WASH. & LEE L. REV.* 1355 (2021).

¹⁴ *Id.* (documenting how medical abortion was moralized in the United States in detail).

¹⁵ Charo, *supra* note 12 at 75–82.

¹⁶ *See* Alexander Dorozynski, *Boycott Threat Forces French Company to Abandon RU486*, 314 *BMJ* 1150 (Apr. 19, 1997), <https://pubmed.ncbi.nlm.nih.gov/9146386/> [<https://perma.cc/FV4X-GRNR>]; *see also* Marlene Cmons, *Boycott Called for Products from Firms Tied to RU 486*, *LA TIMES* (June 2, 1994), <https://www.latimes.com/archives/la-xpm-1994-06-02-mn-65104-story.html> [<https://perma.cc/B8GD-2DMD>].

¹⁷ As described in the GAO report on Mifepristone, the Population Council transferred ownership of the Mifepristone NDA to Danco. *See* U.S. GOV'T ACCOUNTABILITY OFF., *GAO-08-751, FOOD AND DRUG ADMINISTRATION: APPROVAL AND OVERSIGHT OF THE DRUG MIFEPREX 1*, 4 n.12 (2008).

¹⁸ FDA Approval to Market a New Drug, 21 C.F.R. § 314 (2022); *see also* Serpico, *supra* note 9.

a “serious condition” and therefore the extra regulations were necessary.¹⁹ The Population Council acceded to the FDA’s restrictions. The drug was finally approved in 2000 under Subpart H regulations.²⁰

The path of excess regulation of mifepristone continued when, in 2007, amendments to the Food and Drug Cosmetic Act formally established the Risk Evaluation and Mitigation Strategies (REMS) system.²¹ With the creation of the REMS system, all drugs approved under Subpart H were now subject to the newest regulations. The REMS allows for additional FDA restrictions beyond those set forth on the drug’s label. In designating whether a REMS is necessary the FDA looks at (1) the size of the target population, (2) seriousness of the condition, (3) expected benefits, (4) duration of treatment, (5) seriousness and incidence of known or potential adverse events, and (6) whether the drug is a new molecular entity.²² The drugs are evaluated on a case-by-case basis. The FDA might also consider the burden on (1) the health care delivery system and on (2) patient access.²³

The REMS are enforced by the FDA.²⁴ In 2011, the FDA added mifepristone into an additional set of regulations called Elements to Assure Safe Use (ETASU).²⁵ The additional ETASU regulations are imposed on a drug that has “shown to be effective” but is “associated with a serious adverse drug experience.”²⁶ The ETASU regulations require health care providers who dispense mifepristone must certify in a written form that they are able to date pregnancies and identify ectopic pregnancies among other skills,²⁷ that mifepristone must be dispensed in health care settings, and that the drug should be dispensed with evidence of other

¹⁹ U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 17, at 6.

²⁰ Heather D. Boonstra, *Mifepristone in the United States: Status and Future*, 5 GUTTMACHER POLY REV. 1, 4 (2002), <https://www.guttmacher.org/gpr/2002/08/mifepristone-united-states-status-and-future> [<https://perma.cc/996B-946T>]; *The History of Mifepristone*, REPRODUCTIVE HEALTH ACCESS PROJECT (Sept. 30, 2020), <https://www.reproductiveaccess.org/2020/09/history-of-mifepristone/> [<https://perma.cc/2SKL-76R5>]; Letter from FDA Ctr. for Drug Evaluation and Rsch. to Sandra Arnold, Vice President of Corporate Affairs of Population Council (Sept. 28, 2000), https://www.accessdata.fda.gov/drugsatfda_docs/appltr/2000/20687apltr.html [<https://perma.cc/HSE4-YXAK>].

²¹ 21 U.S.C. § 355-1 (2007).

²² *Id.* at § 355-1(a)(1)(A)–(F).

²³ Serpico, *supra* note 9; *see also* 21 U.S.C. § 355-1 (2020). For a comprehensive and detailed history, *see* Donley, *supra* note 13; HAUSSMAN, *supra* note 12.

²⁴ Under the Federal Food, Drug, and Cosmetic Act (“FDCA”) the federal government can enforce REMS against healthcare providers and the manufacturer of the drug, known as the “drug sponsor.” 21 U.S.C. §§ 301–399i (2018).

²⁵ Serpico, *supra* note 9.

²⁶ *What’s in a REMS?*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rem/whats-rem> [<https://perma.cc/H8TW-PK5T>].

²⁷ U.S. FOOD & DRUG ADMIN., QUESTIONS AND ANSWERS ON MIFEPREX (2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex> [<https://perma.cc/49UQ-V2CX>].

documentation of safe-use conditions.²⁸ In practice, this has meant that health care providers who dispense mifepristone must certify in a written form to the drug sponsor that they have the required qualifications, that patients have to visit clinical settings to access the drug, and that patients have signed a form with instructions on how to use the drug.

The FDA did not restrict where and how the initial assessment of pregnancy—to ensure that the pregnancy is not ectopic and is under 10 weeks—occurs, allowing patients to take the first step towards receiving mifepristone at home. It could take place in-person or entirely remotely with the use of telemedicine. In other words, although the initial appointment may take place at home or remotely, according to FDA regulations at the time, the patient must visit a facility to pick up mifepristone. There, they would also sign a Patient Agreement Form and receive a medication guide.²⁹ The patient could take the drug anywhere, including at home, but it was often dispensed in the clinic.³⁰

B. The Current Crisis

On January 31, 2020, Alex Azar, head of Health and Human Services (HHS), declared a public health emergency in the United States in response to the COVID-19 pandemic.³¹ Hospitals across the country were soon inundated with COVID-19 patients. State governors declared states of emergency and limited the provision of healthcare to only “essential services.”³² These orders looked different in each state but resulted in limitations on the delivery of in-person health services and a broad move to the provision of health through telehealth services.³³

Immediately, abortion became a contested issue. Some states took the opportunity to deem abortion a non-essential service.³⁴ For these

²⁸ *Id.*

²⁹ See *GenBioPro: Patient Agreement Form*, GENBIOPRO (2021), <https://genbiopro.com/wp-content/uploads/2019/05/GenBioPro-Patient-Agreement.pdf> [<https://perma.cc/B2DW-L44L>]; see also *Mifeprex: Patient Agreement Form*, DANCO LABORATORIES (2016), <https://www.earlyoptionpill.com/wp-content/uploads/2016/03/Patient-Agreement-Form-March2016-1.pdf> [<https://perma.cc/EPD9-2EYU>].

³⁰ See Yael Swica et al., *Acceptability of Home Use of Mifepristone for Medical Abortion*, 88 *CONTRACEPTION* 122 (2013).

³¹ Alex Azar, *Determination that a Public Health Emergency Exists*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Jan. 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx> [<https://perma.cc/YYYY-67EU>].

³² See States' COVID-19 Public Health Emergency Declarations and Mask Requirements, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 11, 2022), <https://www.nashp.org/governors-prioritize-health-for-all/> [<https://perma.cc/JZG2-YKVT>] (Consolidating of state laws and policies during the pandemic).

³³ See Aziza Ahmed, *How the COVID-19 Response is Altering the Legal and Regulatory Landscape on Abortion*, 7 *J. L. & BIOSCIENCES* 1, 1–5 (2020).

³⁴ See *State Resumption of Elective Surgery Orders, Guidance, and Resources*, AM. COLL. SURGEONS, <https://www.facs.org/for-medical-professionals/covid-19/legislative-regulatory/state->

states, this accomplished a long-desired goal to end abortion access in their state. Other states swung the other way, with state attorneys general advocating that the FDA stop enforcing REMS during the pandemic.³⁵

COVID-19 provided additional momentum to the existing movement to end the excess regulation of mifepristone by the FDA. With the pandemic, women who were made to go to the clinic to pick up mifepristone and sign paperwork were now potentially being exposed to COVID-19. Another option was possible: women could complete their visit virtually and receive the medication by mail. This alternative would be in line with the turn towards telemedicine in the pandemic.

This new pandemic reality and the increasing availability of telemedicine services generally, coupled with long campaign to increase access to medication abortion, brought mifepristone into center stage. Advocates and those pushing to liberalize the rules surrounding the FDA enforcement of its REMS and ETASU restrictions began to pressure the agency to loosen its grip on mifepristone.³⁶ Meanwhile, pro-life advocates, politicians from conservative states, and the Trump administration encouraged the FDA to hold its ground on the enforcement. Conservatives followed a well-worn path: make it more difficult for people to access abortion services by arguing that it is safer for those who need the service.³⁷

In March 2020, attorneys general from twenty-one states sent a letter to the FDA and HHS calling for easier access to medication abortion during this time via telehealth.³⁸ The letter noted the unnecessary

resumption/ [https://perma.cc/RYT3-9Q8Q].

³⁵ Letter from Cal. Att’y Gen. Xavier Becerra, et al., to Alex M. Azar II, HHS Secretary, and Stephen Hahn, FDA Comm’r (Mar. 30, 2020), https://ag.ny.gov/sites/default/files/final_ag_letter_hhs_medication_abortion_2020.pdf [https://perma.cc/LBV2-ZLVE] [hereinafter Letter from Cal. Att’y Gen.].

³⁶ For examples of activism to remove the REMS, see *Bad Medicine: The Government’s Restriction on Medication Abortion*, NAT’L PARTNERSHIP FOR WOMEN & FAMILIES (2020), <https://www.nationalpartnership.org/our-work/resources/health-care/repro/abortion/bad-medicine-the-governments-restriction-on-medication-abortion.pdf> [https://perma.cc/FE5U-BNLY]; see also Press Release, Rob Bonta, Attorney General Becerra Leads Coalition of 21 Attorneys General Asking FDA to Increase Access to Reproductive Telehealth Care During COVID-19, <https://oag.ca.gov/news/press-releases/attorney-general-becerra-leads-coalition-21-attorneys-general-asking-fda> [https://perma.cc/2DPZ-4K9E].

³⁷ *Citizen Petition re: Request for Stay and Repeal of the Approval of Mifeprex (Mifepristone) for the Medical Termination of Intrauterine Pregnancies Through 49 Days’ Gestation*, Am. Ass’n Pro-Life Obstetricians and Gynecologists, https://aaplog.org/wp-content/uploads/2021/01/2002-Aug-Citizen-Petition_Mifeprex-8.20.02.pdf [https://perma.cc/3LEC-CJED]; *Citizen Petition*, Am. Ass’n Pro-Life Obstetricians and Gynecologists (2019), <https://aaplog.org/wp-content/uploads/2021/01/Citizen-Petition-Final-FDA-Mif-REMS.pdf> [https://perma.cc/WW75-SW9G].

³⁸ See Press Release, N.Y. Att’y Gen., Attorney General James Pushes to Increase Abortion Access by Medication During Coronavirus Pandemic (Mar. 30, 2020), <https://ag.ny.gov/press-release/2020/attorney-general-james-pushes-increase-abortion-access-medication-during> [https://perma.cc/26HX-U34J] [hereinafter Press Release Attorney General James]; see also Letter

delays caused by the REMS in accessing medication abortion for women during the pandemic and described how the REMS designation caused women to put themselves and their families at risk of contracting COVID-19. The Attorney General's relied on assessments by the American College of Obstetricians and Gynecologists (ACOG), American Medical Association, and American Academy of Family Physicians to assert that the restrictions are unnecessary.³⁹

Reproductive health practitioners and advocates were also joining forces to challenge the FDA's enforcement of the REMS. In May 2020, several groups came together in a civil action against the FDA, challenging the agency's enforcement of the REMS during the pandemic. The organizations included the American College of Obstetricians and Gynecologists, the Council of University Chairs of Obstetrics and Gynecology (CUCOG), the New York State Academy of Family Physicians (NYSAFP), and Honor MacNaughton, M.D. Along with these physician associations was the SisterSong Women of Color Reproductive Justice Collective, a "national multi-ethnic membership organization dedicated to improving policies and systems related to reproductive lives of marginalized communities."⁴⁰ The organizations challenged the enforcement of the FDA requirements related to in-person dispensing and signature requirements for mifepristone.⁴¹

For the district court, expert testimony clearly advised an injunction: access to abortion medication via telemedicine would solve the problems of an in-person requirement that was not only always medically unnecessary but also created additional burdens during a pandemic. In July 2020, the plaintiffs received a major victory in the District Court of Maryland, which enjoined the FDA from enforcing in-person requirements for the dispensation of mifepristone.⁴² In arriving at the injunction, the district court relied on experts both from the OB/GYN community and women's health advocates. These medical providers testified to the challenges raised by the pandemic. They described how the availability of in-person care had declined, clinics and medical offices had closed, and in-person visits to give mifepristone to patients had been "stopped or delayed."⁴³ Physicians provided concrete

from Cal. Att'y Gen., *supra* note 35.

³⁹ *Improving Access to Mifepristone for Reproductive Health Indications*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (Mar. 2021), <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/improving-access-to-mifepristone-for-reproductive-health-indications> [<https://perma.cc/WPY9-H44Y>].

⁴⁰ *Am. Coll. Of Obstetricians and Gynecologists v. FDA*, 472 F. Supp. 3d 183, 196 (D. Md. 2020).

⁴¹ *Id.* at 195 (referencing expert testimony brought by plaintiffs describing the hardship faced by women seeking abortion under the current FDA REMS regime).

⁴² *Id.*

⁴³ *Id.*

examples of closures of in-person care and how the burdens of the closures were borne by communities of color: 60 percent are people of color and 75 percent are poor or low-income.⁴⁴ The Executive Director of SisterSong offered evidence that people of color are less likely to own a car and rely more heavily on public transportation.⁴⁵ The testifying physicians noted that public transportation and car-sharing increases the risk of COVID-19 transmission.⁴⁶ For women with children, bringing children to clinics was also unsafe and resulted in risk not only for the child but for caretakers.

The district court took this testimony seriously. It based its authority to review in *Whole Woman's Health v. Hellerstedt*,⁴⁷ in which the Supreme Court held that the courts are able to review legislative questions of medical uncertainty.⁴⁸ Against the idea articulated previously by the Supreme Court, that it should defer to the legislature on questions of medical uncertainty,⁴⁹ the Court in *Whole Woman's Health* stated that “the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings.”⁵⁰ For the district court, this opened the door for courts to essentially reconsider factual findings in light of the undue burden standard.

The district court applied the undue burden standard to find that that a preliminary injunction against the FDA's enforcement was necessary.⁵¹ The standard, first articulated in *Casey v. Planned Parenthood*,⁵² states that an abortion regulation is unconstitutional if it has “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”⁵³ The District Court of Maryland traced the contours of the undue burden standard through what was then the most recent applications by the Supreme Court in *Whole Woman's Health* and *June Medical Services v. Russo*.⁵⁴ In these cases, the Supreme Court used the undue burden standard to

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ 136 S. Ct. 2292 (2016), *abrogated by* *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

⁴⁸ *Id.* at 2310.

⁴⁹ *Gonzales v. Carhart*, 550 U.S. 124, 163–65 (2007).

⁵⁰ *Whole Woman's Health*, 136 S. Ct. at 2310.

⁵¹ For a history of the turn to public health evidence in the context of abortion jurisprudence, see Rebouché, *supra* note 13.

⁵² 505 U.S. 833 (1992), *overruled by* *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

⁵³ *Id.* at 877.

⁵⁴ 140 S. Ct. 2103 (2020), *abrogated by* *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

find that legal regulations did constitute a burden.⁵⁵ The Supreme Court did so by balancing the benefits and burdens of the laws under review. The District Court of Maryland considered the facts generated by the lower courts and identified who would suffer the consequences of the regulations at stake.⁵⁶ Following from these two Supreme Court cases, the district court took seriously the need to “consider the burdens a law imposes on abortion access together with the benefits those laws confer.”⁵⁷ The evidence presented to the district court spoke clearly to the burdens at hand for women seeking medication abortion: the need to travel, the need to arrange for childcare, the costs associated with abortion, and, for the providers, the inability to meet patient demand. In turn, the district court found that the FDA rules imposed a “substantial obstacle on a large fraction of the relevant women seeking a medication abortion.”⁵⁸ The District Court placed an injunction on the FDA’s enforcement of the REMS.⁵⁹

Following this ruling, in August 2020, under the Trump administration, the FDA went to the Supreme Court to ask for a stay of the nationwide injunction enacted by the District Court.⁶⁰ Though the undue burden standard as articulated by the District Court of Maryland could have led to a resolution on the question of medication abortion, the highest court would go on to sidestep the question of undue burden and instead articulate a deferential standard to administrative agencies.⁶¹

The FDA made several claims in its appeal to the Supreme Court—first, that the regulations for mifepristone have always existed to “mitigate serious health risks” associated with the drug, “which can increase if the patient delays taking the drug or fails to receive proper counseling and possible complications.”⁶² Second, the FDA asserted that it is the sole authority with the institutional competence and role to regulate medication abortion. This is clear in the agency’s brief to the Supreme Court, which argued that

⁵⁵ See *Whole Woman’s Health*, 136 S. Ct. at 2318; see also *June Medical Services v. Russo*, 140 S. Ct. 2103, 2132 (2020).

⁵⁶ *Am. Coll. of Obstetricians & Gynecologists v. FDA*, 472 F. Supp. 3d 183, 208 (D. Md. 2020).

⁵⁷ *Whole Woman’s Health*, 136 S. Ct. at 2309.

⁵⁸ *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. at 211; Brief for the States of New York, et al. as Amici Curiae Supporting Plaintiffs, *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d 183 (2020) (No. 8:20-cv-01320).

⁵⁹ *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. at 208.

⁶⁰ Brief by Petitioner-Appellant at 8, *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578 (2021) (No. 20A34).

⁶¹ *Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. at 578–79.

⁶² Brief by Petitioner-Appellant, *supra* note 60, at 2.

[T]he circumstances here—in which a single district court, presented with a suit by a single physician and a handful of organizations, displaced the FDA’s scientific judgement with respect to every medication abortion provide in the country—illustrates the problems with allowing district courts to award relief untethered to the established injuries of the specific plaintiffs before them.⁶³

The FDA addressed the issue of undue burden simply by arguing that the existence of surgical abortion mitigated the potential burden created by the lack of access medication abortion.⁶⁴ The agency did not address the issue at stake for those advocating for lifting the REMS: that accessing in-person procedures created risk during the COVID-19 pandemic.

In its response brief, amici stressed their own expertise.⁶⁵ The American College of Obstetrics and Gynecologists highlighted that the organization represents sixty thousand physicians and the department chairs of obstetrics and gynecology at nearly 150 universities across the United States.⁶⁶ ACOG also pointed out its own expertise in the care and treatment of obstetric issues:

Defendants now ask this Court to step in while this case is before the court of appeals and strip the nation’s health care providers—including Plaintiffs American College of Obstetricians and Gynecologists (“ACOG”) and Council of University Chairs of Obstetrics and Gynecology (“CUCOG”), supported by amici including American Medical Association (“AMA”)—of the urgent relief they need to protect their own safety and that of their patients, staff, and families during the pandemic. Defendants have not met the “especially heavy burden” they bear on such an overriding stay petition.⁶⁷

Stated differently, the case teed up two competing groups of experts: the Food and Drug Administration and medical practitioners. Though SisterSong continues to appear on the briefs opposing the injunction, the organization’s particular constituency—women impacted by the laws—shrinks as the contestation before the Court becomes one

⁶³ *Id.* at 3.

⁶⁴ *Id.* at 7.

⁶⁵ Brief by Respondent-Appellee at 3, 7, 13, 34, *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578 (2021) (No. 20A34).

⁶⁶ *Id.* at 1.

⁶⁷ *Id.* at 2.

about scientific and medical expert authority in the regulation of medication abortion.

On January 12, 2021, as the pandemic surged with sickness and deaths soared, the Supreme Court found for the FDA.⁶⁸ In doing so, the Court said that the FDA could continue to enforce the regulations on mifepristone and overturned the District Court.⁶⁹ Chief Justice Roberts wrote a separate concurrence. In it he punted on the question of whether or not the enforcement created an undue burden.⁷⁰ Instead, the Chief Justice said that the Supreme Court should defer to “politically accountable entities with the background, competence, and expertise to assess public health.”⁷¹

Justice Sotomayor wrote a dissent that was joined by Justice Kagan. It resuscitated the perspective of impacted communities in a discussion on the regulation of medication abortion describing the hardships faced under the FDA rules, especially by minorities.⁷² Sotomayor and Kagan describe the regulations as constituting an “unnecessary” and “undue” burden on women seeking an abortion.⁷⁴ They call the FDA’s insistence on their rules “callous.”⁷⁵

The dissent also resets the discussion on who the relevant public health agencies and experts are during the pandemic. From Robert’s perspective, the experts to whom they should defer are the regulators working in the FDA.⁷⁶ Sotomayor and Kagan broaden the field of experts to the CDC, who recommended the use of telemedicine whenever possible.⁷⁷ This is important, according to the dissent, because the Court’s deference to the FDA is misplaced: the agency offered no defense of its own position on mifepristone.⁷⁸ While Sotomayor and Kagan

⁶⁸ FDA v. Am Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 579 (2021).

⁶⁹ *Id.*

⁷⁰ *Id.* (Roberts, C.J., concurring in the grant of application for stay) (“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.”).

⁷¹ *Id.* at 578–79 (quoting *South Bay United Pentacostal Church v. Newsom*, 140 S. Ct. 1613, 1614 (2020)) (Roberts C.J., concurring) (adjudicating question of expertise on the issue of singing in church). In *South Bay*, Roberts says the science and evidence suggest that singing is a risk but that there is no basis in expertise or discretion that the maximum number of people who can workship is zero. He even carves out a role for the judiciary in making these decisions about people’s rights. 141 S. Ct. at 570 (“I adhere to the view that the ‘Constitution principally entrusts the safety and the health of the people to the politically accountable officials of the States.’ But the Constitution also entrusts the protection of the people’s rights to the Judiciary—not despite judges being shielded by life tenure . . . but because they are. Deference, though broad, has its limits.”).

⁷² *Id.* at 582 (Sotomayor, J., dissenting).

⁷⁴ *Id.* at 582 (Sotomayor, J., dissenting).

⁷⁵ *Id.* at 583 (Sotomayor, J., dissenting).

⁷⁶ *Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. at 579.

⁷⁷ *Id.* at 579–80 (Sotomayor, J., dissenting).

⁷⁸ *Id.* at 584–85 (“I agree that deference is due to reasoned decisions of public health officials grappling with a deadly pandemic. But the record here is bereft of any reasoning. The Government

do not specifically reference the politicized approval process for mifepristone, she does note the long history of abortion exceptionalism in U.S. lawmaking and notes that the unnecessary regulations on mifepristone “imposes an unnecessary, irrational, and unjustifiable undue burden on women seeking to exercise their right to choose.”⁷⁹

Since the Supreme Court’s decision, the White House changed parties. Under the Biden Administration, on April 12, 2021, the FDA stated that it had conducted a careful scientific review of in-person dispensing requirements established by the mifepristone REMS and stated that it would use enforcement discretion during the COVID-19 public health emergency.⁸⁰ This revision by the FDA meant that people seeking abortions would be able to do so by mail. In December of 2021, the decision was made permanent by the FDA.⁸¹

II. EXPERTISE IN THE CURRENT LITIGATION

In recent decades, a large literature on expertise has sought to map and explain the rise and role of experts in democratic institutions and deliberations.⁸² In this literature, experts are often designated as someone with a specialist craft or knowledge. An expert is typically perceived to be neutral, impartial, or disinterested.⁸³ It is these qualities that make expertise central to how courts and legal institutions maintain the perception of their own neutrality. Deploying claims of expertise, for example, helps administrative agencies guard themselves against the accusation of arbitrary and capricious rulemaking.⁸⁴ Principles from

has not submitted a single declaration from an FDA or HHS official explaining why the Government believes women must continue to pick up mifepristone in person, even though it has exempted many other drugs from such a requirement given the health risks of COVID-19. There simply is no reasoned decision here to which this Court can defer.” (internal citations omitted).

⁷⁹ *Id.* at 585.

⁸⁰ See QUESTIONS AND ANSWERS ON MIFEPREX, *supra* note 27.

⁸¹ *Id.* (“Even as access at the federal level was liberalized, state laws preventing access to mail order were being passed.”); see, e.g., *The Availability and Use of Medication Abortion*, KAISER FAMILY FOUNDATION (Apr. 06, 2022), <https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/> [<https://perma.cc/T5D2-UMZ7>].

⁸² See Kennedy, *supra* note 7; see also Jasanoff *supra* note 7 at 157-162, JASANOFF *supra* note 7, Levin *supra* note 7.

⁸³ See Reiner Grundmann, *The Problem of Expertise in Knowledge Societies*, 55 MINERVA 25 (2017) (“At the heart of the book is a critique of two commonly accepted paradigms for controlling the use of science by regulatory agencies: the ‘technocratic’ approach, which looks to scientists as primary validators of policies with high technical content, and the ‘democratic’ approach, which views broad public participation as the antidote to abuses of expert authority. Neither approach, in my view, takes adequate account of the nature of science or of politics. Yet players in the regulation game, aware that decisionmaking can be co-opted through strategic choices of procedural and institutional design, have frequently championed one or the other model in pursuit of their immediate political objectives.”) (citing SHEILA JASANOFF, *THE FIFTH BRANCH: SCIENCE ADVISORS AS POLICY MAKERS* (1990)).

⁸⁴ Kathryn A Watts, *Proposing a Place for Politics in Arbitrary and Capricious Review*, 119

the literature on expertise can be utilized to understand how expertise is mobilized in courts. Below, I tease out how three dimensions of the broader literature on law and expertise are particularly useful in the context of the recent Supreme Court litigation.

First, experts and expertise can be mobilized to advance an institutional argument. The assumption that expertise is neutral and objective disguises the political distributional effects of the legal outcome. Science, technology, and society scholar Sheila Jasanoff describes how players in legal regulation, co-opt decision making through the strategic choices of procedural and institutional design.⁸⁵ In doing so, legal players might champion either a “technocratic” approach which shows deference to scientists, or the “democratic” approach which seeks to broaden public participation.⁸⁶ Legal players, including lawyers and judges, reify the distinction between expert and non-expert and assume that the underpinnings of this distinction are true in the course of making claims and adjudication.

In his concurrence in *ACOG v. FDA*, Chief Justice Roberts performs a clear case of mobilizing expertise for the sake of purported institutional preservation. In a well-trodden move which calls upon the logic of separation of powers, Roberts minimizes the role of the Court and defers to the FDA as *the* group of experts whose perspective must rule in the case of medication abortion.⁸⁷ His short concurrence offers no explanation, simply noting that it is necessary to defer, in a pandemic, to public health institutions.⁸⁸ Roberts essentially says: the Court does not have the authority or expertise to make this decision; our institutional legitimacy is preserved through our deference to the FDA. Roberts ignores the line of argumentation offered by the lower court that in light of the present circumstances, referencing the pandemic, the Court can review the evidence on the record of the in-person requirements for dispensation of mifepristone.⁸⁹

The deference to the FDA also performs an act of erasure: It fails to acknowledge that political pressures exerted on the FDA may have impacted their own classification of mifepristone into Subpart H. The inability to see the FDA’s actions in the context of political pressure on

YALE L. J. 1 (2009).

⁸⁵ See JASANOFF, *supra* note 83.

⁸⁶ *Id.*

⁸⁷ See Klare, *supra* note 8.

⁸⁸ *FDA v. Am Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 579 (2021).

⁸⁹ In *June Med. Servs. v. Russo*, Roberts states in the concurrence, drawing on *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) that instances of medical uncertainty are to be left to the legislature. 140 S. Ct. 2103, 2136 (2020) (Roberts, C.J., concurring) *abrogated by* *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022).

the agency undermines the historical reality of regulating mifepristone—that politics shaped the way the FDA first approved of the drug. The assertion that the FDA is the primary expert body suited to regulate mifepristone also implicitly pushes back on Sotomayor’s claim that the abortion restrictions are exceptional rather than part of the normal process of drug regulations. There is a clear distributional and material effect to his decision: some people seeking medication abortion will no longer be able to access the abortion or no longer be able to do so in a manner that is in keeping with COVID-19 precautions. And, there are clear political ramifications: conservatives pushing for enforcement of FDA restrictions would celebrate this decision.

Second, expertise is situated: who counts as an expert and what counts as expertise are products of societal beliefs, politics, and values.⁹⁰ Lawmaking and adjudication relies on, and deploys, particular forms of expertise (e.g. social scientific, medical, scientific, legal) in order to rationalize opinions in a neutral and reasoned way. Yet, even as judges rationalize decisions, they may disclaim their own role in setting the terrain for who and what might be seen as legitimate forms of knowledge and expertise. As I’ve shown in prior works, they play a key role in shaping how sets of ideas or claims about which expert ought to be listened to and why.⁹¹

The majority in *FDA v. ACOG* performs this double move: both exploiting the institutional politics of the management of abortion—the turn to experts—and denying the court’s own role in legitimating a particular type of expertise over others. Justice Roberts’ assertion that it is the FDA that ought to be deferred to makes the FDA the central voice in the question of whether or not to lift REMS requirements. Yet, if the question is of public health expertise in a pandemic, the FDA is not the sole agency whose perspective may matter in thinking through how health regulations ought to be designed during a pandemic. As Justice Sotomayor pointed out, the FDA is not the only voice in the public health response to COVID-19.⁹² By asserting that courts owe deference

⁹⁰ See Donna Harraway, *Situated Knowledges: The Science Question in Feminism and Privilege of the Partial Perspective*, 14 FEMINIST STUDIES 575 (1988); see also SHEILA JASANOFF, *STATE OF KNOWLEDGE: THE CO-PRODUCTION OF SCIENCE AND THE SOCIAL ORDER* (2004). For my work on abortion and expertise, see Aziza Ahmed, *Abortion in a Post-Truth Moment*, TEX. L. REV.; Aziza Ahmed, *Will the Supreme Court Legitimate Pretext?*, SCOTUS BLOG (2020), <https://www.scotusblog.com/author/aziza-ahmed/> [<https://perma.cc/35UK-E6EC>]; Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, AM. J. L. & MED. (2015), for my prior work on the legitimation of evidence by the courts.

⁹¹ See Grundmann, *supra* note 83 at 27 (arguing that “experts mediate between the production of knowledge and its application; they define and interpret situations; and they set priorities for action”). For prior work by Aziza Ahmed see citations in footnote 90

⁹² *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 582–84 (2021) (Sotomayor, J., dissenting) (acknowledging that that CDC, for example, has also issued guidelines suggesting that people avoid indoor spaces).

to entities with the competence to “assess public health,” and deferring to the FDA, Chief Justice Roberts minimized the centrality of the expertise offered by other administrative agencies including the CDC and physicians including ACOG.⁹³

Alongside the obstetricians and gynecologists of ACOG, the order undermines taking SisterSong’s expertise seriously.⁹⁴ SisterSong, for example, is an organization that specifically aims to “raise the voices of indigenous women and women of color” in the struggle around reproductive justice.⁹⁵ In deferring to the expertise of the FDA at the exclusion of others, Roberts ignores the claims by women that it is necessary to access medication abortion to mitigate a range of potential issues from cost and travel to real risk of exposure. By wresting the claim to authority from pro-choice groups and women’s health providers, litigation and adjudication further undermine the claims made by women’s groups.

Third, and related the very question of whose voice counts (or does not) is crystalized through the process of legitimating some forms of expertise over others. The erasure of some voices is particularly relevant for a discussion of abortion rights advocacy, in which affected communities—people who have had abortions or been touched by them—have made assertions of their own expertise.

In a literature on the sociology of medicine, this set of voices has been called “layexperts.”⁹⁶ Layexperts have been particularly important in public health advocacy because of, first, the assertion that personal, embodied experience matters and, second, that even without formal training laypeople can gain the necessary expertise to speak to technical issues in the regulation of public health.⁹⁷ In women’s health advocacy, the assertion of expertise by activists revolutionized the delivery of medicine for women.⁹⁸ Groups like Our Bodies Our Selves

⁹³ *Am Coll. of Obstetricians & Gynecologists*, 141 S. Ct. at 579.

⁹⁴ Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, *supra* note 90.

⁹⁵ *Reproductive Justice*, SISTER SONG, <https://www.sistersong.net/reproductive-justice> [<https://perma.cc/5ARA-ST47>].

⁹⁶ Steven Epstein, *The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials*, 20 SCL, TECH., & HUM. VALUES 408 (1995) (describing how AIDS activists began to speak about scientific issues with credibility); Maria Novotny & Les Hutchinson, *Tracing the Future Lineage for OBOS: Reproductive Health Applications as a Text for Feminist Rhetorical Inquiry*, 21 PEITHO 645 (2019) (describing how Our Bodies Our Selves fused together embodied and medical expertise in their advocacy).

⁹⁷ See ALONDRA NELSON, *BODY AND SOUL: THE BLACK PANTHER PARTY AND THE FIGHT AGAINST MEDICAL DISCRIMINATION* (2013); see also Epstein, *supra* note 96.

⁹⁸ WENDY KLINE, *BODIES OF KNOWLEDGE: SEXUALITY, REPRODUCTION, AND WOMEN’S HEALTH IN THE SECOND WAVE* (2010).

asserted the ability of women to be experts of their own bodies including to self-manage health issues.⁹⁹

In *ACOG v. FDA*, the voices of women's health advocates, or the voices of those speaking to the actual experiences of women, are made invisible in the Roberts concurrence. This is particularly remarkable given the history of Supreme Court justices relying on the testimonial expertise of women in abortion jurisprudence. Most famously, in *Gonzales v. Carhart*,¹⁰⁰ Justice Kennedy relied on the brief of Sandra Cano and others who offered testimony of negative impact of their abortions. Over the protest of a dissent by Ginsburg, Kennedy cites to this brief to make the claim that abortions cause regret.¹⁰¹ In *ACOG v. FDA*, Roberts' brief concurrence makes no mention of those who will be impacted by the law, while Sotomayor's dissent centers around the material effect of the FDA regulations and the experiences of women who may try to access abortion during a pandemic.¹⁰²

III. EXPERTISE AS A FEATURE OF THE CONSTITUTIONALIZATION OF ABORTION POLITICS

Today, abortion rights advocacy has increasingly taken legal form and relied on medical expertise. The social movement turn towards legal and scientific expertise has gone hand-in-hand with the constitutionalization of abortion.¹⁰³ It was Justice Blackmun in *Roe* who set reproductive rights on a path in which there would be deep entanglement between medicine and law.¹⁰⁴ As the well-known story now goes, Blackmun developed a respect for physicians and science while a lawyer for the Mayo Clinic.¹⁰⁵ Blackmun's experience at the Mayo Clinic manifested in the decision, in which Blackmun both historicized the issue of abortion in terms of medical advancements and created a legal rule which relied on medical judgement and the science of abortion.¹⁰⁶

⁹⁹ These groups were part of a larger movement to challenge expertise in healthcare in the 1960s and 1970s. See NELSON, *supra* note 98; Novotny & Hutchinson, *supra* note 96.

¹⁰⁰ 550 U.S. 124 (2007).

¹⁰¹ *Id.* at 129.

¹⁰² *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S.Ct. 578, 582–84 (2021) (Sotomayor, J., dissenting).

¹⁰³ There is a large amount of literature on the constitutionalization of abortion. See, e.g., Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L. J 1394 (2008).

¹⁰⁴ See LINDA GREENHOUSE, *BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN'S SUPREME COURT JOURNEY* (2006).

¹⁰⁵ *Id.*

¹⁰⁶ *Roe v. Wade*, 410 U.S. 113 (1973), *overruled by Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

The reproductive rights movement was optimistic that this was the right path given the strong support from the medical and social science literature for pro-choice positions. This helped solidify the turn towards expertise for progressive legal reform. The well-known slogan “between a woman and her doctor” exemplifies the reliance on experts by reproductive rights advocates.¹⁰⁷

To some degree, the reliance on expertise paid off in *Whole Woman’s Health* and *June Medical*. In *Whole Woman’s Health*, the Court reworked the undue burden standard. Moving away from the standard articulated in *Casey*, which allowed many laws restricting abortion access to be found constitutional, the Court focused in on the question of burdens faced by women in accessing abortion.¹⁰⁸ To be clear, the prior focus was on the *purpose* of a particular law which had long allowed courts to simply defer to a state claim that an abortion regulation was necessary to protect women’s health. Understanding burdens meant a shift from the purpose prong of the undue burden test, to the effect prong. For Breyer, writing the majority in *Whole Woman’s Health*, the turn to understanding how a law impacted people seeking abortions necessitated a turn to experts, from physicians to social scientists, to understand how the burdens manifested.¹⁰⁹ The Court followed suit in *June Medical*, holding an abortion restriction, identical to the one at stake in *Whole Woman’s Health*, unconstitutional based on the burdens the law imposed on women seeking abortions and providers.¹¹⁰

While the Court followed the precedent set in *Whole Woman’s Health* in *June Medical*, the majority did so over the protests of Robert’s concurrence which decried the balancing test employed by the majority.¹¹¹ In his concurrence, Roberts states that a balancing test conducted by judges would open the court up to an “unanalyzed exercise of judicial will” in the guise of a “neutral utilitarian calculus.”¹¹² In other words, he argued that a balancing test necessarily introduces politics into the decision making process.¹¹³ While his concurrence in *June Medical*

¹⁰⁷ I unpack the slogan “between a woman and her doctor” in Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J. L. & MED. 85 (2015).

¹⁰⁸ *Whole Woman’s Health v. Hellerstedt*, 136 S.Ct. 2292 (2016), *abrogated by* *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022).

¹⁰⁹ *Id.*

¹¹⁰ *June Medical Services v. Russo*, 140 S. Ct. 2103 (2020), *abrogated by* *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022).

¹¹¹ *Id.* at 2136 (Roberts, C.J., concurring) (arguing that a balancing test would essentially open the court up to a large range of factors in weighting the legal regulation at hand making it impossible to “objectively assign weight” to “imponderable values . . .”).

¹¹² *Id.* See also Aziza Ahmed, *Will the Supreme Court Legitimate Pretext?*, *supra* note 90.

¹¹³ This is a point long made by critical legal theory scholars. See, e.g., Duncan Kennedy, *From Will Theory to the Principle of Private Autonomy: Lon Fuller’s “Consideration and Form”*, 100

seems to set up his deference to the FDA in *ACOG v. FDA*, in the former Roberts failed to acknowledge that the deference to agency experts, too, can be mobilized for political purpose.

ACOG v. FDA, is, of course, only one of many holdings over the past fifty years that turn towards expertise, sometimes legitimating contested claims (or even false claims) in the process of abortion adjudication. The Supreme Court and lower courts have played an active role in legitimating claims that abortion leads women to negative mental health consequences in denying health exceptions to procedures, that institutions spreading false information about the impact of abortion ought to be protected under First Amendment law, and that support laws under the guise of informed consent which support conveying false information to women seeking abortions.¹¹⁴ While taken on their own terms outside of adjudication, the claim that states ought to have a protectionist regulatory regime on abortion for the sake of women, and the studies they are based on, fail to meet even the most basic tests of rigor.¹¹⁵ Yet when they meet legal institutions, and judges prone to supporting the increased regulation of abortion, they are often treated as legitimate, and the deployment of expert claims helps the court retain its image as a neutral institution despite an overtly political choice to uphold laws that serve no purpose but to block abortion access.¹¹⁶

While writing this paper, the court decided *Dobbs v. Jackson Women's Health*, overturning *Roe v. Wade*. By overturning the fundamental right to abortion, the Supreme Court has left the decision about how to manage abortions to the states. *Dobbs* has also exacerbated the need for access to medication abortion. This has inspired states to regulate of mifepristone in new and unprecedented ways. States are enacting a range of limitations on mifepristone access in contravention of FDA guidance.¹¹⁷

COLUM. L. REV. 94 (2000).

¹¹⁴ Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, *supra* note 90.

¹¹⁵ Many of the arguments for greater waiting periods and informed consent, for example, rest on the idea that abortion could have negative mental health consequences. This claim rests on methodologically questionable data. *see* Steinberg et al., *Fatal Flaws in a Recent Meta-Analysis on Abortion and Mental Health*, 86 *CONTRACEPTION* 430 (2012). For a longer discussion on the politics of abortion and informed consent, *see* Aziza Ahmed, *Science and Democracy: The Shifting Role of Medical Expertise and Evidence in Abortion Jurisprudence*, *BALKINIZATION BLOG* (Oct. 16, 2014), <https://balkin.blogspot.com/2014/10/science-and-democracy-shifting-role-of.html> [<https://perma.cc/2HXX-Y26Q>].

¹¹⁶ *See Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2320–21 (2016) (Ginsburg, J., concurring) (discussing TRAP laws).

¹¹⁷ *Tracking the States Where Abortion is Now Banned*, *NEW YORK TIMES* (Oct. 7, 2022), <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html> [<https://perma.cc/Y7TL-67KW>], Larissa Jiminez, 60 Days After Dobbs: State Legal Developments on Abortion (Aug. 24, 2022), <https://www.brennancenter.org/our-work/research-reports/60-days-after-dobbs-state-legal-developments-abortion> [<https://perma.cc/6VBL-UWZ8>].

These recent legal transformations will lead to a new battle of expertise, one that will share many of the dynamics discussed in this essay, as courts play a role in sorting and validating the claims of competing experts. This will have severe consequences for abortion access.

In the context of new legal challenges, looking to the past reveals that taking a critical posture towards expertise has a long and successful history in feminist women's health advocacy.¹¹⁸ The critique of science from a feminist perspective began with the idea that the distribution of medical resources and knowledge, often justified by law and science, was uneven and needed to be remedied. For reproductive rights advocates, whose history roots in this deep sense of feminist skepticism towards science and law, returning to a critical posture towards law and expertise will open the door to seeing the distributional consequences of the foregrounding of particular types of expertise to help unravel the forces that legitimate some forms of expertise over others with dire consequences both for abortion access. This current political context—in which abortion access is under threat—requires a return to a more critical view of law and expertise, one that sees the two as deeply related.

IV. CONCLUSION

Contemporary legal fights over access to medication abortion reveal how courts deploy ideas of expertise to arrive at particular legal outcomes. Paying attention to experts in the fight for access to medication abortion is a necessary and vital piece of seeing the full landscape of political contestation on abortion as it manifests in courts and the distributional consequences that flow from this jurisprudence.

¹¹⁸ See, e.g., SARAH SHULMAN, LET THE RECORD SHOW, 2021 (discussing how AIDS activists challenged experts to access treatment) and ALONDRA NELSON, BODY AND SOUL, 2013 (discussing the health clinics started by Black Panthers).