Medication Abortion Misinformation

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Introduction

In *Dobbs v. Jackson Women's Health Organization*,[1] the Supreme Court rejected the almost fifty-year recognition of constitutional protection for abortion rights under the Fourteenth Amendment. The rejection of *Roe v. Wade*[2] has led to widening disparities in access and escalating interstate conflict, with consequences for patients, providers, and the political climate.[3] This Essay describes evolving anti-abortion arguments that rely less on evidence of abortion's harm than on strategic claims about coercion and interstate conflict—claims that serve as a vehicle for federal intervention and that may exploit a bipartisan discomfort with mailed medication abortion.

After the *Dobbs* decision overturned *Roe*, states are free to regulate abortion, and indeed ban it, in almost any manner they choose. Thirteen states, concentrated mostly in the South and Midwest, ban abortion from conception; four more states outlaw abortion after six weeks of pregnancy.[4] But state abortion laws now reflect a broader struggle over whether states can extend their abortion-restrictive policies beyond their borders.[5] And the resulting conflict has generated legal strategies on both sides of the abortion divide, with a new type of legislation—so-called shield laws—at the center

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1. 142 S. Ct. 2228 (2022).

2. 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228 (2022).

3. According to the Institute for Women's Policy Research, state-level abortion restrictions now cost the U.S. economy more than $133 billion annually, with nearly half of those losses coming from the sixteen states with the most restrictive policies. Melissa H. Mahoney, *State-Level Abortion Restrictions Cost the US Economy $133 Billion*, INST. FOR WOMEN'S POL'Y RSCH: REPROD. JUST. & HEALTH EQUITY (June 23, 2025), https://iwpr.org/wp-content/uploads/2025/06/Repro-Cost-Analysis-Fact-Sheet-2025.pdf [https://perma.cc/7CGL-LHSK].

4. Allison McCann & Amy Schoenfeld Walker, *Tracking Abortion Laws Across the Country*, N.Y. TIMES (July 7, 2025), https://www.nytimes.com/interactive/2024/us/ abortion-laws-roe-v-wade.html [https://perma.cc/AZ5S-H3VN].

5. *See, e.g.*, David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 44 (2023) ("[T]hese interventions would strike at the heart of basic, fundamental principles of law in the United States' federalist system—interstate comity and cooperation."); *see also* Susan Frelich Appleton, *Gender, Abortion, and Travel After* Roe's *End*, 51 ST. LOUIS U. L.J. 655, 660 (2007) (arguing that state abortion prohibitions are based on policies aimed at regulating gender behavior).

of the debate.[6] States have adopted laws by statute or executive order that seek to protect people who provide or receive abortion care within their state from criminal, civil, or professional liability from a state that has restricted abortion. Shield laws have been enacted by twenty-two states and D.C., mostly by statute but some by executive order.[7]

Shield laws, however, are under threat. Over the last year, legislation, state lawsuits, and statements from elected officials have targeted providers licensed and living in shield states as well as the shield statutes themselves. Texas took the lead when it sued a New York doctor for civil damages, followed by Louisiana, which indicted that same physician in a criminal proceeding for prescribing medication abortion sent into both states.[8] More recently, legislators, states' lawyers, and advocates have called on the Executive Branch to shut down medication abortion sent from shield states.[9]

These actions respond to the reality that the national average number of abortions has increased since 2022; shield laws, or at least a subset of those laws, have facilitated mailed medication abortion across the country.[10] A medication abortion consists of two drugs (a mifepristone pill and a set of misoprostol pills) and is approved by the U.S. Food and Drug Administration (FDA) to end pregnancy before ten weeks of gestation.[11] In efforts to shut down the transit of abortion pills, a coordinated and well-funded campaign

6. *See* Cohen et al., *The New Abortion Battleground*, *supra* note 5, at 2–5 (2023) (describing new legal strategies developed by several states in the wake of *Dobbs*); David S. Cohen, Greer Donley, Rachel Rebouché & Isabelle Aubrun, *Understanding Shield Laws*, 51 J.L. MED. & ETHICS 584, 589–90 (2023) (explaining the emergence of shield laws and their implications across the states); David S. Cohen, Greer Donley & Rachel Rebouché, *Abortion Shield Laws*, NEW ENG. J. MED. EVID. 1, 2–4 (2023) (discussing the design and features of shield laws); David S. Cohen, Greer Donley & Rachel Rebouché, *Abortion Shield Laws in Action*, 185 JAMA INTERNAL MED. 911, 911–12 (2025) (describing how shield laws have been challenged by antiabortion states).

7. *Shield Laws for Reproductive and Gender-Affirming Health Care: A State Law Guide*, UCLA CTR. FOR REPROD. HEALTH, L. & POL'Y (2025), https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/shield-laws-reproductive-and-gender-affirming-health-care-state-law-guide [https://perma.cc/ZD6D-WZ6E].

8. Petition & Application for Temp. & Permanent Injunctive Relief at 1, 8–9, Tex. v. Carpenter, No. 471-08943-2024 (471st Dist. Ct. Collin Cnty., Tex. Dec. 12, 2024); Bill of Indictment, La. v. Carpenter, No. 250187 (La. Dist. Ct. Jan. 31, 2025).

9. *See* Letter from Sen. Lindsey O. Graham et al. to Robert F. Kennedy, Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., and Marty Makary, Comm'r, FDA (Oct. 9, 2025) (requesting that the FDA take steps to restrict access to mifepristone); *see also* Letter from Tim Griffin, Ark. Att'y Gen., et al., to Sen. Bill Cassidy, Chairman, S. Comm. on Health, Educ., Lab. & Pensions (Jan. 13, 2026) (asking the Senate Committee on Health, Education, Labor, and Pensions to introduce legislation that would preempt shield laws).

10. *See #WeCount Report, April 2022 to June 2025*, SOC'Y FAM. PLAN., https://societyfp.org/research/wecount/wecount-june-2025-data/ [https://perma.cc/28E6-ZBA9] ("Abortion volume is higher in 2024 than it was in 2023 or 2022").

11. *See, e.g.*, David S. Cohen, Greer Donley & Rachel Rebouché, *Abortion Pills*, 76 STAN. L. REV. 317, 324–26 (2024). Note that medication abortion, which consists of mifepristone and misoprostol, is often prescribed off label through the first trimester.

seeks to undermine medication abortion's safety record, which has been established by hundreds of studies and over twenty-five years of use.[12] Questioning the safety of mifepristone—the first drug in a medication abortion—is not new. But in the wake of *Dobbs*, a cohort of states and pro-life organizations have called on courts and the federal government to remove mifepristone from the market, and, relevant to this Essay, to reinstate a restriction that requires in-person pickup, and thus precludes online provision, of the drug.[13]

This Essay maps anti-abortion arguments around harm, evidence, and interstate conflict, but then pivots to review how arguments against mailed medication abortion as well as shield laws have taken on new forms in hopes of persuading courts, legislatures, and the Executive Branch. These claims emphasize the purported problem of coercion and encroachment on ban states' rights to enforce their laws, both of which are harder to measure than arguments about the physical and mental health consequences of mifepristone. And both the coercion and interstate conflict arguments seek to intensify controversies between states that may not only set up a case for the U.S. Supreme Court to decide but also provide a justification for federal agencies to intervene with measures that could curtail abortion access throughout the country.

This Essay proceeds in five parts. The first part describes how shield laws operate, with attention to the subset of laws that have facilitated mailed medication abortion. The second part reviews the attempts to discredit medication abortion in lawsuits challenging the FDA's regulation of mifepristone. The third part considers state lawsuits against shield providers and how those cases seek to test the legality and constitutionality of shield laws. The fourth part considers efforts to emphasize coercion narratives in the legal challenges lodged by individual plaintiffs, either in tort or under newly enacted state legislation that targets out-of-state actors. After offering a descriptive account of the legal challenges to shield laws and mailed medication abortion, the final part offers thoughts about what lies ahead for the contestation of fact, evidence, and patient experience in this area. The current arrangement is no doubt precarious: Mailed medication abortion cannot reach everyone, and shield laws are under pressure. Shield laws'

12. *See* Rachel Rebouché, *Facts on Trial:* All. for Hippocratic Med. v. FDA *and the Battle over Mailed Medication Abortion*, 95 COLO. L. REV. 413, 438–39 (2024) ("Since *Roe* was decided, abortion debates have been waged on the terrain of contested expertise and facts. And in the last twenty years, abortion opponents have sought to generate evidence that abortion correlates with negative health effects, leading to breast cancer or mental health problems, for example.").

13. *See* Motion to Intervene at 1, All. for Hippocratic Med. v. FDA, No. 2:22-cv-00223 (N.D. Tex. Nov. 3, 2023) (highlighting how several states are interested in restricting access to mifepristone); *see, e.g.*, Letter from John Mize, CEO Ams. United for Life, et al., to FDA Comm'r (Jan. 22, 2025), https://aul.org/wp-content/uploads/2025/01/AUL-FDA-LETTER_REMS_Final.pdf [https://perma.cc/PUA3-A3V8].

operation depends on a handful of providers who have made risk assessments without judicial pronouncements about their actions, under the cover of laws being tested now.

Even if shield laws were to fall, aspects of the transformation realized in the wake of *Dobbs* will be hard to roll back. People have taken up telehealth for abortion pills in significant numbers, changing the culture of how people gain access to abortion. No matter what happens to shield laws in the short term, people will continue to order and take pills, although their means of gaining access may shift. Indeed, the attacks on mifepristone's safety are belied by the thousands of people who take the drug without adverse effects. Perhaps more importantly, the arguments against mifepristone, and the corresponding misinformation typically accompanying those claims, point to a deeper contestation about who should deliver abortion care and how abortion care should be delivered. This Essay argues that the anti-abortion movement's evolving legal strategies—centered on claims of coercion and state sovereignty rather than the debunked health risks of mifepristone—serve less as genuine efforts to protect patients or preserve federalism than as vehicles to provoke federal intervention, exploit bipartisan discomfort with mailed medication abortion, and ultimately curtail abortion access nationwide.[14]

I. Shield Laws and Mailed Medication Abortion

Shield laws are state laws that differ in their language across jurisdictions yet share common features.[15] Each law begins by defining legally protected reproductive healthcare, which includes, but is not limited to, pregnancy termination.[16] In short, shield laws seek to prevent the provider's home-state from supporting or aiding out-of-state investigations, whether they be civil, criminal, or in furtherance of professional disciplinary

14. *See* Yvonne F. Lindgren, *When Patients Are Their Own Doctors:* Roe v. Wade *in an Era of Self-Managed Care*, 107 CORN. L. REV. 151, 227 (2022) ("At this historic moment, the medical gatekeeper model must be replaced by a direct access model that comports with modern abortion practice and is best able to protect access in the uncertain times ahead."); *see also* Abigail A. Aiken, Elisa S. Wells, Rebecca Gomperts & James G. Scott, *Provision of Medications for Self-Managed Abortion Before and After the* Dobbs v. Jackson Women's Health Organization *Decision*, 331 JAMA 1558, 1559 (2024); Patty Skuster, *Toward Demedicalization of Abortion Under Law*, *in* ACCESSING ABORTION: GLOBAL AND COMPARATIVE PERSPECTIVES 107, 115–17 (Rachel Rebouché & Mindy Roseman eds., 2026) (describing the evolving acceptance of self-managed abortion and its various definitions).

15. Cohen et al., *Understanding Shield Laws*, *supra* note 6, at 585.

16. *See* UCLA CTR. FOR REPROD. HEALTH, L. & POL'Y, *supra* note 7 (discussing how eighteen of the twenty-two states and DC with shield laws have definitions or provisions that also cover gender-affirming care).

action, of abortions performed legally according to the laws of the provider's home state.

New York's shield law, which is subject to the litigation described in Part III, provides an example. New York amended various codes in 2022 and 2023 that collectively constitute the state's shield law.[17] The shield law covers, like others, legally protected reproductive health care through the protection of providers, facilitators, and patients from criminal and civil liability; protection of providers from professional discipline or adverse insurance actions; and a new tort against out-of-state actors for suits against in-state providers, facilitators, and patients.

Given that travel across state lines for abortion care has doubled since *Dobbs*,[18] shield laws seek to support providers who might be concerned that their in-state activities would be subject to out-of-state attack. For instance, New York will not grant demands to extradite people accused of crimes related to legally protected reproductive health care unless the person was physically present in the demanding state and then fled.[19] As in other shield states, the New York shield law prohibits state entities or agents from cooperating with out-of-state individuals or agencies investigating legally protected health activities in New York.[20] So, per New York law, courts and clerks may not issue subpoenas[21] or orders to testify[22] if in furtherance of a ban state investigation of legally protected reproductive health care.[23] Arrest warrants, on the criminal side, cannot be issued related to legally protected reproductive health care.[24]

Separate amendments to the state code attempt to shield providers from professional discipline or insurance actions based on allegations from ban states about conduct that is legal in the provider's home state.[25] The New

17. *See Protecting and Strengthening Abortion Rights*, N.Y. STATE, https://www.ny.gov/abortion-new-york-state-know-your-rights/protecting-strengthening-abortion-rights [https://perma.cc/CG5R-R4T2] (recounting legislation signed into law "in anticipation" of *Dobbs*).

18. *New Data Show that Interstate Travel for Abortion Care in the United States Has Doubled Since 2020*, GUTTMACHER INST. (Dec. 7, 2023), https://www.guttmacher.org/news-release/2023/new-data-show-interstate-travel-abortion-care-united-states-has-doubled-2020 [https://perma.cc/DDA8-Y8P2].

19. *Protecting and Strengthening Abortion Rights*, *supra* note 17; *see* Alejandra L. Caraballo, Cynthia Conti-Cook, Yveka Pierre, Michelle McGrath & Hillary Aarons, *Extradition in Post*-Roe *America*, 26 CUNY L. REV. 1, 29–30 (2023) (discussing the finding of the North Carolina Supreme Court which requires more than constructive presence).

20. N.Y. EXEC. LAW § 837-x (McKinney 2022).

21. N.Y. C.P.L.R. 3119(g) (McKinney 2011).

22. *Id.*; N.Y. C.P.L.R. 3102(e) (McKinney 1963).

23. N.Y. C.P.L.R. 4550 (McKinney 2023) (prohibiting state actors from providing evidence to out-of-state officials of the care delivered to a person not physically present in New York).

24. N.Y. CRIM. PROC. LAW § 140.10(3-a) (McKinney 1970).

25. N.Y. EDUC. LAW § 6531-b (McKinney 2022); N.Y. PUB. HEALTH LAW § 230(9-c) (McKinney 1975); N.Y. INS. LAW § 3436-a (McKinney 2022).

York state medical board may not, for example, suspend or revoke a physician's license for providing legally protected health care[26] and in-state malpractice insurance companies may not raise those providers rates, so long as they were following the laws of the shield state.[27] New York, similar to other shield states, permits a person delivering legally protected reproductive health care to pursue a cause of action for the unlawful interference with their state statutory rights.[28]

Finally, shield laws in eight states, including New York, define legally protected reproductive health care regardless of where the patient lives, seeking to deliver care provided through telehealth as well as delivered to patients traveling to the shield state.[29]

Mailed medication abortion has a history longer than the passage of eight shield laws.[30] The FDA previously required in-person dispensation of mifepristone; the agency suspended that restriction in 2021 and made the change permanent in 2023.[31] Providers began prescribing pills to patients

26. N.Y. PUB. HEALTH LAW § 230(9-c) (McKinney 1975).

27. N.Y. INS. LAW § 3436-a (McKinney 2022).

28. N.Y. CIV. RIGHTS LAW § 70-b (McKinney 2022). Additionally, New York has an address confidentiality program. N.Y. EXEC. LAW § 108 (McKinney 2011).

29. Cohen et al., *Abortion Shield Laws in Action*, *supra* note 6, at 911 ("In 8 states, the shield law protects . . . clinician[s] who deliver care to a person via telemedicine"); *see also* N.Y. CRIM. PROC. LAW § 570.17 (including telehealth services in legally protected health activity). Of those that permit and protect abortion access, California, Colorado, Maine, Massachusetts, New York, Rhode Island, Vermont, and Washington define legally protected reproductive health care regardless of patient location when delivered by a licensed provider physically present in the state. CAL. PENAL CODE § 1549.15(b)(1)(C) (West 2024); COLO. REV. STAT. ANN. § 12-30-121(1)(d) (West 2023); ME. REV. STAT. ANN. tit. 14, § 9002(8)(B) (2024); MASS. GEN. LAWS ANN. ch. 12, § 11I1/2(a) (West 2025); N.Y. CRIM. PROC. LAW § 570.17(1)(a) (McKinney 2025); 23 R.I. GEN. LAWS ANN. § 23-101-2 (West 2024); VT. STAT. ANN. tit. 1, § 150(b)(1)(B) (West 2025). Washington describes its shield law as a matter of public policy. WASH. REV. CODE ANN. § 7.115.020 (West 2025). This is a departure from standard telehealth practice, which considers care to have occurred where the patient is located. Cohen et al., *Abortion Pills*, *supra* note 11, at 330. *See* INTERSTATE MED. LICENSURE COMPACT § 1, https://imlcc.com/wp-content/uploads/2021/02/IMLC-Compact-Law.pdf [https://perma.cc/DC8Q-VJ5X] ("The Compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located."); UNIFORM TELEHEALTH ACT § 10(a) (NAT'L CONF. COMM'RS ON UNIF. STATE L. 2022) ("The provision of a telehealth service under this [act] occurs at the patient's location at the time the service is provided.").

30. Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. REV. 1355, 1384–85 (2021) (describing an Investigational New Drug Approval to deliver medication abortion without the in-person collection requirement in 2016 and a federal district court decision that suspended in-person dispensation during the COVID-19 pandemic).

31. *See* Cohen et al., *Abortion Pills*, *supra* note 11, at 326–27. Describing the FDA restrictions that have historically been in place for mifepristone, the authors explain:

> When the FDA approved mifepristone as an abortifacient in 2000, it required the manufacturer to adhere to distribution limitations that had been rarely applied to other drugs and that were, as many have argued, excessive in light of the drug's safety.

after a telehealth consultation, conducted either in real-time or based on a set of vetted questionnaires, and mailing pills to patients using online pharmacies.[32] For those who can take pills to end their pregnancies, no part of the process needs to be in person: the patient, provider, and pharmacy all interact virtually.[33]

States that ban abortion prohibit all forms of pregnancy termination, including medication abortion, whether delivered in person or online. But under a subset of shield laws, if providers are located and licensed in their home shield states, following their state's laws, the location of the patient receiving the pills should not matter.

> Indeed, after more than twenty years on the U.S. market, mifepristone has become one of the most studied drugs available and has proven to be exceptionally safe—many times safer than common drugs like penicillin or Viagra and fourteen times safer than childbirth. It is currently FDA-approved only through the first ten weeks of pregnancy, but some providers use it off label throughout the first trimester.
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> Despite the drug's exemplary safety record, the FDA imposed a Risk Evaluation and Mitigation Strategy (REMS) with "Elements to Assure Safe Use," which is a tool Congress created to help the FDA regulate particularly risky products. Mifepristone's current REMS has several parts. First, providers must be specially certified to prescribe mifepristone. That is, providers submit a form to the drug sponsor certifying that they can "assess the duration of pregnancy accurately," "diagnose ectopic pregnancies," and "provide surgical intervention" or "have made plans to provide such care through others." Next, providers must review and have patients sign a Patient Agreement Form. The Patient Agreement Form sets out mifepristone's benefits and risks, duplicating the informed consent process already required for every healthcare provider. Finally, the REMS allows only certified pharmacies to dispense the drug (either by mail or in person); these pharmacies must attest that they will engage in a number of recordkeeping, medication-tracking, and confidentiality measures. The pharmacy certification requirement—described below and finalized in January 2023—was part of FDA's removal of the longstanding rule that patients had to collect the drug at a healthcare facility, almost always a clinic. The old rule forced patients to travel to pick up a prescription they could safely take at home without any provider supervision. This rule had negated much of the promise of abortion pills, subjecting them to some of the same burdens as procedural abortion. On the heels of litigation during the COVID-19 pandemic, the FDA lifted the in-person requirement, thus ushering in the broader uptake of telehealth and mailed abortion pills.

Id. (citations omitted).

32. U.S. Food & Drug Admin., Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200 MG, 2–3 (2021).

33. *See* Cohen et al., *Abortion Pills*, *supra* note 11, at 328–29 (describing how telehealth abortion services reach patients in states with abortion bans). For example, Abortion on Demand, the first large-scale, telehealth abortion service operated by a U.S.-based provider, is a virtual clinic for which the entire process, from online, asynchronous counseling to receipt of abortion pills, takes on average forty-eight hours, operating in states where telehealth for medication abortion is legal. *Frequently Asked Questions*, ABORTION ON DEMAND, https://abortionondemand.org/faq/ [https://perma.cc/FD4G-RRJH]. The Massachusetts Medication Abortion Access Project is an "asynchronous telemedicine platform to provide medication abortion care to abortion seekers throughout the United States," using a similar model to Abortion on Demand. Patients attest pills are for their own use, answer a questionnaire that asks about possible coercion, and present photo identification. Cambridge Reproductive Health Consultants, The MAP, https://www.cambridgereproductivehealthconsultants.org/map [https://perma.cc/372T-AM4P].

Medication abortion has become how most people nationally and in abortion-ban states end their pregnancies post-*Dobbs*. According to the latest data from the #WeCount study, which counts abortions since *Roe* was overturned, more abortions occur on average now than in 2022, before *Dobbs*. In fact, the average number of abortions has increased even in states with a near total abortion ban.[34] Shield providers facilitated nearly 15,000 abortions per month in the second quarter of 2025,[35] with patients in states with abortion bans after conception or after six weeks of gestation receiving most of those pills.[36] Mailed pills have blunted some of the effects of *Dobbs* in creating avenues for care, but some populations are left behind. Telehealth for medication abortion depends on patients having access to the internet, an uncomplicated first-trimester pregnancy, not being on medications contraindicated for abortion pills, and patient preferences, among other factors. The need for clinical spaces will remain.

Even with these limitations, mailed medication abortion has changed abortion access.[37] Although policing pills across state lines is not impossible, it would be costly and logistically difficult, potentially requiring increased surveillance and punishment.[38] Given these challenges, the shield laws facilitating the transit of pills into ban states have been the focus of the anti-abortion movement.

The next sections describe the litigation to strip mifepristone of its FDA approval or reimpose prior restrictions, which could upend the online dispensation of mifepristone, before describing the lawsuits taken by states and individuals to challenge shield laws. Each lawsuit claims that mailed mifepristone threatens states' sovereignty to enforce abortion laws and exposes people to pressure or force in ending wanted pregnancies. Both claims are contestable and both represent an evolution in anti-abortion strategy. No one can rule out the possibility of medication diversion, just as no one could prove that a medication never has been misused; there certainly is interstate disagreement over abortion regulation. But the prominence of these arguments is not because of the former's frequency or the latter's consequences for federalism or states' rights. Rather than offering empirical heft, anti-abortion arguments offer a roadmap of where the abortion debate is heading and what is at stake for both sides.

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34. *#WeCount Report, April 2022 to June 2025*, SOC'Y OF FAM. PLAN., https://societyfp.org/research/wecount/wecount-june-2025-data/ [https://perma.cc/28E6-ZBA9].

35. *Id.*

36. Abigail A. Aiken, James G. Scott & Rebecca Gomperts, *Provision of Abortion Medications Using Online Asynchronous Telemedicine Under Shield Laws in the US*, 334 JAMA 1388, 1388 (2025).

37. *See generally* Protecting Women: Exposing the Dangers of Chemical Abortion Drugs Before the S. Comm. Health, Educ., Lab. & Pensions, 119th Cong. (2026).

38. Cohen et al., *Abortion Pills*, *supra* note 11, at 399.

Anti-abortion claims are fundamentally political: they redirect public attention away from the discredited case against mifepristone's safety toward allegations of coercion and interstate conflict, issues designed to provoke outrage and supply a justification for federal intervention. But this strategic move carries an underappreciated cost for the anti-abortion movement. By anchoring its campaign to the legal system—court rulings, federal agency action, and legislation—the movement has ceded terrain related to on-the-ground access. While anti-abortion advocates wait on pronouncements from judges and regulators, the abortion-rights movement can adapt, rerouting care around restrictions as it has done since *Dobbs*. Yet the debate over mailed medication abortion also reveals a vulnerability on the other side: Even among reproductive rights supporters, there remains a reluctance to fully defend abortion care that is untethered from in-person provider oversight—a hesitation that anti-abortion strategies are well positioned to exploit.[39]

II. Challenges to FDA Regulation of Mifepristone

Anti-abortion groups have sought to reinstate the in-person dispensation requirement that previously blocked mailing mifepristone and to rescind the FDA's approval of mifepristone in 2000.[40] If either of these changes were to occur, shield providers would face obstacles in mailing pills into states with bans, either because the FDA would not permit mailing mifepristone, which would change the label and the distribution of the drug, or because mifepristone would not be an FDA-approved drug.[41]

39. Shira Stein, *The Unexpected Opponent of Shield Laws: Planned Parenthood*, S.F. CHRON., (June 11, 2024), https://www.sfchronicle.com/politics/article/planned-parenthood-telehealth-abortion-19494709.php [https://perma.cc/KEZ9-KQT9].

40. *See, e.g.*, Letter from John Mize, CEO Ams. United for Life, et al., to FDA Comm'r (Jan. 22, 2025), https://aul.org/wp-content/uploads/2025/01/AUL-FDA-LETTERREMSFinal.pdf [https://perma.cc/PUA3-A3V8] (urging the FDA commissioner to reconsider the approval of Mifeprex, the brand name for mifepristone, and to dispense of the in-person requirement in obtaining medication abortion).

41. If the FDA changes its approval of mifepristone by, for instance, returning to the requirements in place before 2016, the drug's label would change and thus change distribution, marketing, and use. And the FDA could deem existing supplies of mifepristone as misbranded. *See* Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 331(a), 331(d), 355(a) (outlining prohibitions on misbranded drugs in interstate commerce).

In November 2022, a group of anti-abortion doctors, the Alliance for Hippocratic Medicine (Alliance), sued the FDA.[42] Alliance argued that the agency had not only violated federal law when it eased restrictions on mifepristone, first in 2016 and then in 2021 (the latter change made permanent in 2023), but also by approving mifepristone in the first place in 2000.[43] The core of their argument was that mifepristone resulted in individual, population, and institutional harm the FDA allegedly discounted. In April 2023, the U.S. District Court for the Northern District of Texas issued a preliminary injunction suspending mifepristone's FDA approval.[44]

The Fifth Circuit, on appeal, held that the Alliance likely failed to timely challenge the 2000 FDA approval, or show that they had suffered an injury because of mifepristone's generic approval in 2019. The appellate court agreed with the lower court that the plaintiffs lacked standing to challenge mifepristone's approval, but found standing to attack the agency's post-2016 changes to the regulation of mifepristone—including lifting the in-person dispensation requirement that spurred on telehealth for abortion.[45] A panel of the Fifth Circuit held that the FDA's actions in lifting restrictions on mifepristone might be unlawful by citing the opinion of the lower court, which relied on the declarations of doctors who attested that they had cared for patients experiencing negative side effects after taking mifepristone, drawing time and resources away from other patients.[46] The case was appealed, this time by the FDA, and a unanimous U.S. Supreme Court found that the Alliance did not have standing to bring its claims because neither the organization nor its members could show that the FDA's actions caused them actual injury.[47]

Decided on procedural grounds, the Supreme Court did not take up the substantive issues of the *Alliance* case and remanded it.[48] But Justice Kavanagh, who wrote the Court's majority opinion, noted that "it is not clear that no one else would have standing to challenge FDA's relaxed regulation of mifepristone," signaling that the Court might be willing to hear the case so long as the parties establish standing.[49] Anticipating the Supreme Court's decision, the Attorneys General of three states—Missouri, Kansas, and

42. Complaint at 1, All. for Hippocratic Med. v. FDA, 668 F. Supp. 3d 507 (N.D. Tex. 2023) (No. 2:22-cv-00223-Z).

43. *Id.* at 6–7.

44. All. for Hippocratic Med. v. FDA, 668 F. Supp. 3d 507, 560 (N.D. Tex. 2023).

45. All. for Hippocratic Med. v. FDA, 78 F.4th 210, 239–40, 242 (5th Cir. 2023), *rev'd and remanded sub nom.* FDA v. All. for Hippocratic Med., 144 S. Ct. 1540 (2024).

46. *See id.* at 230–32 (relying on declarations of emergency-care doctors to establish standing).

47. FDA v. All. for Hippocratic Med., 144 S. Ct. 1540, 1563 (2024).

48. *See id.* (holding that the plaintiffs lack Article III standing as the alleged injury in fact was too speculative in nature).

49. *Id.* at 1564.

Idaho—intervened in the case to assert their state's standing.[50] These states argued that mailing abortion pills across their borders under shield laws harms their citizens and threatens their states' rights to enforce abortion bans.[51] On remand, the district court judge allowed the intervention[52] but transferred the case to the U.S. District Court for the Eastern District of Missouri after the Trump Administration's Department of Justice (DOJ) supported a motion to dismiss the case.[53]

In October 2025, Louisiana brought a lawsuit against the FDA, making the same arguments and adding an individual complainant. The complainant alleged that she ended a pregnancy under coercion and had the FDA "required an in-person office visit, a medical professional would have screened [the complainant] for coercion and abuse."[54] Louisiana only challenged removal of the in-person dispensation requirement.[55] In December 2025, Texas and Florida sued the FDA for all the agency's actions regarding the drug since mifepristone's approval in 2000.[56] Texas and Florida, according to their complaint, seek "[t]o protect their residents and vindicate their economic and sovereign interests";[57] those economic interests included "the expense of investigating, prosecuting, and enforcing judgments for illegal mail-order abortions."[58]

The arguments in each lawsuit tracked those offered by the Alliance but depart in notable ways with an emphasis on coercion and states' sovereign or quasi-sovereign interests. These claims are designed not only to establish standing but also to raise the political stakes and demonstrate the broader costs of mailed mifepristone.

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50. Motion to Intervene at 1, All. for Hippocratic Med. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. Nov. 3, 2023).

51. Motion to Intervene Exhibit 1, Complaint at 4, 9, All. For Hippocratic Med. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. Nov. 3, 2023).

52. All. for Hippocratic Med. v. FDA, No. 2:22-cv-00223-Z, 2024 WL 1260639, at *7 (N.D. Tex. Jan. 12, 2024).

53. Defendants' Reply Memorandum in Support of Motion to Dismiss at 10, Mo. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. May 5, 2025); Plaintiff's Motion for Leave to Supplement the Amended Complaint, Mo. v. FDA, No. 4:25-cv-01580 (E.D. Mo. Nov. 19, 2025) ("[T]he Northern District of Texas issued an order transferring this case to the Eastern District of Missouri.").

54. Complaint at 45, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Oct. 6, 2025); *id.* at 3 (noting that the complainant felt forced to take abortion drugs that her boyfriend obtained via the U.S. Postal Service and that "[b]ut for FDA's 2023 REMS, [the complainant] would have received the protection of a private in-person medical appointment . . . to tell a doctor that she did not want an abortion"). The anti-abortion movement has long cast doubt on the judgment of abortion providers yet now argues that in-person provider contact is necessary to screen for intimate partner violence—a reversal that underscores the strategic, rather than evidence-based, nature of the coercion claim.

55. Complaint at 2, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Oct. 6, 2025). At the time of writing, the FDA has asked for a stay of this case detailed in this part.

56. Complaint at 1, 6, Fla. v. FDA, No. 7:25-cv-126-O (N.D. Tex. Dec. 9, 2025).

57. *Id*. at 6.

58. *Id.* at 76.

First, according to the amended complaint of the *Alliance* suit against the FDA in which Missouri, Kansas, and Idaho intervened, "the FDA has enabled online abortion providers to mail FDA-approved abortion drugs to women in states that regulate abortion—dispensing abortion drugs with no doctor care, no exam, and no in-person follow-up care. These dangerous drugs are now flooding states like Missouri and Idaho and sending women in these States to the emergency room."[59] However, the shield provision described by the briefs involves doctor care, through a virtual exam and vetted questionnaire, instructions for use, contacts for advice or help, and follow-up communication.[60] Nevertheless, these recent legal actions emphasize both physical and mental harms as well as the threat of coercion by "people other than pregnant women [who] can order abortion drugs with ease."[61] As Mary Ziegler and Dov Fox recently wrote:

> Woman-protective antiabortion arguments are not new, but abortion-coercion claims are different: they suppose that individual decision-makers lack the moral or legal voluntariness required to qualify their consent to abortion as meaningfully free. This argument that the *choice* to end one's pregnancy itself overrides a woman's true will is distinct from the argument that abortion has *consequences* that harm her, or that the abortion decision is voluntary but uninformed.[62]

The arguments in the FDA briefs bypass allegations of post-abortion regret or incomplete informed consent and attack the premise that women will be robbed of any meaningful choice at all.[63]

Second, the states (as did the Court of Appeals for the Fifth Circuit in the original *Alliance* litigation) assert that the FDA acted unlawfully because it did not consider the proper evidence on the safety of mifepristone.[64] For instance, the FDA purportedly did not assess the cumulative effects of the changes made to mifepristone's restrictions and erred in removing the requirement that prescribers report all adverse effects.[65] In both instances, the FDA had no duty to collect that data, and there is no evidence that the safety

59. Amended Complaint at 2, Mo. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. Oct. 11, 2024).

60. Angel M. Foster, Alice Mark, Kyle J. Drouillard, Maureen Paul, Susan Yanow, Sarah Shahi, Dipesh Suvarna & Andrea Peña, *"Trust Women": Characteristics of and Learnings from Patients of a Shield Law Medication Abortion Practice in the United States*, 56 PERSP. SEX & REPROD. HEALTH 295, 295–96 (2024) (detailing the shield provision from Massachusetts and patient-clinician contact).

61. Complaint at 29, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Oct. 6, 2025).

62. Dov Fox & Mary Ziegler, *Reproductive Abuse*, 74 UCLA L. REV. (forthcoming 2026) (manuscript at 4) (on file with author).

63. Defendants' Memorandum in Support of Motion to Stay the Case and in Response to Plaintiffs' Motion for Preliminary Relief, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Jan. 27, 2026).

64. Amended Complaint at 31–33, Mo. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. Jan. 16, 2025).

65. *Id.*

or efficacy record of mifepristone would change had the FDA done what litigants claim was required.[66] Indeed, in January 2026, the Journal of the American Medical Association (JAMA) published a study of the FDA's decision-making process of mifepristone, and the authors, having reviewed over five-thousand pages of the agency's internal documents, found that the FDA made decisions based on the scientific and medical evidence.[67] The only two times the FDA appeared to act in contradiction to scientific evidence occurred when the agency retained, rather than lifted, a restriction on mifepristone—one of which concerned mifepristone's in-person pick-up rule during the COVID-19 pandemic.[68]

Third, the various states' briefs in each lawsuit charged that the FDA's decision to eliminate in-person dispensing was unlawful because it contravenes "the federal laws that prohibit the distribution of abortion drugs by postal mail, express company, or common carrier and by interactive computer service."[69] This federal law, the Comstock Act, and efforts to revive it are described in Part IV.

Fourth, and representing another departure from the original *Alliance* litigation, the states' complaints argue that shield provision is an "extra-territorial effort"[70] which "caus[es] hundreds of unlawful abortions in [pro-

66. *E.g.*, Rebouché, *Facts on Trial*, *supra* note 12, at 435 (noting that the FDA considered the cumulative effect of the 2016 changes and decided that they were safe, but, according to the Fifth Circuit, did not use the Fifth Circuit's preferred wording); *see also* Adam Unikowsky, *The Fifth Circuit's Mifepristone Opinion Is Wrong, Part 2*, ADAM'S LEGAL NEWSL. (Aug. 20, 2023), https://adamunikowsky.substack.com/p/the-fifth-circuits-mifepristone-opinion-157 [https://perma.cc/6BWG-C5JV] (noting that the FDA stated at the time of the 2016 revisions: "'After 15 years of reporting serious adverse events, the safety profile of Mifeprex is essentially unchanged . . . reporting of labeled serious adverse events other than deaths can be collected in the periodic safety update reports and annual reports to the Agency.'").

67. Sophie Dilek, Joanne Rosen, Anna Levashkevich, Joshua M. Sharfstein & G. Caleb Alexander, *The US Food and Drug Administration's Regulation of Mifepristone*, 335 JAMA 619, 619–20 (2026).

68. Discussing two moments in which the FDA should have intervened:

> In our document review, we identified 2 moments of potential intervention from FDA political appointees on decisions that ran contrary to the perspective of agency scientists on appropriate evidence-based regulation. In 2016, the FDA commissioner decided, over the apparent objections of the review division, to maintain a requirement for a patient agreement form. . . . In June 2020, the scientific team's conclusion that in-person dispensation was not required during the COVID-19 pandemic was not adopted as the agency's position in response to a court challenge by ACOG against the continuation of this requirement during the pandemic. On the same day that a memo from the scientific team concluded that the in-person dispensation requirement was not needed, the agency filed a brief opposing the challenge.

Id. at 623.

69. Amended Complaint at 5, Mo. v. FDA, No. 2:22-cv-00223-Z (N.D. Tex. Oct. 11, 2024).

70. Complaint at 8, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Oct. 6, 2025).

life] states every month"[71] and "with impunity and without any fear of liability."[72]

This fourth assertion has inspired political leaders to weigh in on the FDA's regulation of mifepristone.[73] All but two Republican senators signed a letter that "abortion pills [are] systematically undermining states' rights and violating pro-life state laws."[74] Citing a study by the Ethics & Public Policy Center (EPPC), an anti-abortion non-profit organization whose research has been the subject of criticism for its lack of scientific method and rigor,[75] the letter asserts the dangers of mifepristone and the "thousands of abortion drugs [ ] shipped into states that have otherwise limited access to abortion after *Dobbs*."[76] The senators' letter to the U.S. Department of Health and Human Services (HHS) followed one drafted by sixteen state attorneys general in July 2025[77] and another from 176 Republican Members of Congress in November 2025 asking for the HHS, through the FDA, to reconsider the restrictions on mifepristone.[78]

The FDA has pledged to study mifepristone's safety in response.[79] HHS Secretary, Robert F. Kennedy Jr., issued a letter that cited the refuted study published by the EPPC. In contradiction to the findings of the JAMA study described above, the letter referred to the FDA's "lack of adequate consideration" of the safety risks "underlying the prior REMS [Risk

71. *Id.* at 23.

72. *Id*. at 31. On this point, it is worth noting that a 2022 study documenting the number of abortions post-*Dobbs* had been published only a month before the *Alliance* case was first initiated.

73. For example, before the Senate Committee on Health, Education, Labor and Pensions (HELP) on the safety of mifepristone, Liz Murrill, Attorney General of Louisiana, repeated accounts of women who assert that they were coerced into taking mail-ordered abortion drugs or even poisoned by their partners with them. *Witnesses Testify on the Use of Chemical Abortion Drugs*, C-SPAN (Jan. 14, 2026), https://www.c-span.org/program/senate-committee/witnesses-testify-on-the-use-of-chemical-abortion-drugs/671632 [https://perma.cc/5KXZ-K62D] (video of hearing).

74. Graham et al., *supra* note 9.

75. Irving Washington, Hagere Yilma & Joel Luther, Established Report Aims to Undercut Established Research on Abortion Pill Safety, Plus How a Federal Initiative to Study Autism May Overemphasize Environmental Toxins, KFF (June 12, 2025), https://www.kff.org/health-information-trust/flawed-report-aims-to-undercut-established-research-on-abortion-pill-safety-plus-how-a-federal-initiative-to-study-autism-may-overemphasize-environmental-toxins/ [https://perma.cc/9QVJ-JQC6].

76. Graham et al., *supra* note 9.

77. Letter from Tim Griffin, Ark. Att'y Gen., et al., to John Thune, Senate Majority Leader, Charles Schumer, Senate Minority Leader, Mike Johnson, Speaker of the House & Hakeem Jeffries, House Minority Leader (July 29, 2025), https://media.ark.org/ag/Letter-to-Senate-HELP-cmte-Shield-Laws-FINAL.pdf [https://perma.cc/DR8R-SDJC].

78. Letter from Rep. Christopher H. Smith et al., to Robert F. Kennedy Jr., Sec'y, U.S. Dep't Health & Hum. Servs., and Martin Makary, Comm'r, FDA (Nov. 20, 2025), https://drive.google.com/file/d/1LPEGlb4k16V7A7tqbztTCLRbTdETcotX/view?pli=1 [https://perma.cc/4FZZ-USE4].

79. Letter from Martin A. Makary, Comm'r, FDA., to Sen. Josh Hawley (June 2, 2025), http://media.aclj.org/pdf/Makary-Letter-6.2.25.pdf [https://perma.cc/9W2S-YME4].

Evaluation and Mitigation Strategies] approvals," including the decision to "remov[e] the in-person dispensing requirement" and the "potential dangers that may attend offering mifepristone without sufficient medical support or supervision."[80] Secretary Kennedy indicated that the HHS plans to conduct "its own review of the evidence, including real-world outcomes and evidence, relating to the safety and efficacy of the drug."[81] The letter failed to mention that mifepristone is one of the most studied drugs in the country with a consistent track record of safety and efficacy.[82]

Both Republicans and Democrats have expressed frustration with the agency: Republicans for the FDA's "slow walking" the review and Democrats for the agency's failure to articulate the need for or a process for the review the first place.[83] The Center for Reproductive Rights sued the FDA and HHS for failure to answer its FOIA requests about "the process the FDA plans to use to conduct this review, and whether the FDA will be considering data from EPPC and/or other third parties during such review."[84] Then, the full Democratic Caucus wrote a response to Secretary Kennedy calling on

80. Letter from Robert F. Kennedy, Sec'y, U.S. Dep't of Health & Hum. Servs., and Martin Makary, Comm'r, FDA, to Attorneys General (Sep. 19, 2025), https://democracyforward.org/wp-content/uploads/2025/09/Fda_Hhs_Letter-1.pdf [https://perma.cc/5W9M-REQ9]. "Mifeprex and its generic, Mifepristone Tablets, 200 mg, are available under a single, shared system risk evaluation and mitigation strategy (REMS), known as the Mifepristone REMS Program, which sets forth the requirements that must be followed for prescribing and dispensing mifepristone for medical termination of pregnancy through ten weeks gestation." *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation [perma.cc/YZ2K-UVYQ].

81. Kennedy & Makary, *supra* note 80.

82. Morgan Coulson, *What Is Mifepristone?*, JOHNS HOPKINS BLOOMBERG SCHOOL OF HEALTH (Oct. 8, 2025), https://publichealth.jhu.edu/2025/what-is-mifepristone-aka-the-abortion-pill [https://perma.cc/YB86-V39H].

83. *See generally* Protecting Women: Exposing the Dangers of Chemical Abortion Drugs Before the S. Comm. on Health, Educ., Lab. & Pensions, 119th Cong. 3–4, 13 (2026) (statements of Senators Patty Murray and Jim Banks) (with Republican Senator Jim Banks expressing concern about FDA's "slow-walking" and Democratic Senator Patty Murray emphasizing the lack of basis for FDA's review); *see also* Alice Miranda Ollstein, *GOP Senators Rail at FDA after Closed-Door Briefing on Abortion Drug*, POLITICO (Feb. 11, 2026), https://www.politico.com/live-updates/2026/02/11/congress/bitter-pills-00775740 [https://perma.cc/GWB5-XQWV] (quoting concerns voiced by several Republican senators regarding the speed of the FDA's review of mifepristone).

84. Complaint at 5, Ctr. for Reprod. Rts. v. Dep't of Health & Hum. Serv., No. 1:25-cv-03023-RCL (D.D.C. Sep. 5, 2025). The Center for Reproductive Rights filed FOIA requests after Secretary Kennedy's testimony before the Senate Health, Education, Labor and Pensions Committee, where he stated that he had directed FDA Commissioner Makary to conduct a review of mifepristone in part because of the EPPC study. *Hawley Secures Pledge from RFK to Review 'Alarming' Mifepristone Data, Support Bill Cracking Down on Big Pharma Ads*, JOSH HAWLEY U.S. SENATOR FOR MISSOURI (May 14, 2025), https://www.hawley.senate.gov/hawley-secures-pledge-from-rfk-to-review-alarming-mifepristone-data-support-bill-cracking-down-on-big-pharma-ads/ [https://perma.cc/SA7Q-EKSD].

the FDA to disclose the information on which it will rely and the process by which it will conduct a review—a process, the letter makes clear, that is unnecessary given mifepristone's history of safety.[85]

On the basis of the FDA's review, in the Louisiana litigation, the agency asked for a stay because "[g]iven this widespread debate over the safety of mifepristone, FDA has concluded that the best path forward is for the agency to reconsider the restrictions on mifepristone based on all the evidence before the agency."[86] The FDA continued:

> Plaintiffs now threaten to short circuit the agency's orderly review and study of the safety risks of mifepristone by asking this Court for an immediate stay of the 2023 REMS Modification approved three years ago. They would have this Court set aside the 2023 REMS Modification—all without the benefit of FDA's expertise, and even as the agency is already reconsidering the matter in its review. And Plaintiffs' requested relief may prove as unnecessary as it is disruptive, if FDA ultimately decides that the in-person dispensing requirement must be restored.[87]

Again, it is not clear what process the FDA will use, or on what information it will rely, but reinstating the in-person dispensation requirement would be ripe for a legal challenge because the agency's decision would contradict established evidence as well as a federal district court decision.[88]

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85. Letter from Sen. Patty Murray et al. to Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., and Marty Makary, Comm'r, FDA. 1, 4–5 (Nov. 6, 2025), https://www.murray.senate.gov/wp-content/uploads/2025/11/11.06.2025-Letter-to-HHS-and-FDA-re-Mifepristone-Review-FINAL.pdf [https://perma.cc/JQQ2-9RP9].

86. Defendants' Memorandum in Support of Motion to Stay the Case and in Response to Plaintiffs' Motion for Preliminary Relief at 3, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Jan. 27, 2026). Recognizing that its restrictions on mifepristone have been deeply contested for many years, the FDA observed:

> Louisiana and Ms. Markezich are not the only plaintiffs to have challenged the current requirements for dispensing mifepristone. Indeed, five other states are challenging either the approval of mifepristone or subsequent actions easing restrictions. See Missouri v. FDA, No. 4:25-cv-1580-CMS (E.D. Mo.) (Missouri, Idaho, and Kansas challenging actions easing REMS restrictions) . . . Still other plaintiffs have challenged FDA's restrictions as too burdensome. And aside from litigation, before the FDA are numerous citizen petitions—citing voluminous material and seeking mutually inconsistent relief, such as suspending approval of the drug, restoring previous REMS requirements, or eliminating the REMS entirely.

Id. at 2 (citations omitted).

87. Defendants' Memorandum in Support of Motion to Stay the Case and in Response to Plaintiffs' Motion for Preliminary Relief at 3, La. v. FDA, No. 6:25-cv-01491 (W.D. La. Jan. 27, 2026).

88. *See infra* Part V (discussing what might happen in the wake of FDA reimposition of the in-person dispensation requirement).

The Democratic Caucus's letter cites that decision by a federal district court, which held that the FDA erred in regulating mifepristone too strictly.[89] In an almost mirror image of the *Alliance* litigation, on October 30, 2025, a federal district court in Hawaii handed down the decision, *Purcell v. Kennedy*,[90] which struck down part of the FDA restrictions on mifepristone as unsupported by the evidence and unwarranted as a matter of law.[91] And *Purcell* is not the first time a federal court has concluded that restrictions on mifepristone are unnecessary given the drug's safety and efficacy.[92]

For now, per *Purcell*, the REMS stays in place as it is.[93] In asking the FDA to review its restrictions to be consistent with the findings of the opinion, the *Purcell* court held that the FDA failed to engage evidence that mifepristone's restrictions are medically unnecessary, ignoring voluminous peer-reviewed research on mifepristone's safety.[94] The crux of the FDA's error, according to the court, was its failure to apply the statutory factors mandated for the initial and continuing FDA review of a drug.[95] Those factors include weighing the risks and benefits of the drug as well as the burdens that restrictions impose on patients' ability to gain access to the medication.[96] The court opined that the agency had engaged in "cherry pick[ing]" which factors, and thus what research, to emphasize in its review processes.[97] So, while

89. Letter from Sen. Patty Murray et al., to Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., and Marty Makary, Comm'r, FDA. 1, 4–5 (Nov. 6, 2025), https://www.murray.senate.gov/wp-content/uploads/2025/11/11.06.2025-Letter-to-HHS-and-FDA-re-Mifepristone-Review-FINAL.pdf?utm_source=substack&utm_medium=email [https://perma.cc/JQQ2-9RP9].

90. No. 17-00493 JAO-RT, 2025 WL 3101785 (D. Haw. Oct. 30, 2025).

91. *Id.* at *23, *28.

92. As happened during the *Alliance* litigation, contradictory federal court judgments on the legality of the FDA's regulation of mifepristone are likely. *See* Wash. v. FDA, No. 1:23-cv-3026-TOR, 2025 WL 1888794, at *1–*3 (E.D. Wash. 2025) (discussing another case in which plaintiffs challenged REMS as too restrictive); Complaint for Declaratory and Injunctive Relief at 5, Whole Woman's Health All. v. FDA, No. 3:23-cv-00019 (W.D. Va.) (challenging the restrictiveness of REMS).

93. The 2023 REMS protocol requires clinicians who intend to prescribe mifepristone to be certified under the Mifepristone REMS Program; they must review and sign a patient agreement form along with the patient and discuss the risks of the medication abortion regimen. The patient must be provided a copy of the signed form and an FDA-approved medication guide. The clinician reviews the patient's medical and pregnancy history and then may prescribe the medication through a telehealth consultation. *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. FOOD & DRUG ADMINISTRATION, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation [https://perma.cc/P6Q5-DJJ3].

94. *Purcell*, 2025 WL 3101785, at *27–*28.

95. *Id.* at *2.

96. *Id.* at *21–*22.

97. *Id.* at *25. A study critiquing flawed research on medication abortion mentions:

> [D]ecades of scientific evidence amassed through more than 100 studies—based on hundreds of thousands of patient outcomes—have established the safety record for

states' briefs assert the FDA ignored pertinent evidence of mifepristone's dangers, the *Purcell* court held that the FDA did not give due weight to evidence of its safety or the benefits versus the costs of its use.

The fight among states over shield laws extends beyond what the FDA will or will not do. In a separate letter, several state attorneys general wrote to "urge [Congress] to consider preempting abortion shield laws," which they described as "blatant attempts to interfere with States' ability to enforce criminal laws within their borders, and disrupt our constitutional structure."[98] This call for federal legislation followed actions by Texas and Louisiana to punish a New York shield provider and to test the enforcement, and ultimately the constitutionality, of shield laws.[99] This litigation sets the stage for federal action, by Congress or by the Trump Administration, as well as a potential case before the Supreme Court. Although this Essay will not analyze the various justifications states could offer to defend shield laws, shield provision does not pose a threat to federalism or states' right.[100] Yet the point of concentrating on state conflict is not to arrive at a new understanding of states' power to protect or prohibit abortion. Rather, as further described below, the point is to refocus on the debate on federal solutions to stop mailed pills.

> mifepristone use in medication abortion. At several key points, the FDA reviewed this body of science in the past 25 years and confirmed, each time, the safety and effectiveness of mifepristone.

Ushma Upadhyay, *Rev. of Hall & Anderson Rep. on Abortion Safety*, ANSIRH, 1, 1 (2025), https://www.ansirh.org/sites/default/files/2025-09/Anderson%20and%20Hall%20ReviewFinal.pdf [https://perma.cc/3YB6-7MKJ].

98. Griffin et al., *supra* note 77 (arguing that the HELP committee should pass legislation preempting state shield laws to "preserve the principles of federalism while ensuring each State retains the ability to restrict abortions as it sees fit within its borders without interference from other States"). Attorney General Ken Paxton, a signatory of the letter, followed up the joint statement with a press release that read in part, "[shield laws] embolden lawlessness, weaken our ability to enforce Texas laws, and trample on the rights of sovereign states to protect the unborn. Congress has the constitutional authority to rein in these 'shield laws' and stop other radical pro-abortion laws. . . ." Press Release, Ken Paxton, Att'y Gen. Tex., Attorney General Ken Paxton Urges Congress to Use Its Constitutional Authority to Stop Radical Pro Abortion Policies, https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-urges-congress-use-its-constitutional-authority-stop-radical-pro [https://perma.cc/MPE3-JU2F].

99. Petition and Application for Temp. and Permanent Injunctive Relief at 1, Tex. v. Carpenter, No. 471-08943-2024 (471st Dist. Ct. Collin Cnty. Tex., Dec. 12, 2024); Pam Belluck & Emily Cochrane, *New York Doctor Indicted in Louisiana for Sending Abortion Pills There*, N.Y. TIMES, (Jan. 31, 2025), https://www.nytimes.com/2025/01/31/health/abortion-louisiana-new-york-prosecution-shield-law.html [https://perma.cc/LDB8-Q4MY].

100. *See infra* notes 137–40 and accompanying text.

III. Lawsuits Against Shield Providers by States

In December 2024, the Attorney General of Texas, Ken Paxton, sued a New York physician for mailing abortion pills to a Texas woman.[101] Texas's allegation is based on the report of her former partner who found pill bottles in the woman's home that bore the doctor's name.[102]

Texas sued the provider, who is licensed in New York, for practicing medicine in Texas without a Texas medical license[103] and for violating Texas's abortion laws, which prohibit abortion in all forms at all points of pregnancy except in very limited circumstances.[104] Per the state's civil penalty for unlawful abortion, Texas sought a fine of $100,000 and asked the court to enjoin the defendant from mailing pills into Texas.[105] In February 2025, a Texas district court issued a default judgment against the doctor, who did not appear in court.[106]

The State of Texas sought to compel the doctor to satisfy the judgment in New York, but the court clerk where the doctor lives refused to docket the out-of-state judgment, citing the state's shield law.[107] New York's Governor, Kathy Hochul, issued a statement affirming the clerk's actions and declaring, "[o]ur response to their baseless claim is clear: no way in hell. New York won't be bullied. And I'll never back down from this fight."[108]

Texas petitioned a New York court to force the clerk to file a motion to domesticate the judgment against the shield provider.[109] The New York court dismissed Texas's lawsuit and held that the clerk, in invoking the shield law, acted lawfully. According to the court, New York's shield law "barred respondent from using 'time, resources, equipment or personnel' in

101. Tex. v. Carpenter, No. 471-08943-2024 (471st Dist. Ct. Collin Cnty. Tex., Dec. 12, 2024).

102. *Id.* at 5–6.

103. TEX. HEALTH & SAFETY CODE § 171.003; 22 TEX. ADMIN. CODE § 174.8 (repealed 2025); Petition and Application for Temporary and Permanent Injunctive Relief, *supra* note 99, at 4.

104. TEX. HEALTH & SAFETY CODE § 170A.002(a); Petition and Application for Temporary and Permanent Injunctive Relief, *supra* note 99, at 1.

105. Petition and Application for Temporary and Permanent Injunctive Relief, *supra* note 99, at 8–9.

106. Final Judgment and Order Granting Permanent Injunction at 1, Tex. v. Carpenter, No. 471-08943-2024 (471st Dist. Ct., Collin Cnty., Tex. Feb. 13, 2025).

107. Michael Hill, *New York Clerk Again Refuses to Enforce Texas Judgment Against Doctor Who Provided Abortion Pills*, A.P. NEWS (July 14, 2025), https://apnews.com/article/abortion-pills-lawsuit-texas-new-york-carpenter-2601c059ed475f97e8c8bdd722cce7da [https://perma.cc/MF79-HHN6]. Unlike some other states' shield laws, New York's shield law does not have a provision prohibiting enforcement of out-of-state judgments with respect to lawfully protected reproductive health care. New York authorities have cited the prohibition against cooperating with out-of-state efforts to punish providers of legally protected healthcare.

108. Governor Kathy Hochul, *Statement from Governor Kathy Hochul*, OFF. OF THE GOVERNOR OF N.Y. (July 14, 2025), https://www.governor.ny.gov/news/statement-governor-kathy-hochul-93 [https://perma.cc/RC4D-ZAM9].

109. Verified Petition at 4–5, Tex. v. Bruck, No. EF2025-2536 (Sup. Ct. N.Y. July 28, 2025).

furtherance of a proceeding that sought to impose civil liability . . . for engaging in 'legally protected health activity.' It is beyond cavil that to process a filing involves the use of time, resources, equipment and personnel."[110] At the time of writing, Attorney General Paxton suggested he will appeal to the New York appellate court for the Third Judicial District and, in February 2026, Paxton commenced a civil suit against a provider in Delaware.[111]

An argument Texas will make on appeal is that the Full Faith and Credit Clause of the U.S. Constitution requires states to recognize other states' judgments in civil matters, as the state argued at the lower state court.[112] Section IV of the Constitution, provides that "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State."[113] Supreme Court precedent states that "[t]he purpose of the Clause is to ensure that judgments rendered in one state are enforceable

110. Texas v. Bruck, No. EF2025-2536, 1, 3 (Sup. Ct. N.Y. Oct. 31, 2025) (quoting N.Y. EXEC. § 837-x (McKinney 2022)).

111. Steve Ellman, *Paxton Launches Another Attack on Ulster County Clerk*, NEWS AUTOMATIC: KINGSTON WIRE (Nov. 18, 2025), https://newsatomic.com/news/2025/11/18/paxton-launches-another-legal-attack-on-ulster-county-clerk/112fpi?open=1&force_ignore_preferences=1 [https://perma.cc/YWZ3-FBPY]. In February 2026, Attorney General Paxton sued a provider in Delaware for allegedly prescribing medication abortion sent to the state of Texas. Texas's complaint relies heavily on stories featured in media outlets in which the provider is quoted as stating that she prescribes medication abortion to Texas residents. Petition & Application for Temp. & Permanent Injunctive Relief at 4, *Tex. v. Debra Lynch*, No. 26DCCV0146 (136th Dist. Ct. Jefferson Cnty., Tex. Jan. 27, 2026) ("Defendant Lynch is not a physician. Despite not having a license to practice medicine in Texas, Lynch and other Her Safe Harbor providers prescribe abortion drugs via telehealth consultations to Texas residents."). Early responses from Delaware officials suggest that they believe the provider is protected under the state's shield law, although the Delaware shield statute does not define legally protected reproductive health care as occurring regardless of patient location. Aidan Johnstone, *AG Ken Paxton Sues Another Out-of-State Provider Accused of Illegally Sending Abortion-Inducing Pills to Texans*, TEX. TRIB. (Jan. 27, 2026), https://www.texastribune.org/2026/01/27/texas-delaware-abortion-pill-lawsuit/ [https:// perma.cc/RXP5-J8F3].

112. Petitioner's Memorandum of Law in Support of Petition Pursuant to Article 78 of the CPLR at 6, Tex. v. Bruck, No. EF2025-2536 (Sup. Ct. N.Y. July 28, 2025). Texas raised the Full Faith & Credit issue in its brief to the New York court:

> The State of New York's statutory enactments of 2022 were not only hostile to the earlier enacted Texas statutes but were aimed specifically to frustrate or counteract the laws of a sister-state by not allowing a sister-state to register a civil judgment in the State of New York.

Id.

The New York court did not weigh constitutional issues: "While Texas raised the Full Faith and Credit Clause in its briefing, its petition to the court did not mention any constitutional challenge to New York's shield law." Alicia Bannon, *New York's Shield Law Survives First Challenge by Texas*, STATE CT. REP. (Nov. 6, 2025), https://statecourtreport.org/our-work/analysis-opinion/new-yorks-abortion-shield-law-survives-first-challenge-texas [https://perma.cc/MM2L-WH79].
The court also declined to allow the New York Attorney General to intervene in the case as the court was not asked to decide a constitutional issue. *Bruck*, No. EF2025-2536, at 4.

113. U.S. CONST. art IV, § 1.

in all others, even if the enforcing state did not itself issue the judgment."[114] Indeed, federal and state laws facilitate cooperation to enforce out-of-state judgments, and such cooperation is the norm. However, there is an exception to the Full Faith and Credit Clause that might apply: the penal exception.[115]

State and federal courts have recognized the penal exception for over one hundred and fifty years, although the Full Faith and Credit Clause has not been applied to a legal dispute concerning abortion.[116] Criminal judgments are not covered by the Full Faith and Credit Clause, and neither are civil judgments if their purpose is punishment or they function too much like a criminal decision.[117] The Texas judgment does not provide for individual compensation or damages to redress any civil wrong against a person in Texas. Texas does not claim that it has suffered economic loss and it does not represent a claim on behalf of a person who would allege a civil injury. Instead, the complaint centers around "a breach and violation of public rights and duties, which affect the whole community"[118]—the intent of the penalties under Texas abortion law.

The essence of a penal judgment, like a criminal conviction, is to punish those who offend the public policy of a state. States cannot force their policies on other states in the name of comity or reciprocity or under the guise of enforcing judgments or damages that do not sound, for example, in tort or contract. Indeed, shield laws contemplate this distinction. Shield protection is not afforded to lawsuits sounding in tort or contract, or alleging violations of state law.

Shortly after Texas filed its civil complaint, Louisiana officials brought criminal charges against the same New York physician.[119] In January 2025, a West Baton Rouge grand jury indicted the doctor for prescribing medication abortion to a mother who allegedly gave the pills to her

114. Haley Amster, *Abortion, Blocking Laws, and the Full Faith and Credit Clause of the Constitution*, 76 STAN. L. REV. ONLINE 110, 113 (2024).

115. Nelson v. George, 399 U.S. 224, 229 (1970). In addition to the relevant penal exception to the application of the Full Faith and Credit Clause, if the state had no personal jurisdiction over the defendant, then there is no constitutional imperative to recognize an out-of-state judgment. Milliken v. Meyer, 311 U.S. 457, 462 (1940). The jurisdiction exception does not apply because the provision of telehealth services probably serves as a basis for personal jurisdiction. *See* Bullion v. Gillespie, 895 F.2d 213, 216–17 (5th Cir. 1990) (assessing "minimum contacts" to establish personal jurisdiction).

116. Diego A. Zambrano, Mariah E. Mastrodimos & Sergio F.Z. Valente, *The Full Faith and Credit Clause and the Puzzle of Abortion Laws*, 98 N.Y.U. L. REV. ONLINE 382, 400–01 (2023).

117. Nelson v. George, 399 U.S. 224, 229 (1970); Walker McKusick, *The Penal Judgment Exception to Full Faith and Credit: How to Bind the Bounty Laws*, 99 WASH. L. REV. 649, 664 (2024)

118. Huntington v. Attrill, 146 U.S. 657, 668–69 (1892).

119. Louisiana also brought charges against a California provider, the existence of which surfaced in its brief suing the FDA (described above); however, details of that prosecution are not yet publicly known.

seventeen-year-old daughter.[120] After police learned that the minor had taken abortion medication,[121] a grand jury indicted the doctor and the mother for the felony of criminal abortion by means of abortion-inducing drugs.[122]

Like Texas, Louisiana has run into conflict with New York's shield law.[123] The defendant-doctors did not enter a response to the charges, prompting the Louisiana governor to sign an extradition order requesting that New York force the doctor to appear in Louisiana to stand trial.[124] New York's Governor Hochul responded, "I will not be signing an extradition order that came from the governor of Louisiana: not now, not ever."[125] Louisiana Attorney General Liz Murrill countered that "New York officials, including the governor, are not at liberty to ignore interstate compacts and laws regarding extradition."[126] In January 2026, Louisiana indicted a California shield provider and issued an order of extradition,[127] which Governor Newsom pledged to disregard.[128] Then, in February 2026, Attorney General Murrill announced the state would sue New York and California.[129]

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120. Bill of Indictment, La. v. Carpenter, No. 250187 (La. Dist. Ct. Jan. 31, 2025); Belluck, *supra* note 99.

121. Belluck & Cochrane, *supra* note 99. The authors recount:

> Mr. Clayton, the West Baton Rouge district attorney, said the authorities became aware of the case after a police officer responded to a 911 call placed by the teenager. "The officer at the time thought he was dealing with a child who was having a miscarriage," Mr. Clayton said. After the police took the teenager to a hospital, the authorities learned that she had taken abortion medication and the investigation became criminal, he said.

Id.

122. *Id.*; Lorena O'Neil, *Louisiana Mother Pleads Not Guilty Following Abortion Pill Indictment*, LA. ILLUMINATOR (Mar. 11, 2025), https://lailluminator.com/2025/03/11/abortion-pill-10/ [https://perma.cc/P26K-RG5A].

123. O'Neil, *supra* note 122.

124. Jeff Landry, *Extradition Warrant for Margaret Carpenter*, LA. STATE (Feb. 11, 2025), https://gov.louisiana.gov/assets/2025-Extras/Extradition-warran-Doctor-Margaret-Carpenter.pdf [https://perma.cc/GSX2-H4Z8].

125. Kathy Hochul, *Video, Audio, Photos & Rush Transcript: Governor Hochul Makes a Reproductive Freedom Announcement*, N.Y. STATE (Feb. 13, 2025), https://www.governor.ny.gov/news/video-audio-photos-rush-transcript-governor-hochul-makes-reproductive-freedom-announcement [https://perma.cc/8F95-FRYU].

126. Lorena O'Neil, *Louisiana Attorney General Signs Off on Extraditing NY Doctor in Abortion Pill Case*, LA. ILLUMINATOR (Feb. 12, 2025), https://lailluminator.com/2025/02/12/extradition-doctor/ [https://perma.cc/V2LN-9SSN].

127. Emily Cochrane & Pam Belluck, *Louisiana Indicts Another Out-of-State Doctor Over Abortion Pills*, N.Y. TIMES (Jan. 13, 2026), https://www.nytimes.com/2026/01/13/us/louisiana-abortion-pills-california-indictment.html [https://perma.cc/LC6K-87GL].

128. *Id.*

129. Lilianna Badeaux, *AG Murrill Plans to File Lawsuits against New York and California over Abortion Pills*, KTAL NEWS (Feb. 5, 2026), https://www.ktalnews.com/news/louisiana/ag-murrill-plans-to-file-lawsuits-against-new-york-and-california-over-abortion-pills/ [https://perma.cc/E8MR-5ZFF]; *see* Raheem Hosseini, *Newsom's Response to Louisiana AG plan to Sue over Abortion Access: 'Go f- yourself'*, S.F. CHRON. (Feb. 6, 2026), https://www.sfchronicle.com/california/article/newsom-louisiana-21338647.php [https://perma.cc/

Louisiana Attorney General Murrill contends that California and New York have acted unconstitutionally by violating both the Full Faith and Credit Clause and the Extradition Clause, which requires states to send accused people to the accusing state so that they can face charges.[130] However, according to the ExtraditionClause's text and the Supreme Court's caselaw, the Clause only applies to someone physically present in the state during the crime (virtual presence is not enough) who then fled to another state.[131] Because the accused shield providers were never physically present in Louisiana, they arguably are not covered by the Constitution's Extradition Clause.[132]

It remains to be seen what shape Louisiana's prosecutions of the New York and California providers will take.[133] The caselaw of the Constitution's Extradition Clause has not been applied to an alleged abortion crime and its applicability here seems dubious.[134] As a matter of state compacts, almost every state has passed laws, based on a uniform law that serves as a model statute for governing extradition, which create obligations to extradite even if the accused was not physically present at the time of the crime.[135] Louisiana and New York have passed such laws, but those statutes confer discretion on

9TSY-ZK9B] (explaining California Governor Newsom's extradition request denial in the context of the Full Faith and Credit clause).

130. U.S. CONST. art. IV, § 2.

131. *See* Paul Benjamin Linton, *Transporting Abortifacients Across State Lines: Prospects for Indictment and Extradition*, 26 FED. SOC'Y REV. 245, 249–50, 253–54 (2025) (arguing that shield laws are constitutional in preventing extradition and that states trying to extradite shield providers cannot force another state to do so).

132. Cohen et al., *The New Abortion Battleground*, *supra* note 5, at 47–48.

133. *See* John Simerman, *DA Tony Clayton Says Evidence Against New York Abortion Provider Too Strong to Ignore*, NOLA.COM (Feb. 14, 2025), https://www.nola.com/news/courts/louisiana-new-york-abortion-pills-arrest/article_de900a40-ea83-11ef-8992-23264ecdc5e6.html [https://perma.cc/BR59-5463] (highlighting that Louisiana District Attorney Tony Clayton and New York Governor Kathy Hochul have conflicting views on the outcome of Louisiana's charges against New York physician); *see also* Pam Belluck, *Newsom Says California Will Not Extradite Abortion Provider to Louisiana*, N.Y. TIMES (Jan. 14, 2026), https://www.nytimes.com/2026/01/14/us/california-louisiana-extradite-abortion-doctor.html [https://perma.cc/5WAN-XSD2] (detailing opposing views on extradition between California Governor Gavin Newsom and Louisiana Attorney General Liz Murrill).

134. *See* Lea Brilmayer, *Abortion, Full Faith and Credit, and the "Judicial Power" Under Article III: Does Article IV of the U.S. Constitution Require Sister-State Enforcement of Anti-Abortion Damages Awards?*, 44 COLUM. J. GENDER & L. 441, 444–45 (2024) (finding that the constitutionality of extradition enforcement legislation regarding abortion could depend on the Full Faith and Credit Clause, "but the case law addressing such issues [generally] is quite sparse"); *see also* Diego A. Zambrano, Mariah E. Mastrodimos & Sergio F.Z. Valente*, The Full Faith and Credit Clause and the Puzzle of Abortion Laws*, 98 N.Y.U. L. REV. ONLINE 382, 384–86, 388 (2023) (discussing the lack of case law surrounding a Texas abortion law and whether the extradition clause is applicable).

135. *See, e.g.*, N.J. STAT. ANN. § 2A:160-14 (West 2022) ("The governor of this state may also surrender, on demand of the executive authority of any other state, [any person] . . . even though the accused was not in that state at the time of the commission of the crime.").

states regarding extradition decisions outside of the constitutional mandate.[136] Shield laws create an exception for lawful reproductive healthcare from these state extradition agreements.[137]

Like the FDA litigation, both Louisiana and Texas argue that shield provision has upended states' rights to enforce their abortion laws. That claim is contestable as a matter of constitutional law, statute, and interstate custom, and it is weaker than its proponents suggest. To begin, the claim inverts the constitutional presumption. Under the Supreme Court's extraterritoriality jurisprudence, it is the state reaching beyond its borders that bears the burden of justification, not the state legislating within its borders.[138]

Shield states like New York have rights recognized by the Supreme Court to decline cooperation with another state's enforcement apparatus. New York can opt not to extradite its citizens for conduct that is lawful within its borders—a position grounded not only in the statutory text but also in the penal exception to the Full Faith and Credit Clause, which has shielded states from being conscripted into enforcing another state's punitive judgments. And, as noted, the Extradition Clause provides New York with a textual defense because it applies only to persons physically present in the demanding state who then fled.

Beyond these constitutional defenses, shield laws rest on an independent and affirmative source of state authority. Under the doctrine of *parens patriae*, states bear a responsibility to secure the health, safety, and welfare of their residents—a power that, as Professor Lindsay Wiley has argued, delineates "a division between private rights that are individually held and distinctively public interests . . . which states bear special responsibility to secure."[139] New York's shield law is an exercise of precisely that power: it defines abortion as healthcare, protects in-state providers who deliver that care, and insulates its residents from the punitive reach of jurisdictions that have made a different policy choice. The fact that Texas and Louisiana classify the same conduct as a crime does not diminish New York's sovereign authority to protect what it has determined to be a public

136. La. Code. Crim. Proc. Ann. art. 262.1 (2003); N.Y. Crim. Proc. Law § 570.17 (2025).

137. Cohen et al., *The New Abortion Battleground*, *supra* note 5, at 47–48.

138. *See* Leslie P. Francis & John G. Francis, *Crossing State Lines for Contested Health Care: The Case Against Extraterritoriality Within the United States*, THE APPENDIX: J. HEALTH CARE LAW & POL'Y, 58–59 (2025) ("major justifications for federalism—achieving collective goals as a union of states while recognizing a substantive measure of governing authority for subnational units, allowing experimentation, and locating government closer to the people—depend on the availability of movement for people who do not share the perspectives dominant within subnational units"); *see, e.g.*, Nat'l Pork Producers Council v. Ross, 143 S. Ct. 1142, 1152 (2023) (holding that state laws are not "almost per se" unconstitutional merely because it has substantial extraterritorial economic effects—a principle that cuts directly against the assertion that New York's decision to license and protect its own providers somehow offends the sovereignty of Texas or Louisiana).

139. Lindsay Wiley, *States as Shields*, 110 MINN. L. REV. 1, 14 (2025).

health interest. And critically, New York's shield law is not extraterritorial in the manner Texas and Louisiana allege. It does not seek to nullify any other state's abortion ban, dictate what laws Texas or Louisiana may pass, or prevent either state from enforcing those laws against persons within their own jurisdictions. Rather, it declines to lend New York's judicial machinery, law enforcement resources, and professional licensing apparatus to the enforcement of another state's prohibitions—a refusal that, far from being anomalous, has deep roots in U.S. federalism. Noncooperation with sister-state enforcement efforts is neither new nor necessarily constitutionally suspect.[140] The claim that shield laws "upend" federalism has it backwards: it is the demand that New York subordinate its own public health policy to Louisiana's criminal code that would represent a departure from constitutional norms.

The constitutional issues, primarily those concerning the Full Faith and Credit Clause and the Extradition Clause, could land before the Supreme Court as Texas appeals the state court's decision and as Louisiana seeks support for its extradition requests. But while these cases work their way through the courts, Louisiana has issued warrants for the New York doctor's arrest in all fifty states; all states recognize out-of-state warrants.[141] This underscores the limits of shield laws; they do not protect providers once they leave the shield state. Only Vermont has amended their shield law to offer its law's shield protection to people traveling to Vermont from other shield states.[142] Were more states to enact provisions like Vermont's, which many appear on the precipice to do, shield-state reciprocity could help protect providers moving across states and signal the strength of interstate cooperation around protecting abortion access. But shield providers are not only under threat by anti-abortion states, but also in lawsuits commenced by individuals.

IV. Lawsuits against Shield Providers by Individuals

Taking another tack to the legal actions described in the previous parts, individuals have sued shield providers under Texas tort law, alleging the termination of a partner's pregnancy was a wrongful death. Two cases filed in federal courts rely on claims of coercion, or, as stated in one of the briefs,

140. *See* Mary D. Fan, *Shielding Freedoms: State Noncooperation in Hunts for Evidence and People*, 100 WASH. L. REV. 911, 915 (2025).

141. *See* Greg LaRose, *New York Governor Rejects Louisiana Extradition Request for Doctor Accused of Mailing Abortion Pills*, LA. ILLUMINATOR (Feb. 13, 2025), https://lailluminator.com/2025/02/13/new-york-extradition/ [https://perma.cc/6QKZ-9FC8] (noting Louisiana Attorney General's statement that the New York doctor should be "careful with her travel plans").

142. VT. STAT. tit. 1, § 150(b)(4) (2025); TOM BOWMAN, SHIELD LAWS IN FLUX 41 (2026).

that the pregnant person was pressured "to kill [an] unborn child and obtain abortion pills [from the defendant] to commit the murder."[143]

In July 2025, a resident of Texas filed a wrongful death lawsuit against a California doctor alleging that the provider mailed medication abortion to his then-pregnant girlfriend, who ended her pregnancy under the coercion of an ex-partner.[144] A second case, filed in August 2025, which names as a defendant the non-profit Aid Access, alleges that a putative father tricked the complainant into ingesting medication abortion without her knowledge or consent, ending the complainant's pregnancy.[145]

These lawsuits are novel requests for civil damages under the Texas wrongful death statute which, per Texas law, may apply to the unborn.[146] Moreover, the cases are filed in federal court in diversity jurisdiction by claiming damages of over $75,000 between parties from different states.[147] In *Rodriguez v. Coeytaux*, the plaintiff seeks damages as well as a nationwide injunction "on behalf of a class of all current and future fathers of unborn children."[148] Both lawsuits argue that the basis of the "wrongful act" was the state crime of "murdering" the fetus, in violation of Texas homicide laws, and a federal crime under the Comstock Act.[149]

The Comstock Act dates to 1873, though it has not been enforced in over one hundred years after a series of court challenges limited its application.[150] Section 1461 of the Act prohibits mailing:

> Every article or thing designed, adapted, or intended for producing abortion, or for any indecent or immoral use; and every article, instrument, substance, drug, medicine, or thing which is advertised or

143. Complaint at 3–4, Rodriguez v. Coeytaux, No. 3:25-cv-00225 (S.D. Tex. July 20, 2025), 2025 WL 2052916.

144. *Id.* at 2–3. Rodriguez filed a separate case in state court against two individuals he claims provided the pills and provided the place for the abortion to occur, respectively. Plaintiff's Original Petition, Rodriguez v. Garza, No. 25-CV-1294 (212th Dist. Ct., Galveston Cnty., Tex. July 21, 2025).

145. Complaint at 22, Davis v. Cooprider, No. 2:25-cv-00220 (S.D. Tex. Aug. 11, 2025).

146. *Protecting Doctors from Texas's Bounty Hunter Law*, CTR. FOR REPROD. RTS. (Feb. 1, 2026), https://reproductiverights.org/cases/protecting-doctors-texas-bounty-hunter-law/ [https://perma.cc/SFC4-KUKM].

147. Complaint, *supra* note 145 at 1.

148. Complaint, *supra* note 143, at 10.

149. *Id.* at 1, 7; Complaint, *supra* note 145, at 31, 33. *See* Karen Engle & Jennifer E. Laurin, *Criminalization by Other Means: New Sites and Strategies for Stifling Abortion Access*, 68 ARIZ. L. REV. (forthcoming 2027) (on file with author). Karen Engle and Jennifer Laurin show that these wrongful death cases seek to "broaden[ ] application of a theory of 'direct' murder to all providers of abortion medication," smuggling into civil lawsuits "a capacious notion of who might 'directly' commit murder to include actors significantly upstream from the immediate act of abortion in criminal claims." *Id.*

150. Reva B. Siegel & Mary Ziegler, *Comstockery: How Government Censorship Gave Birth to the Law of Sexual and Reproductive Freedom, and May Again Threaten It*, 134 YALE L.J. 1068, 1167–68 (2025).

> described in a manner calculated to lead another to use or apply it for producing abortion, or for any indecent or immoral purpose . . .[151]

Proponents of bringing this federal criminal law back to life believe the Act would ban abortion across the country because almost everything used for any abortion moves through the mail at some point.[152] As set out in the wrongful death suits, with an "anti-coercion" focus, the Comstock Act seeks to "protect[] women from coercion rather than exposing them to federal felony charges."[153] This argument elides the fact that remaking the Comstock Act into a *de facto* abortion ban is contrary to its purpose and to its application when it was enforced a century ago.[154]

Texas legislators have crafted a new cause of action for individuals suing shield providers—House Bill 7 (HB 7).[155] Texas currently has three abortion bans on the books,[156] and a separate law limiting medication abortion by making it a crime to provide anything intended to cause an abortion to another person.[157] HB 7, however, directly targets those mailing pills into Texas from shield states.[158] Unlike the existing Texas abortion bans, which only apply when the prohibited activity occurs in Texas, HB 7 creates a civil cause of action for any person who alleges an attempt or the intent to mail or deliver abortion medication into Texas.[159] The bill deploys a mechanism unknown in the abortion context but used within healthcare fraud—a *qui tam* action—in which the individual sues on behalf of the state for violation of a state's laws, keeping a portion of the fines recovered.[160] HB 7 entered into force in December 2025 but, at the time of writing, has yet-to-be enforced by an individual. However, lawyers in one of the Texas

151. 18 U.S.C. § 1461.

152. David Cohen & Rachel Rebouché, *Repeal Comstock*, 104 B.U. L. REV ONLINE 265, 266–67 (2025); Andrew Beck, *Anti-Abortion Extremists Want to Use the 150-Year-Old Comstock Act to Ban Abortion Nationwide*, ACLU (May 30, 2024), https://www.aclu.org/news/reproductive-freedom/anti-abortion-extremists-want-to-use-the-150-year-old-comstock-act-to-ban-abortion-nationwide [https://perma.cc/K5YL-3Y9E].

153. Fox & Ziegler, *supra* note 62, at 24.

154. *See* Siegel & Ziegler, *supra* note 150, at 1156–62 (explaining current anti-abortion interpretations of the Comstock Act as not grounded in federal precedent).

155. Tex. H.B. 7, 89th Leg., C.S. (2025) (enacted).

156. Tex. Penal Code §§ 19.02, 19.06; Tex. Civ. Prac. & Rem. Code § 71.001(4) (defining "individual" to include an unborn child); Tex. S.B. 8, 87th Leg., R.S. (2021) (enacted); Tex. H.B. 1280, 87th Leg., R.S. (2021) (enacted).

157. Tex. S.B. 4, 87th Leg., C.S. (2021) (enacted).

158. Tex. H.B. 7, 89th Leg., C.S. (2025) (enacted).

159. *Id.*

160. *Id.*; Jonathan Coleman, *The Cost of Qui Tam: Assessing the Constitutional Challenges to the False Claims Act*, 4 U. CHI. BUS. L. REV., 453, 457–58 (2025).

wrongful death suits amended their complaint in February 2026 to contemplate future HB 7 actions.[161]

HB 7 is an explicitly anti-shield law policy with ambitions to hold out-of-state residents—such as providers, drug manufacturers, and distributors—civilly liable for their actions related to abortion pills. Although any debate on mailed medication abortion will not be won on the ground of consistency, it is striking that Texas at once disputes the extraterritorial effects of New York's shield law while enacting a law that seeks to reach out-of-state actors and impede them from availing of the provisions of their own state's law.[162]

V. Continued Contestation Across the Political Divide

The conflicts over medication abortion that have been playing out between the states are moving to the federal level. And attacks on mailed medication abortion as facilitated by shield laws lay the groundwork for the Trump Administration to provide a national solution to interstate disagreement and to restrict access to what anti-abortion advocates claim is a dangerous medication. Reimposed FDA restrictions and enforcement of the Comstock Act have been the solutions advanced, though they will have different consequences.

If the FDA reinstates the original or a revised in-person pick-up requirement, mailing mifepristone would not be permitted under FDA rules.[163] The decision would be subject to litigation, as a federal court has already held in *Purcell* that *existing* regulations contravene the FDA's duties under federal law.[164] Even so, FDA actions would apply only to mifepristone, leaving open the possibility that providers would prescribe and send misoprostol, the second drug in a medication abortion. Misoprostol is approved for ulcer treatment and prescribed off label with mifepristone to

161. First Amended Complaint at 9–10, Rodriguez v. Coeytaux, No. 25-cv-00225 (S.D. Tex. Feb. 1, 2026). Indiana is considering a bill similar to HB 7, Indiana Senate Bill 236, to enact in the state. Leslie Bonilla Muñiz, *Indiana Abortion-Inducing Drug Ban Passes Senate, Heads to House*, IND. CAP. CHRON. (Jan. 28, 2026), https://indianacapitalchronicle.com/2026/01/28/indiana-abortion-inducing-drug-ban-passes-senate-heads-to-house/ [https://perma.cc/RW66-5GC9].

162. Perhaps one of the more interesting aspects of HB 7 is its prohibition on a "claw back" lawsuit against a Texas individual from a shield state. Tex. H.B. 7, 89th Leg., C.S. (2025) (enacted).

163. *See supra* Part II (discussing the implications of an FDA change in mifepristone requirements).

164. The FDA can only reimpose an in-person dispensing requirement if it concludes, after reviewing the medical research, that the requirement is necessary to ensure that the drug's benefits outweigh its risks. *See* 21 U.S.C. § 355-1(a)(2), (f)(1), (f)(3). If the FDA were to reimpose the in-person dispensing requirement, a case could be made that the agency acted arbitrarily and capriciously under the Administrative Procedure Act because the decision would be in direct contradiction to medical research, the agency's previous action, and federal court decision. *See* Purcell v. Kennedy, No. 17-00493 JAO-RT, 2025 WL 3101785, at *2–*5 (D. Haw. Oct. 30, 2025) (explaining that the FDA must consider certain factors when issuing regulations).

complete an abortion.[165] FDA action would not impede its use or its distribution, and misoprostol has been used alone to end pregnancies in various countries for decades.[166] In other words, abortion pills will not disappear if the FDA reverses course and requires patients to pick up mifepristone at healthcare facilities. People will continue to order pills online (from national and international sources), and abortion providers in states where it remains legal will pivot, as they did after *Dobbs*, to serve out-of-state patients.[167]

Regarding the Comstock Act, anti-abortion groups like the Heritage Foundation have urged the Department of Justice to apply the 1873 law as a nationwide ban on mailing all items connected to an abortion, including pills and anything else (such as clinic equipment) a provider needs.[168] To date, the Trump Administration has suggested that it will not attempt to enforce the Comstock Act.[169] But if that position changed, and courts upheld enforcement of the Act, mailing abortion pills would violate federal criminal law. Policing the mail for any "thing" used to "procure an abortion"—the language in the Act—will increase risks for patients and providers alike.[170] Application of the Act would make abortion access more difficult, but applying an antiquated federal criminal law would not make abortion safer just as it cannot effectively eliminate abortion. For one, the Comstock Act would not reach international provision or movement of materials without use of the mail.[171] For another, the Act's enforcement might result in backlash on the heels of punitive and intrusive government action like that which resulted in the practical collapse of the Comstock Act early in its life.[172]

More immediately, conflict between shield states and ban states will intensify as litigation moves through the courts and as states enact legislation, like HB 7, targeting shield provisions. Congressional Republicans will continue to advocate for Congressional and Executive intervention to address

165. Cohen et al., *Abortion Pills*, *supra* note 11, at 324, 385.

166. The World Health Organization (WHO) defines the drug as an essential medicine for reproductive health and people in countries like Brazil have relied on misoprostol to end pregnancies before the introduction of mifepristone. *See* Skuster, *supra* note 14 at 111-12.

167. Rosemary Westwood, *After Historic Indictment, Doctors Will Keep Mailing Abortion Pills Over State Lines*, NPR (Mar. 19, 2025), https://www.npr.org/sections/shots-health-news/2025/03/19/nx-s1-5312115/margaret-carpenter-indictment-telemedicine-abortion-louisiana-mail-mifepristone-misoprostol [https://perma.cc/JU5B-Q3EB]. *See generally* DAVID S. COHEN & CAROLE JOFFE, AFTER DOBBS: HOW THE SUPREME COURT ENDED ROE BUT NOT ABORTION (2025).

168. Siegel & Ziegler, *supra* note 150, at 1156–62 (2025).

169. Alice Miranda Ollstein, '*It's Not a Pro-Life Position': Anger After Trump Says No to Comstock*, POLITICO (Aug. 20, 2024), https://www.politico.com/news/2024/08/20/trump-comstock-enforcement-00175068 [https://perma.cc/R84Y-YC5U].

170. 18 U.S.C. § 1461.

171. *Id.*

172. Fox & Ziegler, *supra* note 62, at 23.

the interstate conflict over abortion and claims of coercion.[173] But such interventions are solutions in search of a problem. No evidence has established that there is an epidemic of coerced abortion, for instance.[174] As Elizabeth Tyler-Tobin and her colleagues argued, "evidence shows that preventing access to wanted reproductive health care, including abortion, is a much more common form of reproductive coercion [and] restricting access to medication abortion—especially in states with abortion bans—will disproportionately harm women experiencing reproductive coercion and/or intimate partner violence (IPV)."[175] And it is notable that neither Louisiana's case against the FDA nor the wrongful death actions seek to hold the alleged perpetrator accountable for harm to the pregnant person.[176] Perhaps more saliently, "there's no reason to think that requiring in-person contact between patients and doctors would prevent abusers from pressuring women to end their pregnancies."[177]

Despite problems of proof and accuracy, the focus on coercion is a strategically important shift from a concentration on abortion's purported mental and physical harms to the potential misuses of pills in order to discredit telehealth for abortion.[178] This taps into longstanding concern that abortion is used as a weapon against the vulnerable rather than a choice for

173. *See, e.g.*, Griffin et al., *supra* note 77 (asking the Senate HELP committee to introduce legislation that would preempt shield laws).

174. *See, e.g.*, Karen T. Grace & Elizabeth Miller, *Contraceptive and Abortion Interference by People Assigned Male at Birth*, 151 CONTRACEPTION 111067, Table 2 (2025) (showing the 2.4% of the sample of men reported coercing a partner to get an abortion; almost all coercion is related to getting and keeping a partner pregnant); M. Antonia Biggs, Heather Gould & Diana Greene Foster, *Understanding Why Women Seek Abortions in the US*, BMC WOMEN'S HEALTH (2013) (observing how pressure from family or friends accounts for less than two percent of abortions); Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh & Ann M. Moore, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. SEXUAL & REPROD. HEALTH 110, 118 (2005) ("The proportion of women citing influence from partners or parents is . . . fewer than 1%"). *But see* David C. Reardon, Donna J. Harrison, Ingrid Skop, Maka Tsulukidze, Christina A. Cirucci & James Studnicki, *Overlooked Dangers of Mifepristone, the FDA Reduced REMS, and Self-Managed Abortion Policies: Unwanted Abortions, Unnecessary Abortions, and Unsafe Abortions*, CHARLOTTE LOZIER INST. (2021) (claiming that as many as 64% of women with a history of abortion have been pressured to abort). And, of course, pressure and coercion are not the same phenomena.

175. Elizabeth Tobin-Tyler, Kari White, Maeve Wallace & Samuel Dickman, *Restricting Access to Medication Abortion Will Not Help Survivors of Intimate Partner Violence*, HEALTH AFFS., Feb. 26, 2026, https://www.healthaffairs.org/content/forefront/restricting-access-medication-abortion-not-help-survivors-intimate-partner-violence [perma.cc/LD62-BSBB].

176. *Id.* The Louisiana lawsuit targets the physician who prescribed the medication and the FDA, not the complainant's estranged boyfriend. *Id.* One of the Texas wrongful death cases seeks to hold Cooprider accountable for wrongful death of the fetus, but not any harm to Davis. *Id.*

177. Fox & Ziegler, *supra* note 62, at 5.

178. Fox & Ziegler, *supra* note 62, at 19 ("Abortion opponents have looked for ways to undermine shield laws and tame post-*Dobbs* backlash, and coercion arguments have become central to that effort.").

those who are statistically more likely to have a child already and understand their options in ending a pregnancy.[179]

Similarly, the focus on the legality of shield provisions and state sovereignty attempts to exaggerate the state-based and national costs of an escalating disagreement over extraterritorial abortion. Anti-abortion states claim that shield laws run counter to interstate comity and encroach on states' right to enforce their laws. Yet, as argued above, states are within their authority to pass, and enforce, laws protecting in-state providers even if they depart from previously established cooperation. Nothing in a shield law dictates what another state can or cannot do within their jurisdictions. Even as Texas or Louisiana demand that New York courts enforce their orders, neither the U.S. Constitution nor any statute forces New York to give effect to other states' decisions to punish New York citizens.[180]

Interstate disagreement is neither a constitutional crisis nor an indication of an existential threat to federalism.[181] But the invocation of states' rights does work that has nothing to do with preserving the relationships among sister states. Mailed medication is a threat to the goal of ending abortion in ban states and, indeed, nationwide. Having been debatably unsuccessful in proving the harms of mifepristone, the movement to stop abortion has had to revise its arguments to entreat the federal government and the public to pay attention.

Their strategies may gain traction because they tap into an ambivalence about shield provision of medication abortion. Although research firmly supports virtual delivery of medication abortion, there appears to be persistent skepticism of disconnecting abortion care from in-person provider oversight.

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179. Consider the campaign to block minors' access to abortion, which relies on coercion arguments to suggest that bypassing parental involvement or leaving a state for a legal abortion allows abusive men to hide sexual activity with younger women. *See* Child Interstate Abortion Notification Act (CIANA), H.R. 748, 109th Cong. (2005) (federal bill prohibiting transporting minors across state lines to evade parental involvement laws); Abortion Trafficking Acts: IDAHO CODE § 18-623 (2025) (prohibiting assistance to minors when leaving or returning to the state when obtaining a legal abortion out-of-state); TENN. CODE. ANN. § 39-15-201 (2025) (prohibiting the same in Tennessee). Then consider who avails of telehealth for medication abortion: Less than 6%, in one study, were under the age of 20; 59% had at least one child; none indicated any coercion or duress in a questionnaire; many indicated financial stress as their reason to end a pregnancy. Foster et al., *supra* note 60 at 297, 299. Nothing in this Essay condones a system in which people feel forced to choose between economic stability and having a child. That choice demonstrates the paucity of support for parents and pregnant people and the necessity of adopting a reproductive justice framework. Leah Litman, *Redefining Reproductive Rights and Justice*, 118 MICH. L. REV. 1095, 1106–09 (2020).

180. Cohen et al., *The New Abortion Battleground*, *supra* note 5 at 40.

181. *See* Fan, *supra* note 140 at 915 ("The rise of shield laws challenges the normative assumptions behind the march toward interstate comity and cooperation as a teleological good and invites lessons from the past when states resisted other freedom-stifling tactics from neighboring states").

For example, in a recent hearing before the Senate Committee on Health, Education, Labor, and Pensions, not one Democratic senator could articulate a defense of telehealth for medication abortion, despite its safety track record or the uptake in its use.[182] Contemporary pro-life arguments, despite being ungrounded in evidence around safety or efficacy, might make use of *pro-choice* discomfort with care untethered from place or, for that matter, a face-to-face encounter with a provider.[183] Asynchronous care is new for abortion telehealth and healthcare professionals may feel unfamiliar and uncomfortable with shield provision which, because of scale, is not conducted in real time. That discomfort, among other varied and important factors, might explicitly or implicitly marginalize shield provision. That marginalization will erect barriers to investing in shield services, such as wrap-around care, that could make shield provision stronger.[184]

Moreover, telehealth for medication abortion is not only under attack in the ways described above but also may face ambivalence from medical associations which must now contend with what virtual provision means for the future of obstetrics practice and training. Most residency programs or professional organizations have yet to develop protocols for teaching telehealth-based medication abortion, even as it becomes a significant avenue to care. There is, for instance, no standardized pathway for teaching asynchronous telehealth counseling, risk assessment, or remote aftercare.[185]

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182. *See generally* Protecting Women: Exposing the Dangers of Chemical Abortion Drugs Before the Senate Committee on Health, Education, Labor, and Pensions, 119th Cong. (2026).

183. *See* Lindgren, *supra* note 14 at 158 (noting that "self-managed abortion falls outside of the narrow framing of the medical gatekeeper model of the abortion right").

184. This marginalization might lead patients to perceive telehealth for medication abortion as a "scam"—broader acceptance would build patient trust and make virtual care more mainstream, with possible downstream effects such as stronger support for state Medicaid reimbursement for providing asynchronous care. One reason for the marginalization of shield provision is its potential impact on brick-and-mortar clinics. But the dynamics between telehealth provision and clinic-based services is complex. Entirely virtual services can deprive clinics of patients, particularly in states that are not hubs for patient travel. Another reason is that shield provision is concentrated in only two or three entities. Foster et al., *supra* note 60 at 300 ("The MAP is one of two Shield Law providers offering medication abortion care via telemedicine in all 50 states. That a new Shield Law practice provided care to nearly 2000 patients in the 6 months after its launch demonstrates that this model of service delivery is feasible and demand exists.").

185. *See* Rachel Rebouché, *Training by Travel: OB/GYN Residency Programs after* Dobbs, 51 AM. J.L. & MED. 433, 434 (2026) (noting the uncertainty that characterizes abortion care training, particularly for learners and residents in ban states). Organizations like the Reproductive Health Access Project and Training in Early Abortion for Comprehensive Healthcare (TEACH) are beginning to train providers in telehealth-based medication abortion, but this model remains fragmented and has not been incorporated into residency protocols through professional guidance or training materials. *Id.* at 448. In fact, there is no updated or comprehensive protocol or guidance for the asynchronous telehealth for medication abortion, which incorporates best practices in screening, counseling, delivery, and aftercare as well as patient follow-up. Patient information and aftercare strategies are key for patients taking pills in ban states, so that they know what to expect and have resources if questions or issues arise.

This may reflect a lag time between changes in provision and incorporating shifts in delivery of training. But it also may underscore an uneasiness with care that is simultaneously ascendant and under siege, and a form of pregnancy termination that portends the increasing acceptability of self-managed abortion.[186]

Self-managed abortion is commonly understood to be abortion without clinician oversight or outside of the healthcare system.[187] That description does not characterize shield or telehealth provision in the United States, which is supervised by a clinician, either through synchronous or asynchronous means.[188] But, undoubtedly, telehealth for medication abortion blurs the lines between traditional delivery of care in a brick-and-mortar clinic and the procurement of pills online without clinician involvement.

Abortion-rights supporters have not, to this point, challenged one of the anti-abortion movement's rhetorical conflations: labeling clinician-supervised shield provision as "self-managed abortion." Shield provision involves prescriber certification, patient screening, and follow-up contact—hallmarks of medical oversight, not self-administration. By allowing the label to stand unchallenged, advocates cede ground that the evidence does not require them to surrender. Both telehealth-facilitated medication abortion and self-managed abortion have been shown to be safe and effective. The reluctance to press this case may stem from a deeper discomfort with asynchronous care that mirrors, rather than counters, the central premise of the anti-abortion coercion narrative: women lack the capacity to assess their own reproductive needs and act on them without real-time professional gatekeeping. To leave that premise uncontested is to do the anti-abortion movement's work for it.

186. Lucía Berro Pizzarossa & Rishita Nandagiri, *Self-Managed Abortion: A Constellation of Actors, a Cacophony of Laws?*, 29 SEXUAL AND REPROD. HEALTH MATTERS 23, 23–24 (2021).

187. Heidi Moseson, Stephanie Herold, Sofia Filippa, Jill Barr-Walker, Sarah E. Baum & Caitlin Gerdts, *Self-Managed Abortion: A Systematic Scoping Review*, 63 BEST PRAC. & RSCH. CLINICAL OBSTETRICS & GYNAECOLOGY, 87, 88 (2020) ("Self-managed abortion, also referred to as self-induced, self-sourced, self-administered, or, colloquially, 'DIY' abortion, can be defined as when a person performs their own abortion outside of a medical setting…we define self-managed abortion explicitly as any action a person takes to end a pregnancy without clinical supervision.").

188. Maya Manian, *A Health Justice Approach to Abortion*, 34 HEALTH MATRIX 261, 321 (2024) ("[Self-managed abortion] differs from telehealth abortion, which involves the use of traditional health care systems to deliver abortion care remotely.").

Conclusion

The conventional post-*Dobbs* story is one of widening geographic disparity—a patchwork in which a person's zip code determines access. That story is accurate but incomplete, because it underestimates how dramatically medication abortion has disrupted the expected consequences of *Dobbs*. The anti-abortion movement faces a problem: People living in ban states are getting pills in the mail. But the current situation is on uncertain ground, and its stability could depend on the yet-to-be-determined positions of the Trump Administration and on the possibility of a Supreme Court ruling. As legal controversies unfold shield provision is reshaping how abortion happens in the United States.

The Administration has issued an Executive Order pledging to study real-world outcomes and adhere to "Gold Standard Science."[189] How will that pledge translate to the contestation over medication abortion, particularly in the course of the FDA's review of mifepristone regulation? States fundamentally disagree about what they are regulating—healthcare in one state is a crime in another—and states cannot agree on basic facts. Officials in Louisiana claim that medication abortion is as dangerous as fentanyl, a highly addictive substance, and House Republicans described mifepristone as "poison."[190] At the same time, abortion-protective states cite medical and scientific evidence that mifepristone has a better safety record than Tylenol.[191] If real-world outcomes were assessed and gold-standard science applied (transparent, unbiased, without conflicts of interest),[192] the conversation might be more honest: Mifepristone is safe but its increasing use poses a political and social problem for the anti-abortion movement. For

189. Exec. Order No. 14303, 90 Fed. Reg. 22601, 22602 (May 23, 2025).

190. *See* Rosemary Westwood, *Louisiana Reclassifies Drugs Used in Abortions as Controlled Dangerous Substances*, KFF HEALTH NEWS (July 24, 2024), https://kffhealthnews.org/news/article/louisiana-mifepristone-misoprostol-abortion-pills-reclassified-dangerous-controlled-substances. [https://perma.cc/J7GJ-RYRL] (noting Louisiana's reclassification of abortion medication as a controlled substance). Calvin Freiburger, *Rep. Chris Smith Condemns Abortion Pill as 'Baby Poison' in March for Life Speech*, LIFESITE (Jan. 23, 2026), https://www.lifesitenews.com/news/rep-chris-smith-condemns-abortion-pill-as-baby-poison-in-march-for-life-speech/ [https://perma.cc/8EJ4-SSLC].

191. *But see Florida AG Uthmeier sues Planned Parenthood, accusing nonprofit of falsely advertising abortion pill "safer than Tylenol,"* CBS NEWS (Nov. 7, 2025), https://www.cbsnews.com/miami/news/florida-attorney-general-uthmeier-sues-planned-parenthood-abortion-tylenol/ [https://perma.cc/93VM-PRSU] (discussing a lawsuit against Planned Parenthood for advertising abortion medication as safer than Tylenol). To be clear, since 2000, the time of mifepristone's approval, 7.5 million people have used medication abortion with less than .3% serious complications. U.S. Food & Drug Admin., Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2024, at 1–2 tbl. 2 (Dec. 2024), https://www.fda.gov/media/185245/download [https://perma.cc/QBJ3-E6ZS].

192. Exec. Order No. 14303, § 3(a)(ii), (vii), (ix), 90 Fed. Reg. 22601, 22602 (May 23, 2025).

abortion-rights supporters, this is the moment to focus on what is at stake and what would have to shift should shield provision change.

Yet parts of the abortion rights movement have not come to terms with shield provision, even though mailed medication will not disappear. The lack of consensus about how to defend telehealth for medication abortion, as well as self-managed abortion, presents a ripe opportunity to introduce misinformation about medication abortion's effects. To be sure, shield provision of medication abortion confronts a historic unease about the distinction of safe and unsafe abortion against the backdrop of the medicalization of abortion.[193] Misinformation about how abortion occurs, who seeks it, and what happens after abortion plays upon that unease, potentially with some success. For federal and state supporters of reproductive rights, the scope of abortion access in this country may depend not only on confronting misinformation, but also on articulating the importance of access to pills disconnected from place and provider, with or without shield laws.

193. *See* Manian, *supra* note 188, at 278–98 (describing the concept of medicalization and the history of medicalizing reproductive health care).