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Reproductive Justice after the Pandemic

How "Personal Responsibility" Entrenches Disparities and Limits Autonomy

*Rachel L. Zacharias, Elizabeth A. Dietz, Kimberly Mutcherson, and Josephine Johnston**

I INTRODUCTION

COVID-19 laid bare the responsibility that American laws, policies, and society have long placed on individuals to ensure their own health and well-being. Policies guided by an ethic of "personal responsibility" particularly restrict reproductive justice (RJ),[1] a framework and set of objectives first defined by Black women as the human rights to have children, not have children, and parent children in safe, healthy, and sustainable communities.[2] RJ goes beyond an articulation of reproductive rights; it is an analytic and movement-building tool that describes how people are inseparable from the systems that they are in,[3] and how those systems make their choices possible (or not).[4] As we will make clear, the RJ framework is relevant not

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1 Ron Haskins, The Sequence of Personal Responsibility, Brookings (July 31, 2009), www.brookings.edu/articles/the-sequence-of-personal-responsibility.

2 Reproductive Justice, SisterSong Women of Color Reprod. Just. Collective, www.sistersong.net/reproductive-justice.

3 RJ centers women but explicitly acknowledges gender non-conforming and trans people and how interlocking systems of power bear on people of all genders in reproduction. See Loretta J. Ross & Ricki Solinger, Reproductive Justice: An Introduction 6 (2017). We therefore use "people" rather than "women."

4 What is Reproductive Justice?, If/When/How: Lawyering for Reproductive Justice, www.ifwhenhow.org/about/what-is-rj/.

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only to issues of reproduction and family, but also to understanding the social conditions in which individuals create families with children.

American laws and policies obstruct RJ when they ascribe blame to Black and Brown people for not meeting societal standards of family, health, and flourishing. These polices presuppose that there are certain normatively correct family structures and ways to be in the world, which are largely defined by racist, classist, and sexist ideals.[5] Personal responsibility policies attribute harms – including reproductive and other health inequities, environmental exposures, poverty, and food and housing insecurity – to individuals' choices, rather than to the social, economic, historical, or political conditions that shape those choices. These policies additively punish marginalized people who already experience structural forms of injustice, concentrating their force on Black people, other people of color, and trans people, instead of creating conditions to foster RJ.

Overall, COVID-19 policy under the Trump Administration relied heavily on an ethic of personal responsibility, as illustrated by those lawmakers who called for people to wear masks and socially distance without creating policy mechanisms that would require them to do so.[6] Yet certain responses to COVID-19 resulted in a small number of long-standing barriers to RJ falling away. For instance, some laws, policies, court orders, and procedures catalyzed by COVID-19 temporarily *increased* access to reproductive health care for some and allowed workers paid and protected time off from work to care for themselves and their family members.[7] These responses employed personal responsibility in a way that was empowering rather than controlling, facilitating recognition of reproductive autonomy by removing barriers to it and entrusting individuals to manage their own care needs.

Enacting RJ-enhancing policies should not require a pandemic. In this chapter, we call for more laws and policies that equitably enable personal power consistent with RJ. These laws and policies see people as worthy and capable of making decisions about their own and their family's health, and therefore remove barriers to, and provide the underlying support for, personal decisions. We begin by outlining how the ideology of personal responsibility has been woven into the fabric of US policy, consistently holding marginalized people accountable for maintaining prescribed standards of family, health, and well-being, while simultaneously neglecting structural conditions that impact many marginalized communities and exacting heavy tolls for non-compliance. Then, we identify three examples of RJ-enhancing policy changes enabled by the COVID-19 pandemic. While states and the federal government continued to invoke personal responsibility during the pandemic, certain policy changes recognized individuals' personal power and removed barriers to reproductive autonomy.

[5] Elisa Minoff, The Racist Roots of Work Requirements (Ctr. for the Study of Social Pol'y ed., 2020).

[6] Kimberlee Kruesi, Governors Stress "Personal Responsibility" Over Virus Orders, PBS News Hour (July 4, 2020), www.pbs.org/newshour/health/governors-stress-personal-responsibility-over-virus-orders.

[7] See infra Section III.

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Although these RJ-enhancing, COVID-19-based policies were in some cases time-limited and predominantly benefited people who already had means, they provide a kind of "proof-of-concept" for further RJ-enhancing changes to law and policy. To be truly consistent with RJ, future such measures must exist outside an ideology that conditions deservingness on blamelessness. Instead, conditions must exist which make such enhancements available to and possible for everyone. We conclude that RJ, as a goal and a framework, should undergird all US reproductive and social policy.

II RESPONSIBILITY IN US REPRODUCTIVE AND SOCIAL POLICY

COVID-19 did not inaugurate policies structured by personal responsibility. The ethics of personal responsibility and individual autonomy have been deeply engrained in US culture since the country's founding.[8] In the twentieth century, Republican and Democratic administrations alike promulgated policies demanding personal responsibility, particularly reproductive, health, family, welfare, and housing policies – some of the realms most critical to RJ.[9] Two national Democratic-administration initiatives – the Moynihan Report and Clinton-era welfare reforms – offer incomplete but instructive historical insight into the logic of personal responsibility and its opposition to RJ. These initiatives promoted the shifting of care for families from governments to individuals, while determining that individuals' worthiness of social assistance (needed for said family care) depended on their ability to care for themselves. They created a punitive regime that conditioned financial assistance on satisfying bureaucratic requirements of correct family structure, vastly reducing the aid available directly to individuals and families.

In the 1965 report *The Negro Family: The Case for National Action*, the assistant secretary of labor to the Johnson Administration, Daniel Patrick Moynihan, argued that Black families' matriarchal structures would slow the progress of Black men, and, in turn, that of Black women.[10] The report articulated the racial injustice that Black families experience in terms of individual failings that could be acted on through government policy.[11] It did so through a focus on what it called the "pathology" of "broken homes," which, it concluded, are too often headed by women dependent on welfare.[12] These supposed indictments helped to explain why,

[8] Elizabeth H. Bradley & Lauren A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less* 41 (2013).

[9] See, for example, Sandra Morgen, The Agency of Welfare Workers: Negotiating Devolution, Privatization, and the Meaning of Self-Sufficiency, 103 *Am. Anthropol.* 747, 747–61 (2001); Adam Gaffney, The Neoliberal Turn in American Health Care, 45 *Int'l J. Health Servs.* 33, 33–52 (2015); Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients Into Consumers* 1–16 (2016).

[10] Daniel Patrick Moynihan, The Negro Family: The Case for National Action 29–45 (Mar. 1965), https://web.stanford.edu/~mrosenfe/Moynihan's%20The%20Negro%20Family.pdf.

[11] Id. at 47.

[12] Id. at 12.

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in Moynihan's words, "the circumstances of the Negro American community in recent years has probably been getting worse, not better."[13] The report and its policy proposals are then framed as an act of care: attending to racial inequity and proposing interventions. But the mechanisms through which it understood that inequity, and therefore the interventions that it proposed, framed individuals and the ways that they behave and engage in family-making as the source of their own difficulties. In an analysis of the Moynihan Report, Professor Grace Hong notes that "[i]n the neoliberal moment, 'care' becomes the conduit for violence."[14] Government abrogates responsibility for injustice in favor of punishing Black people, and particularly Black women, for making what it sees as the "wrong" choices.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA),[15] signed by President Clinton, formed part of the set of Congressional Republican-led "Contract with America" reforms that sought to streamline government and require work.[16] The Act is a defining moment in the history of personal responsibility-based US policy. Its advocates promised that PRWORA would reduce the number of people on welfare and create self-sufficiency through employment by imposing limits on the number of years that people could receive cash assistance and the work requirements for that assistance.[17] PRWORA also sought to use welfare eligibility rules to bring about "proper" families (i.e., those with two married parents);[18] it did this by imposing work requirements on people with past-due child support payments,[19] and by seeking to prevent teen pregnancy through abstinence-only sex education.[20] The law substantially reduced the number of people who received assistance, though it did so largely through cuts to benefits,[21] and through imposing sanctions (disproportionately for people of color) that made those in need ineligible for benefits – not by lifting people out of poverty.[22] White people were also able to

[13] Id. at ii.

[14] Grace K. Hong, *Death Beyond Disavowal: The Impossible Politics of Difference* 20 (2015).

[15] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

[16] Brendon O'Connor, The Protagonists and Ideas Behind the Personal Responsibility and Work Opportunity Reconciliation Act of 1996: The Enactment of a Conservative Welfare System, 28 *Soc. Just.* 4, 4 (2001).

[17] Presidential Statement on Signing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 32 Weekly Comp. Pres. Doc 1487, 1488 (Aug. 22, 1996) (hereinafter, Presidential Signing Statement); see also Personal Responsibility and Work Opportunity Reconciliation Act of 1996 Conference Report Consideration, 142 Cong. Rec. S9387 (daily ed. Aug. 1, 1996) (statement of Rep. Howell Heflin).

[18] Notably, the Defense of Marriage Act, Pub. L. No. 104-199, 110 Stat. 2419 (1996), passed the same year, forbade federal programs from recognizing marriages between gay or lesbian couples.

[19] Personal Responsibility and Work Opportunity Reconciliation Act § 365; see also Presidential Signing Statement, supra note 17.

[20] Personal Responsibility and Work Opportunity Reconciliation Act § 912.

[21] Vann R. Newkirk, The Real Lessons from Bill Clinton's Welfare Reform, Atlantic (Feb. 5, 2018), www.theatlantic.com/politics/archive/2018/02/welfare-reform-tanf-medicaid-food-stamps/552299.

[22] Michael Bonds, The Continuing Significance of Race: A Case Study of the Impact of Welfare Reform, 9 *J. Afr. Am. Studs.* 18, 20 (2006).

leave welfare rolls for jobs (a key goal of the Act) in greater proportions than racial minorities, in part due to employer preferences for White employees.[23] In effect, the Act required personal responsibility, but did not create the conditions for equitably realizing and supporting it.[24]

Like other invocations of personal responsibility, PRWORA is inextricable from its racial context, including the erroneous and racist suppositions that Black people are lazy and need to be coerced into work.[25] PRWORA imagined a kind of undesirable Black family (headed by a poor single mother intent on gaming the system) that could be improved through legislation tethering work to notions of stronger and better families.[26] Sexist notions of White womanhood that praised stay-at-home parenting for women with young children did not extend to Black women, who were expected to find and pay for substitute care for their children while engaging in low-wage work.[27] Accordingly, some state welfare systems, afforded more discretion to administer cash assistance under the Act,[28] conditioned families' receipt of cash assistance on whether their family structure and practices were acceptable to the state. Some states enacted caps on cash assistance based on family size,[29] thereby casting family size as a privilege of the wealthy and as a sign of irresponsibility in the low-income community. Poor children were presumed to be both a drain on taxpayer dollars and an impediment to their mothers' transition from welfare to work. Welfare caps sought to both control Black and other low-income individuals' reproductive and familial choices and make Black women "available" to engage in more low-wage work.

Dangerous rhetoric about personal responsibility was also a hallmark of the Obama presidency. In the wake of the 2008 financial collapse, President Obama declared that "[w]hat is required of us now is a new era of responsibility – a recognition on the part of every American that we have duties to ourselves, our nation[,] and the world."[30] That speech, which did not talk meaningfully about race, asked

[23] Id.

[24] The Effects of the Personal Responsibility and Work Opportunity Reconciliation Act on Working Families: Hearing Before the H. Comm. on Educ. & Workforce, 107th Cong. (Sept. 20, 2001) (statement of Heather Boushey), www.epi.org/publication/webfeatures_viewpoints_tanf_testimony/.

[25] Minoff, supra note 5, at 9.

[26] Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 17–19 (1997). This idea is not new: before PRWORA, state legislators proposed to mandate or incentivize sterilization or long-acting birth control for women receiving welfare benefits. Elizabeth Siegel Watkins, From Breakthrough to Bust: The Brief Life of Norplant, the Contraceptive Implant, 22 *J. Women's Hist.* 88, 93 (2010).

[27] Nina Banks, Black Women's Labor Market History Reveals Deep-Seated Race and Gender Discrimination, Econ. Pol'y Inst. (Feb. 19, 2019), www.epi.org/blog/black-womens-labor-market-history-reveals-deep-seated-race-and-gender-discrimination/.

[28] Pamela Loprest, Stefanie Schmidt & Ann Dryden Witte, Welfare Reform Under PRWORA: Aid to Children With Working Families?, in *Tax Policy and the Economy* 157, 161 (14th ed. 2000).

[29] Sojourner A. v. N.J. Dept. of Hum. Servs., 828 A.2d 306 (N.J. 2003); Roberts, supra note 26, at 70.

[30] President Barack Obama's Inaugural Address (Jan. 21, 2009), https://obamawhitehouse.archives.gov/blog/2009/01/21/president-barack-obamas-inaugural-address.

Americans to make then-unspecified hard choices, anchored by values of "honesty and hard work" – the bedrocks of personal responsibility. Yet even cursory scrutiny of the causes of the 2008 recession makes clear that catastrophic losses of housing, savings, and jobs were not a failure of hard work but the result of predatory lending and poor government oversight.[31] Solutions to the recession did not lie in individual people making better choices, but in better industry practices and stronger government policies.

The kind of personal responsibility in reproductive matters called for in the Moynihan Report, enacted into the Clinton welfare reforms, and invoked by President Obama demands that everyone take responsibility for their own actions and individually contribute toward a common goal, with both the goal and the means to effectuate it limited by racist notions of deservingness and what constitutes "good" families. This is manifest in the punitive regime PRWORA created: (1) a set of requirements to work, undergirded by notions of proper family structures, in order to receive assistance; (2) the lack of an attendant guarantee of jobs; and (3) a social system that makes job acquisition more difficult for those already marginalized and where much available work does not pay a living wage.

RJ stands in ideological opposition to this regime of personal responsibility. Where personal responsibility forecloses structural explanations for people's personal struggles (while creating the conditions for many of those struggles), the RJ framework is an explicit invitation to analyze structures and develop solutions that acknowledge interdependence. As our federal policy examples illustrate, when applied to reproduction and families, the ideology of personal responsibility generates policies that control individuals' choices about reproduction and family form. Myriad examples also exist in state and local policy; for instance, some states condition the receipt of public health insurance on individuals' perceived self-sufficiency and deservingness, choosing not to expand their Medicaid programs under the Affordable Care Act,[32] or to enact work requirements to access Medicaid.[33] RJ instead insists that people can and ought to be considered instead as autonomous, capable of acting in the best interests of themselves and their communities, and, perhaps most importantly, of making their own calculations about what it means to be responsible. To enhance RJ, reproductive and social policies must not merely recognize individuals' reproductive autonomy and personal power, but must also create the conditions to enable them.

[31] The Financial Crisis Inquiry Report: Final Report of the National Commission on the Causes of the Financial and Economic Crisis in the United States, at xvii–xxii (2011).

[32] Allison K. Hoffman & Mark A. Hall, The American Pathology of Inequitable Access to Medical Care, in *The Oxford Handbook of Comparative Health Law* (David Orenlicher & Tamara K. Hervey eds., 2020).

[33] Laura D. Hermer, Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform, 38 *Hastings Ctr. Rep.* 16, 17 (2008); Minoff, supra note 5.

III THE DISPARATE IMPACTS OF PERSONAL RESPONSIBILITY IN COVID-19

Personal responsibility, long an ideological lodestar in US policy, was easy to adopt for the pandemic response, especially given the role that individual behavior has in public health efforts to prevent viral transmission.[34] In lieu of robust and uniform policy actions and social support, the United States, led by an Administration sorely lacking public health expertise or the basics of good government, left people to personally manage their COVID-19 prevention and care. The federal government issued no stay-at-home mandates and provided sparse funding for protective equipment, testing, treatment, and, initially, vaccines.[35] Aside from a $1,200 stimulus check in April 2020 and another $600 check in January 2021, as well as a temporary top-up to unemployment benefits, individuals have received very little financial assistance from the federal government, particularly when compared with other developed nations, many of which were less hard hit but provided more financial assistance to individuals, families, and small businesses.[36]

The federal government left vulnerable Americans to navigate their own financial solvency, including the cost of health care and other necessities, even while millions of jobs were lost and poverty rates rose.[37] States and localities varied widely in terms of whether or not they considered lack of federal pandemic support to be a problem. Some states considered individual choice – afforded by ideologies of personal responsibility – to be a moral necessity, while others saw relegations to individual choice as critically endangering their most vulnerable residents.

Once again, the individual was the wrong object of responsibility. COVID-19 does not merely infect and affect individuals: people live, work, travel, and commune with others – some because they want to, many others because their jobs or families require it.[38] Essential health care and other workers are disproportionately women and people of color.[39] They are most likely to be exposed to COVID-19 through their labor; their exposure risk is compounded by the improper mask

[34] Lindsay F. Wiley & Samuel R. Bagenstos, The Personal Responsibility Pandemic: Centering Solidarity in Public Health and Employment Law, 52 *Ariz. State L. J.* 1235, 1240–43 (2020).

[35] Lindsay F. Wiley, *Federalism in Pandemic Prevention and Response, in Assessing Legal Responses to COVID-19* 65, 66–67 (2020); Nancy J. Knauer, The COVID-19 Pandemic and Federalism: Who Decides?, 23 *N.Y.U. J. Leg. Pub. Pol'y* 1, 3–4 (2020).

[36] Tracey Lindeman, What Canada's COVID Response Can Teach the U.S. About Social Safety Nets, Fortune (Oct. 23, 2020), https://fortune.com/2020/10/23/canada-unemployment-cerb-economy-growth-coronavirus/.

[37] Zachary Parolin et al., Monthly Poverty Rates in the United States During the COVID-19 Pandemic 2, 4–5 (Ctr. on Poverty & Soc. Pol'y, Working Paper on Poverty and Social Policy, Oct. 2020).

[38] David Holtz et al., Interdependence and the Cost of Uncoordinated Responses to COVID-19, 117 *Proc. Nat'l Acad. Scis.* 19837 (2020).

[39] Francesca Donner, How Women are Getting Squeezed by the Pandemic, NY Times (May 20, 2020), www.nytimes.com/2020/05/20/us/women-economy-jobs-coronavirus-gender.html.

wearing, lack of vaccination, and other risky behaviors of those they encounter.[40] Research shows that racial and ethnic minorities across all ages, and particularly those aged between twenty-five and fifty-four years, have experienced significantly higher COVID-19 mortality than White people.[41] Once exposed, these same people were more vulnerable to morbidity and mortality from the virus.[42] Treating risk as an individual responsibility ignores the ways that an individual's risk is affected by the actions of others. Once again, personal responsibility fails by imagining that people will voluntarily do the work of accounting for one another without requiring them to do so.

Given this, it is surprising that the emergency conditions surrounding COVID-19 also catalyzed some long-needed reforms, which move toward RJ by reframing notions of responsibility. Here, we provide three examples of RJ-enhancing policy changes prompted by the pandemic: (1) telemedicine-supported abortion access; (2) remote access to judicial bypass hearings; and (3) paid family and medical leave. Their immediate justification was health, specifically the reduction of risk of viral spread due to in-person contact. But their impact was to remove the presumption that people are blameworthy for the social conditions in which they find themselves; that they are at fault for their own need. The fact that these changes were possible, but politically feasible only with the catalyst of a pandemic, makes manifest that often policies are conditioned on the idea that deserving help requires that a person be deemed blameless for their need.

A *Telemedicine-Supported Abortion Access*

Telemedicine allows physicians to supervise patients remotely accessing abortion care. Allowing individuals to remotely access medication abortions increases access to abortion care, especially for people of color, people with disabilities, people living in rural areas, and low-income people.[43]

At the beginning of the pandemic, policy changes by both public and private actors supported the near-instant adoption and implementation of telemedicine care, which included reproductive health care services, such as contraception prescriptions and

[40] William F. Marshall, Why Are People of Color More at Risk of Coronavirus Complications?, Mayo Clinic (2020), www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802.

[41] Mary T. Bassett, Jarvis T. Chen & Nancy Krieger, The Unequal Toll of COVID-19 Mortality by Age in the United States: Quantifying Racial/Ethnic Disparities, 19 Harv. Ctr. for Population & Dev. Studs. Working Paper Series 2 (June 12, 2020).

[42] Samantha Artiga & Kendal Orgera, Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010–2018, Kaiser Fam. Found. (Mar. 5, 2020), www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018.

[43] Megan K. Donovan, Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care, 21 *Guttmacher Pol'y Rev.* 41, 43 (2018); David S. Cohen & Carole Joffe, *Obstacle Course: The Everyday Struggle to Get an Abortion in America*, 13, 60–63 (2020).

some preventative, screening, and routine care.[44] Initially, telemedicine implementations could not include medication abortion due to a Food and Drug Administration (FDA) "Risk Evaluation and Mitigation Strategy" (REMS) policy, which bars the distribution of mifepristone, the first of two medications used in medication abortion, at pharmacies and limits it to registered providers at clinics and hospitals, on the pretextual basis of safety.[45] But in 2020, litigation brought by the American College of Obstetrics and Gynecology, with the RJ collective SisterSong as one of the co-plaintiffs, successfully enjoined the REMS policy nationwide for several months to enable medication abortion by telemedicine during the COVID-19 pandemic.[46] The plaintiffs' American Civil Liberties Union lawyers particularly framed the legal issue in terms of the disproportionate impact of the FDA policy on low-income people of color.[47]

Even with the FDA's policy enjoined, a number of state regulations continue to forbid telemedicine exclusively for abortion care.[48] And, in January 2021, the Supreme Court stayed the federal district court's injunction order, reinstating the FDA REMS policy and again singling out abortion care for unnecessary and harmful burdens to treatment.[49] In her dissent, Justice Sonia Sotomayor reiterated the particular RJ concerns, noting that the FDA allowed many other drugs, including some controlled substances, to be dispensed without in-person visits, and questioning why a similar approach could not be taken to abortion medications, especially given the disparities in prevalence, morbidity, and mortality from COVID-19 for Black and Brown communities.[50]

Despite existing state bans and the Supreme Court's ruling on the REMS policy, the conditions of the pandemic may yet catalyze lasting change for remote abortion access. At the time of writing, the Biden Administration's FDA is "exercising enforcement discretion" of its REMS policy for mifepristone and reviewing the policy more broadly.[51] If this review leads to policy change, it will be long overdue – multiple administrations have failed to take on board RJ-centered advocacy and lawyering highlighting the harmful effects of FDA's REMS policy, particularly on

[44] Carmel Shachar, Jaclyn Engel & Glyn Elwyn, Implications for Telehealth in a Post-Pandemic Future, 323 *JAMA* 2375, 2375–76 (2020).

[45] Compare Food & Drug Admin, Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200MG 1-3 (Apr. 2019), with Ctr. for Drug Evaluation & Rsch., Risk Assessment and Risk Mitigation Review: 202107Orig1s000, at 2 (2012), and Nat'l Acads. of Sci., Eng'g & Med., The Safety and Quality of Abortion Care in the United States 55 (2018).

[46] Food & Drug Admin. v. Am. Coll. Obstetricians & Gynecologists, 472 F.Supp.3d 183, 233 (D. Md. 2020).

[47] Complaint at 33, 36–37, Food & Drug Admin. v. Am. Coll. Obstetricians & Gynecologists, 472 F.Supp.3d 183, 233 (D. Md. 2020) (No. 8:20-CV-01320).

[48] The Availability and Use of Medication Abortion, Kaiser Fam. Found. (June 16, 2021), www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/.

[49] Food & Drug Admin. v. Am. Coll. Obstetricians & Gynecologists, 141 S.Ct. 578, 578 (2021).

[50] Id. at 590.

[51] Carrie N. Baker, Advocates Cheer FDA Review of Abortion Pill Restrictions, Ms. Mag. (May 11, 2021), https://msmagazine.com/2021/05/11/fda-review-abortion-pill-restrictions-mifepristone-biden/.

marginalized people.[52] However, the pandemic's conditions laid bare these harms for policymakers and made clear that RJ-centered abortion care is possible and necessary. What has been missing is the will of federal and state governments to adopt policies centering on the collective, rather than the individual.

B *Remote Access to Judicial Bypass Hearings*

Following the Supreme Court's affirmation of laws requiring parental consent for abortion on the basis of minors' safety in *Bellotti v. Baird* and *Planned Parenthood v. Casey*, more states have required that minor patients seeking abortion obtain parental consent.[53] In these jurisdictions, minors who are not able to get parental consent for any reason may receive an abortion *only if* they receive a "judicial bypass" order from a judge. It is well documented that judicial bypass requirements pose particular barriers to low-income and disabled young people, people who live in rural communities, and young people who became pregnant as the result of violence from accessing safe and legal abortion.[54] Accessing abortion through judicial bypass is further known to be a humiliating and traumatic experience for many young people.[55]

During COVID-19, court proceedings in some jurisdictions were moved to remote venues, a change that anecdotally increased young peoples' access to abortion by alleviating the logistical and emotional barriers of judicial bypass hearings.[56] With remote hearings, young people did not have to miss school, pay for or arrange travel to court, or experience acutely daunting or traumatic in-person hearings in courtrooms or judicial chambers discussing their reproductive decisions. Although we believe that the underlying laws should be fully repealed, we note that this small policy change inches toward RJ. If made permanent, it could be especially impactful to young people for whom travel, missed school, or the in-person hearing represent even greater hardships or trauma.

C *Paid Family and Medical Leave*

The pandemic has made obvious the interconnectedness of America's underpaid workforces. The pandemic catalyzed Congress to pass temporary paid family and

[52] Id.; see also Greer Donley, Medication Abortion Exceptionalism, 107 *Cornell L. Rev.* 627 (2021), https://scholarship.law.pitt.edu/cgi/viewcontent.cgi?article=1403&context=fac_articles.

[53] Bellotti v. Baird, 443 U.S. 662, 649 (1979); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 899 (1992); Jon Wong, Young People Deserve Access to Abortion Care Swiftly, Without Shame or Stigma, If/When/How: Lawyering for Repro. Just. (July 16, 2018), accessible at www.ifwhenhow.org/resources/overview-young-peoples-access-to-abortion-care/.

[54] Wong, supra note 53.

[55] Kate Coleman-Minahan, Amanda Jean Stevenson, Emily Obront & Susan Hays, Young Women's Experiences Obtaining Judicial Bypass for Abortion in Texas, 64 *J. Adolescent Health* 20 (2019).

[56] This anecdote stems from one of the author's (RLZ) work supporting minors seeking judicial bypass in Pennsylvania.

medical leave,[57] for which Americans have advocated for decades. Paid medical, family, and sick leave is essential for people to have time, funds, and for many within America's current structure of health coverage, insurance to care for their own health needs as well as those of their dependents. Paid leave, as well as pay for family home care, are also critical to people's financial stability,[58] and is thus especially critical for marginalized people who are more likely to work in jobs that most expose them to the pandemic. Economic stability has lifesaving importance for many, including victims of domestic violence who are separating from and leaving abusive partners.[59]

Unfortunately, mandatory COVID-19 paid leave, already limited to employees at large companies, health care employers, and otherwise,[60] expired on December 31, 2020 and was only replaced by a voluntary tax credit for employers through March 2021.[61] However, like remote abortion care, the pandemic's conditions catalyzed long-requested conversations about the necessity for paid leave. At the time of writing, Congress is considering including some form of paid leave in its 2021 domestic social policy bill.[62]

These changes are particularly laudable because they model policy that is materially beneficial without conditioning access on blamelessness. But, as already noted, the three examples of long-overdue, RJ-enhancing policy changes described above are or were temporary and limited in scope. More problematically, even these temporary advances best serve those who already have means: people who have legal, financial, and logistical access to telehealth providers to manage abortion and people in employment positions from which paid leave can be taken.[63] Thus, while these COVID-19-stimulated policy changes were laudable, some were not only ineffectual for marginalized individuals (for whom they were most needed), but in practice further entrenched harms to them by requiring them alone to continue to work when they or their family members were sick and to overcome numerous barriers to seek reproductive care in person. Despite these limitations, the three examples provide proof-of-concept for more robust future changes.

Centering the RJ framework in future policies is critical to remedying inequity. Mainstream reproductive rights discourse, which has been largely controlled by

[57] Families First Coronavirus Response Act, Pub. L. No. 116-127 § 3102, 141 Stat. 178, 189 (2020).

[58] Mercer Gary & Nancy Berlinger, Interdependent Citizens: The Ethics of Care in Pandemic Recovery, 50 *Hastings Ctr. Rep.* 56, 1–2 (2020).

[59] Ralph Henry, Domestic Violence and the Failures of Welfare Reform: The Role for Work Leave Legislation, 20 *Wis. Women's L.J.* 67, 68–69 (2005).

[60] Paid Leave Under the Families First Coronavirus Response Act, 85 Fed. Reg. 19,326, 19,327 (Apr. 6, 2020).

[61] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 § 286, 134 Stat. 1182, 1989 (2020).

[62] Caitlyn Kim, House Democrats are Bringing Back Paid Leave in Their Spending Bill, NPR (Nov. 3, 2021), www.npr.org/2021/11/03/1052121244/pelosi-says-house-democrats-are-bringing-back-paid-leave-in-their-spending-bill.

[63] Families First Coronavirus Response Act, Pub. L. No. 116-127 § 3102, 141 Stat. 178, 189 (2020).

White middle and upper-class women and from which COVID-19 telemedicine abortion and paid leave changes stemmed, is rooted in the neoliberal conceptions of choice that "locate[] individual rights at [their] core, and treat[] the individual's control over her body as central to liberty and freedom."[64] While this conception of reproductive rights is distinct from the personal responsibility policies discussed that seek to *explicitly* punish individuals for non-compliance with social standards, any policy focused on individual choice "obscures the social context in which individuals make choices, and discounts the ways in which the state regulates populations, disciplines individual bodies, and exercises control over sexuality, gender, and reproduction."[65]

In contrast, as we have shown, an RJ approach rejects conceptions of blameworthiness and addresses the ways that economic and institutional constraints on women of color and other marginalized people can restrict their choices.

IV A CALL FOR RESPONSIBILITY COMPATIBLE WITH AND ENABLING RJ

In her dissent from the Court's decision to reinstate FDA's REMS program, Justice Sotomayor made plain the intersectional implications of requiring pregnant people to risk exposure to COVID-19 to receive a prescription for medication abortion. First, she explained that COVID-19 makes pregnant people more susceptible to bad outcomes.[66] Then, she noted that:

> [M]ore than half of women who have abortions are women of color, and COVID-19's mortality rate is three times higher for Black and Hispanic individuals than non-Hispanic White individuals. On top of that, three-quarters of abortion patients have low incomes, making them more likely to rely on public transportation to get to a clinic to pick up their medication. Such patients must bear further risk of exposure while they travel, sometimes for several hours each way, to clinics often located far from their homes. Finally, minority and low-income populations are more likely to live in intergenerational housing, so patients risk infecting not just themselves, but also elderly parents and grandparents. These risks alone are significant deterrents for women seeking a medication abortion that requires in-person pickup.[67]

Justice Sotomayor's dissent, which Justice Elena Kagan joined, focuses not on those who are most able to move forward with abortion care despite the in-person requirement, but on those for whom this rule creates an undue burden to accessing

[64] *Policing the National Body: Race, Gender and Criminalization in the United States*, at xi (Anannya Bhattacharjee & Jael Silliman eds., 2003).
[65] Id.
[66] Food & Drug Admin., 141 S.Ct. at 582.
[67] Id. at 585.

care. In true RJ fashion, Sotomayor centers those most vulnerable people who are affected by the outcome of this case – women of color and women who are low-income – and finds that the policy imposes an "unnecessary, unjustifiable, irrational, and undue burden" on the constitutionally protected right to abortion. Unfortunately, Sotomayor's RJ-informed approach did not convince the majority of Supreme Court justices, who saw no reason to interfere with the FDA's assessment that, even in a pandemic, in-person prescription of abortion medications should be required. As Justice Sotomayor points out, the majority maintained this view despite the failure of the FDA to provide any reasons "explaining why the Government believes women must continue to pick up mifepristone in person, even though it has exempted many other drugs from such a requirement given the health risks of COVID-19."[68] The majority's refusal to require reasons from the FDA and lack of interest in the real-world impact of the FDA's policy is consistent with an approach to personal responsibility that understands financial and logistical (and in this case, even health-related) barriers to accessing abortion care as the responsibility of the individual rather than as facts about American society that American regulators have a responsibility to consider when making policy. In this way, the majority upheld and affirmed an atomistic and hands-off conception of responsibility – and, through it, of individual autonomy – rather than an understanding that seeks to empower individuals so that they can choose how to care for themselves and their families. Though people seeking abortions received no relief from the Supreme Court, the FDA did finally relent under the continued weight of advocacy and evidence that its rule inhibited access to needed care without creating safety benefits to those seeking medication abortions. On December 16, 2021, the agency reversed course by announcing that it would jettison the unnecessary in-person dispensing requirement for mifepristone – thus easing a burden that had persisted for far too long.[69]

This expression of personal responsibility has long structured reproductive policy in the United States, bolstered by a sense that it is an uncontroversial and bipartisan appeal to an individualism highly prized by Americans. But it rests on an impoverished and often unrealistic notion of individual autonomy that foregrounds the idea of individual choice while failing to support the necessary conditions to enable all, or even most, individuals to actually make choices consistent with their own values and interests. The COVID-19 pandemic has further exposed the failure of this conceptualization of autonomy by making clear the profound ways in which individual flourishing is not an individual matter.

Recognizing a fuller understanding of autonomy has driven this move in reproductive ethics from a negative to a positive rights approach – an approach led by the RJ movement. In the RJ approach, responsibility is not eliminated. Rather, RJ calls

[68] Id. at 590.

[69] See Food & Drug Admin., Questions and Answers on Mifeprex (2021), www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex.

for policies that enable and promote personal power, simultaneously recognizing interdependence and facilitating autonomy. Such policies are even more necessary in light of state laws, including those in Texas, Mississippi, and up to twenty other states, that imminently challenge the constitutional right to abortion.[70]

The pandemic catalyzed limited expressions of RJ-centered policymaking, in changes permitting remote management of reproductive care and remote judicial bypass of laws requiring parental consent for minors' abortions, as well as policies expanding access to paid family leave. These policies reflected the reality of our interconnected existence, if obliquely. They removed barriers to people making personal decisions, if temporarily. They illustrate that RJ-consistent policy is possible in the United States. Adopting an RJ approach in future policy allows us to recognize our society's interdependence. Doing so is necessary for all our health and flourishing.[71]

[70] Elyssa Spitzer & Nora Ellmann, State Abortion Legislation in 2021, Ctr. for Am. Progress (Sept. 21, 2021), www.americanprogress.org/issues/women/reports/2021/09/21/503999/state-abortion-legislation-2021/; Abortion Policy in the Absence of Roe, Guttmacher Inst. (Oct. 1, 2021), www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe.

[71] Since the writing of this chapter, abortion rights and access have been fundamentally diminished following the Supreme Court's overturning of Roe v. Wade, Planned Parenthood of Pennsylvania v. Casey, and the acknowledgement of a constitutional right to abortion in Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228 (2022), subsequently passed or triggered state laws significantly or completely limiting abortion rights and access, and pending litigation challenging the FDA's long-standing approval of mifepristone to be used as a first step in medication abortions. (In contrast with this chapter's call for the FDA to use its expertise and discretion to further increase access to mifepristone, this litigation seeks to entirely overturn the FDA's expert judgment and eliminate access to mifepristone for abortion.) These and further attacks on the legal right to access reproductive health care only make greater and more urgent the need for laws and policies rooted in reproductive justice and providing for conditions enabling personal power and autonomy.