

EXHIBIT 57

Risking Everything to Offer Abortions Across State Lines

Doctors and midwives in blue states are working to get abortion pills into red states — setting the stage for a historic legal clash.



By Emily Bazelon

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When Linda Prine learned she was pregnant in 1970, she was a first-year college student in Wisconsin, where abortion was largely illegal. The doctor who gave her the news saw the look on Prine's face and handed her a slip of paper with a phone number. Prine waited until other students in her dorm left for class to call from a phone in the hallway. The woman she spoke to gave her the names of psychiatrists and told her to persuade them that she would be suicidal if she were to have a baby. Prine followed the instructions and was able to get an appointment for an abortion at the university hospital.

The night before, she checked into a room on the maternity ward with seven other women. A few of them, in their second trimester, were given large injections of saline into their uteruses, a means of inducing labor. Nurses refused to give them pain medication, and the women went into labor through the night, crying, as Prine and the other patients held their hands and wiped their brows.

The suffering of that night stayed with her, and after college, Prine became a labor organizer and a nurse. At her 10th high school reunion, she ran into an ex-boyfriend who had become a doctor. Prine decided that if he could do it, so could she. By the late 1980s — a decade and a half after *Roe v. Wade* made abortion legal — she was a resident in family medicine in New York, and her program offered training in surgical abortions, which was (and still is) unusual for that specialty. "I didn't realize how lucky I was," Prine told me recently over the phone. "They were training us to be activists as much as doctors."

When she became a physician, Prine worked at a primary-care center. If patients in her practice needed an abortion, she referred them to a stand-alone Planned Parenthood clinic, where she also worked. Outsourcing the procedure made little sense to Prine. "We did maternity care," she says. "We delivered babies. Why wouldn't we do abortions, which were so much less complicated? It seemed like we were swallowing the stigma." In 2000, she included surgical abortions as part of her regular practice and received funding in part to create a protocol for other primary-care clinicians to incorporate them as well.

That same year, the Food and Drug Administration approved a combination of two pills — mifepristone and misoprostol — for medication abortions, and Prine saw another way to make abortion care more accessible. She offered her primary-care practice as a site for clinical trials, run by other researchers, who found that it was safe and effective to give women the pills and send them home to miscarry, with backup care. "It was just

so much easier to integrate taking care of people with pills than with a surgical procedure in a busy primary-care office,” she says. “Anybody in primary care can do a pill — doctors, advanced-practice nurses, physician assistants. It takes about one hour of training to learn what you need to learn.”

But to her frustration, the F.D.A. erected barriers by requiring providers to obtain a special certification to dispense the pills and by placing a warning on mifepristone about life-threatening effects, citing safety risks to women (from the rare event of an incomplete abortion or a serious infection). The rules also mandated that providers see patients and give them the pills in person — blocking the path for medication abortion through telemedicine. And yet evidence mounted that it was safe and effective for patients to consult with doctors over phone or video when they were prescribed the pills, rather than having to go to a clinic. So abortion rights advocates including Prine pushed the F.D.A. to lift the rules preventing telemedicine abortions. Abortion opponents saw a threat that could put abortion, self-managed at home, in women’s hands, and they campaigned to prevent it. Beginning in 2011, 19 conservative states made it illegal to provide a medication abortion without seeing a patient in person, adding their own rules and penalties alongside the F.D.A.’s requirement of an in-person visit.

To providers like Prine, finding ways to increase access in red states became imperative when Texas imposed restrictions on abortion clinics in 2013 that led more than half of them to close. Prine started flying to New Mexico once a month to be the abortion provider at a clinic in Las Cruces, near the Texas border. As clinics continued to shut down in conservative parts of the country, she decided it was time to adopt more radical tactics. In 2019, Prine called Rebecca Gomperts, a Dutch physician and international activist, who, like her, saw abortion pills as the future.

More than a decade earlier, Gomperts started an online help desk, Women on Web, for people in countries where abortion was illegal or unavailable. In 2018, she expanded to the United States, starting a new telemedicine service called Aid Access, in response to pleas from women in states where clinics were closing and doctors were barred from offering telemedicine abortions. Gomperts used her Austrian medical license and prescribed pills to be mailed by a distributor in India — thus operating, she has found, beyond the reach of U.S. authorities.

Prine asked Gomperts how she could help, and with another doctor, she created the Miscarriage and Abortion Hotline, to answer questions from Aid Access patients and anyone else ending a pregnancy at home. A dozen doctors volunteered for hotline shifts. A year later, the pandemic began. Flights from India were grounded, and Aid Access’s supply of pills could not get to the United States. Gomperts appealed to clinicians in the United States for help. In July 2020, a federal judge eased the way by suspending the in-person requirement for medication abortion in light of the pandemic. A small group of doctors, including Prine, began supplying pills to Aid Access patients in states where they legally could. In the chaotic early months of the pandemic, the providers shipped pills themselves. “Handwriting the mailing labels was time consuming, so I got a labeling machine,” says Erika Bliss, a 53-year-old family-medicine doctor in Washington State. “I had a table in my office with 70 packages at a time ready to go.” When flights from India resumed, Gomperts and her network of American providers became the only telemedicine abortion service to publicly serve the whole country.

On June 24, when the Supreme Court overturned *Roe v. Wade*, Prine was in the car as her phone blew up with calls directed from a clinic in a blue state. She talked to dozens of women whose appointments for an abortion had just been canceled in Texas, Louisiana and Oklahoma. “People were a mess, so upset and angry, crying,” she says.



“Make the pills affordable and ensure that the most vulnerable people have access to them,” says Rebecca Gomperts, a Dutch physician who began prescribing abortion pills online in 2006 to women in places where they are illegal or unavailable. Alana Paterson for The New York Times

When the landscape settles, abortion is likely to be illegal or severely restricted in at least 20 states — where just two years ago, in 2020, about 250,000 people had abortions. It is clear that clinicians in those states will face imminent prosecution if they continue to provide abortions. What is much less clear is what happens if providers in blue states offer telemedicine abortions to women in states where that’s against the law. These clinicians, too, could be arrested or sued or lose their medical licenses. To protect themselves, they may have to give up traveling to certain parts of the country — and it’s still no guarantee.

In the face of so much uncertainty and an invigorated anti-abortion movement, large organizations and most clinicians are loath to gamble. But Aid Access providers think that the end of Roe calls for doctors to take bold action. Their answer is to mail many more pills to women who otherwise may be forced to carry pregnancies they don’t want.

Sitting in her office in New York, hundreds of miles from states that could go after her, Prine, at 71, was close to retirement and willing to take chances. “I don’t want younger physicians to be embroiled in lawsuits or criminally charged,” she said. “I’m the one that should happen to. Doctors like me who are at the end of our

careers, we should be the ones to step up.”

The court’s decision overturning Roe last June, Dobbs v. Jackson Women’s Health Organization, polarized the public while opening the door to a new threat — a direct clash among the states over abortion law. In jettisoning the single national standard Roe established, the court invited states to pass or enforce their own laws, which could be diametrically opposed to those of neighboring states. “In some states, voters may believe that the abortion right should be even more extensive” than Roe, Justice Samuel A. Alito Jr. wrote for the majority. “Voters in other states may wish to impose tight restrictions based on their belief that abortion destroys an ‘unborn human being.’”

Alito didn’t discuss what would happen if the new regime wound up pitting states against one another. Yet those tensions seem inevitable. Some advocates are turning to states to either end abortion — by treating it as a felony, including murder — or to safeguard it as a fundamental human right. “In a post-Roe country, states will attempt to impose their local abortion policies as widely as possible, even across state lines, and will battle one another over these choices,” three law professors, David S. Cohen of Drexel University, Greer Donley of the University of Pittsburgh and Rachel Rebouché, the dean of Temple University’s law school, wrote in a draft article for The Columbia Law Review in February. “In other words, the interjurisdictional abortion wars are coming.”

Cohen, Donley and Rebouché laid out legal strategies that could benefit an organization like Aid Access as it serves women seeking abortions in newly restricted states. The most promising, in their telling, were abortion shield laws — protections that states in favor of abortion access could offer their providers. Pro-access states can “promise that their law-enforcement agencies won’t investigate” a local provider who is accused by another state of helping a woman there have an abortion, Cohen told me. In civil as well as criminal cases, “their courts won’t recognize an anti-abortion state’s subpoena or a summons. They won’t extradite you.” A pro-access state could also try to protect providers from losing their medical licenses and prevent malpractice-insurance carriers from raising rates or dropping policies based on an out-of-state lawsuit.

State shield laws for abortion undermine basic premises of interstate cooperation. One state effectively throws a wrench into the enforcement of another state’s laws. Cohen, Donley and Rebouché argue that shield laws are a means for the abortion rights movement to “pivot from defense to offense.”

In March, Cohen testified before a committee of the Connecticut Legislature on behalf of the first abortion shield law. The bill, which passed in late April, said that Connecticut would not cooperate if Texas, for example, tried to prosecute or sue a Connecticut health care provider who performed an abortion for a patient who traveled to the state for the procedure.

Cohen saw Connecticut’s shield law as an important first step. But it didn’t address the scenario that he and providers like Prine think matters most: helping women for whom travel is out of reach. A quarter of women of childbearing age in the United States currently live — or will soon live — at least 200 miles from an abortion clinic. That distance tends to pose an insurmountable obstacle for a significant number of people, research shows, especially if they have low incomes. A trip out of state can easily run to \$2,000 or more and often requires lining up a place to stay and child care (most people who get abortions have children). If the burden of travel delays an abortion into the second trimester, the cost and strain rise.

A pro-access state could try to help more women by passing a shield law that covers providers who live within its borders and prescribe pills through telemedicine across state lines. But legally speaking, this is far more disruptive to state relations than protecting providers when patients travel to see them. “The whole model for telehealth law and policy is that telemedicine takes place where the patient is,” Rebouché says.

Article IV of the Constitution, which addresses the relationships among states, says that if a person charged with a crime in one state flees to another, she must be “delivered up,” or extradited, to the first state. If a doctor from Connecticut, for example, went to Texas, performed an illegal abortion there and then went home, Connecticut would have to send that doctor to Texas for prosecution. But courts have held in the past that if the person never set foot in the state that is prosecuting her, then she didn’t flee, and her state of residence has no constitutional obligation to extradite her. (For example, three suspects in an Ohio murder who were living in North Carolina successfully fought their extradition to Ohio in 1979 by saying they weren’t there when the crime was committed.) States often permit or require extradition even without an act of flight. Cohen, Donley and Rebouché argue that pro-access states could make an exception for providers of telemedicine abortions.

But there’s a catch. If a provider travels outside her home state while Texas has a warrant for her arrest, another state without a shield law could follow the customary practice of interstate cooperation — and extradite her to Texas. In addition, if an abortion provider in a pro-access state like Connecticut is *sued* in Texas rather than prosecuted, Article IV requires the states to help enforce a civil judgment. Connecticut would probably be obligated to comply in collecting damages, for example, if a family member of a woman who had an abortion won a lawsuit for the wrongful death of a fetus. To deter these sorts of suits, Cohen, Donley and Rebouché suggest that states that want to shield their abortion providers could authorize them to countersue for interfering with legally protected health care. “If you’re hoping for a \$1 million judgment in Alabama, but you know New York will let someone try to get it back from you, maybe you don’t sue in the first place,” Cohen says.

The closest historical analogy, however imperfect, for the coming clash may be the conflict between Southern and Northern states over fugitive slave laws in the 19th century. “There are genuinely significant differences between slavery and abortion, morally and legally,” says Jamal Greene, a law professor at Columbia University. “But it’s a reasonable starting point for understanding why it’s a problem, in a nation that wants to hold itself together, when individual states are allowed to make policy about basic rights that people feel extremely strongly about, on both sides.”

Tensions among the states can become corrosive. The framers of the Constitution gave enslavers the power to recapture enslaved people who escaped to free states. As the cause of abolition gained support, some free states passed personal liberty laws that protected Black people from kidnapping. In 1842, in *Prigg v. Pennsylvania*, the Supreme Court weighed in on the side of the South, striking down the conviction in Pennsylvania of a slave catcher for kidnapping a mother and her children.

Seizures of formerly enslaved people increased in the wake of the court’s ruling, but so did the resistance in free states, where people rejected the rule imposed by *Prigg*. The case “could easily be called the worst Supreme Court decision ever issued,” Greene wrote in *The Harvard Law Review* in 2011. The ongoing state-on-state clashes were one of many factors that contributed to the dissolution of the Union and the Civil War.

Today, with Republicans in power in states with abortion bans and Democrats in control of states with shield laws, partisan division could fuel the fight. Eventually, a case is likely to make its way to the Supreme Court, but Prigg shows that may not be the last word. “No legal rule says who has to stand down,” Greene says. “There could just be eternal conflict.”

Last December, when the Supreme Court heard the arguments in Dobbs, abortion rights groups rushed to get a response underway in states where they had political power. They offered an array of proposals, including state constitutional amendments enshrining the right to an abortion and funding for out-of-state patients.

The effort took on new urgency when a draft of Justice Alito’s opinion in Dobbs leaked to Politico in the beginning of May. Prine received a call from Shelley Mayer, a Democratic state senator in Westchester County and a supporter of abortion rights, who was also thinking about whether New York could pass a law that would allow providers to help women in other states who weren’t able to travel hundreds of miles for abortions.

Prine knew that to pass, a bill needed support from medical and abortion rights groups. It became clear that some were more open than others to the legal uncertainty of a telemedicine shield law. The Center for Reproductive Rights, a global legal group, which had already been researching how states could ensure access to abortion as widely as possible, came on board. “The risk is real, but the need is incredibly great, and we need to protect providers as best we can so they can help meet it,” says Elisabeth Smith, the center’s director for state policy. The New York State Academy of Family Physicians passed a resolution in favor of a telemedicine shield bill and set up meetings with other lawmakers. Reproductive Health Access Project, a group Prine helped found (and retired from in 2020), supported a petition drive for telemedicine and other abortion rights proposals.

But some abortion rights groups — the New York Civil Liberties Union and Planned Parenthood in New York — did not put their weight behind a telemedicine shield proposal. “We think it’s high legal risk,” Katharine Bodde, a lawyer for the N.Y.C.L.U., told me. “You don’t want to send providers false assurances that they are totally protected by the law” when an anti-abortion state still might try to sue or prosecute them. She was also concerned about “various consequences beyond our ability to reduce that risk.” For example, she says, a state like Alabama could retaliate by shielding Alabama therapists who use telemedicine to provide conversion therapy for L.G.B.T. patients in New York, where it’s illegal.

One reason the N.Y.C.L.U. and other groups didn’t use their political capital to push for telemedicine shield laws was that they had a different legislative priority: amending the State Constitution to broadly protect the right to birth control and abortion and prevent discrimination on the basis of pregnancy, as well as several other categories. (Passing an amendment is a multiyear process in New York; the first stage passed in a special legislative session on July 1.)

To Prine, the caution about legal risk was frustrating and familiar. “I just want to scream, ‘This is a public health emergency!’” she texted me at one point. Three years ago, when she started the Miscarriage and Abortion Hotline to help Gomperts, she heard similar arguments from some lawyers who supported abortion rights. “They said: You’ll get sued for malpractice. You’ll lose your licenses. You’ll face charges.” She went ahead anyway and never faced those dire consequences. The hotline has since become an essential resource for people who end their pregnancies at home. “These people who say ‘bad things will happen to providers’ — let us decide for ourselves. If we want to stick our necks out, what is the point of holding us back if it might benefit people who need abortions?”

But Prine and her allies couldn't muster enough support for a telemedicine shield proposal in New York. Instead, alongside Connecticut, California, Delaware, New Jersey, and New Mexico, New York passed a law that covers abortion providers when patients travel to the state.

In July, the kind of telemedicine shield law that Prine wanted advanced in a single state: Massachusetts. Cynthia Friedman, a state senator from the Boston suburbs, attached it to a bill that included the state's annual budget. Without using the word "telemedicine," Friedman sought to reduce risks to her state's health care providers from out-of-state charges and lawsuits "regardless of the patient's location" if they performed abortions that complied with Massachusetts law.

Prine watched with some envy as a broad progressive coalition, including reproductive rights, racial justice, labor and L.G.B.T. advocates, united behind Friedman's bill. It also included protection for providers of gender-affirming medical treatment. "We said, We can try to strengthen protections in our state as much as we can," says Carol Rose, the executive director of the A.C.L.U. of Massachusetts, which in contrast to the N.Y.C.L.U. helped draft the telemedicine shield provision with the state attorney general's office. Attorney General Maura Healey, a Democrat who is running for governor, said in a statement to me, "We cannot allow our agencies and institutions to become complicit in other states' efforts to block access to critical health care."

As the bill worked its way through the Legislature, the implicit protection for telemedicine received little press coverage, which was fine with the bill's supporters. It passed the State House 136 to 17 at the end of June and passed 40 to 0 in the State Senate. All that remained was the signature of Gov. Charlie Baker, a Republican who favors abortion rights. On July 29, Baker signed the bill into law. (Through a staff member, he declined to comment on why he supported a telemedicine abortion shield law.)

The Massachusetts law gave Prine and the other Aid Access providers momentum. They hoped it would set a new standard for other states to follow.

In August, Prine and Gomperts spent the weekend at a rented house outside Toronto with a group of doctors and midwives who work for Aid Access. Though some of the providers were friends or colleagues before they joined, this was the first time they were all meeting in person, after months of working over email and video chats.

There were seven Americans in the group, between the ages of 32 and 74. They saw reproductive health as endangered in the United States, and that propelled them. Erika Bliss in Washington State and another doctor in the Hudson Valley (who asked me not to name her for security reasons) had practices that included end-of-life care. Ruchi Kaul integrated Eastern and Western medicine in her primary-care practice in New Jersey. Christie Pitney and Robin Tucker were nurse midwives from the Washington, D.C., area. Razel Remen, a family-medicine doctor in Michigan, credited her activism to the progressive talk radio she listened to with her mother while growing up in Brooklyn. Suzanne Poppema, a 74-year-old reproductive rights leader in Washington State, joked that when people warned her she could lose her medical license, she told them that she was retired and didn't care.

"Imagine a very large number of providers prescribing from states with shield laws," says Razel Remen, a doctor in Michigan who works with Aid Access. "It would be really hard to go against all of us." Alana Paterson for The New York Times

The providers left their shoes at the door, took turns cooking meals and talked about how to get more abortion pills into women's hands in red states. They knew that Aid Access was singularly willing to do so. Since the lifting of the F.D.A. requirement of an in-person visit for prescribing mifepristone — a change the Biden administration made permanent in late 2021 — several start-ups had entered the telemedicine abortion market. They included nonprofit ventures (Just the Pill, Carafem) and private companies, like Abortion on Demand, Choix and Hey Jane, which has raised more than \$3 million in venture capital funding. Like Aid Access, the start-ups asked patients to fill out an intake form about their medical history and date of pregnancy, which a medical professional reviewed. But the start-ups offered more limited services. Most provided pills through the 10th week of pregnancy; Aid Access offers them through the 12th week, which studies have shown to be safe. Most notable, the start-ups didn't write prescriptions for pills in states with bans.

After Dobbs, queries to Aid Access tripled to about 3,600 a month from about 1,200, roughly two-thirds of them from women in states with abortion bans. A Mexican nonprofit, Las Libres, has started providing abortion pills to women in the United States. Individuals also send them privately. And it is possible to order pills straight

from a foreign drug distributor. (Neither Las Libres nor foreign distributors include a medical screening.)

For the Aid Access providers, who wanted to build trust with women and reach more of them, the main challenge was delivery times, which were affected by the patchwork of state laws. When Gomperts prescribed pills to people in states where abortion is illegal, they sometimes had to wait two or three weeks for the packages to arrive from India. Patients in states where telemedicine abortion is legal, by contrast, obtained prescriptions from the U.S. providers and received pills in just a few days from a California-based mail-order pharmacy, Honeybee Health.

On the Sunday afternoon of their weekend gathering near Toronto, the providers sat in a living room with burgundy marbled wallpaper and spoke with Francine Coeytaux, a longtime ally of Prine and Gomperts's and a founder and director of Plan C, which promotes access to self-managed abortions with pills. She floated an idea: What if the U.S. providers said they were prescribing pills for miscarriage management rather than abortion? That would allow the prescriptions to fall outside the scope of abortion bans, which meant an American pharmacy might fill them, speeding up delivery times.

The suggestion exposed an internal tension that the women in the room felt. They were desperate to figure out ways to continue doing what they had always done: provide abortions for women who needed them. And they knew that medically speaking, there was little distinction between abortion and miscarriage. "But that doesn't work for us legally," said the doctor from the Hudson Valley. "Two years ago, we were talking about how we might lose our licenses. The stakes have changed." In more than a dozen states, providing an abortion was now a felony. The punishment included a prison term ranging from two to 99 years. "We're talking about serious criminal charges."

"Those are life-changing consequences," Coeytaux acknowledged.

"We should be thinking first about a legal way to do this," the Hudson Valley doctor said.

There were already a couple of ways for women in states with abortion bans to receive pills without shipping from India. They could rely on mail-forwarding companies, which allow them to give an address in one state and receive a package in another. Aid Access also encouraged people to order pills in advance of being pregnant and stock them (as they might do with emergency contraception). But these options were a little complicated.

The best solution, from the perspective of most of the group's members, would be for more states to pass laws like the one in Massachusetts to shield telemedicine abortion. "Imagine a very large number of providers prescribing from states with shield laws," Remen said. She thought of all the clinicians in the country who supported abortion rights banding together, and her eyes widened with possibility. "It would be really hard to go against all of us. It would challenge the validity of the laws in the red states. It would look terrible for the U.S."

In such a scenario, the providers thought a U.S. pharmacy in a state with a shield law would fill the orders, cutting delivery times. And they saw another benefit. Poppema leaned forward. "The more people who are doing it, the harder it would be to find us," she said.

It's next to impossible to imagine doctors at larger, more established reproductive rights organizations debating risk in the way the Aid Access providers did. Gomperts, whom I wrote about in 2014 for the magazine, created the organization to "make the pills affordable and ensure that the most vulnerable people have access

to them,” she says. Aid Access asks for a fee of \$105 to \$150 (less than other telemedicine ventures) and accepts less or nothing from people who say they can’t afford to pay. The service is small and independent; Gomperts consults with the other providers and has final say.

“I had a table in my office with 70 packages at a time ready to go,” says Erika Bliss, a 53-year-old family-medicine doctor in Washington State who mailed abortion pills from her office in the beginning of the pandemic. Alana Paterson for The New York Times

Big institutions, by contrast, have lawyers who steer them toward strict legal compliance. For major groups that support abortion access, the history of abortion rights in the United States has created an exceptional basis for caution. Around the time of Roe in 1973, abortion care was anchored firmly in hospitals, which accounted for about 80 percent of the country’s abortion facilities. But as protesters, and the threat of violence, appeared, many doctors and medical institutions distanced themselves from the procedure. Today only 3 percent of abortions take place in hospitals and doctor’s offices. Planned Parenthood performs 37 percent of abortions, and independent clinics account for 58 percent, according to a 2021 report by the Abortion Care Network.

Segregated from the medical establishment, abortion providers can’t rely on that broad base of political and financial support. Instead, two organizations have become pillars of U.S. reproductive health care, giving them power and influence — but also making them prime targets for lawsuits and other legal attacks. Planned Parenthood, a \$2.5 billion nonprofit corporation, has affiliates with about 600 local and regional health centers. “For many patients of reproductive age, Planned Parenthood providers are their only source of health care,” a spokeswoman for the organization says. National Abortion Federation, which provides training and sets

standards for hundreds of clinics, runs the biggest abortion fund in the country, helping to pay for tens of thousands of procedures at its member clinics. “If we were not here, I can’t imagine what that would do to people looking for care,” Veronica Jones, N.A.F.’s chief operating officer, says.

Most brick-and-mortar clinics don’t offer telemedicine abortions, according to a 2021 study by the Abortion Care Network. Amid the legal uncertainty created by Dobbs, a few Planned Parenthood clinics and N.A.F. have put in place policies that underscore their full compliance with the new state bans and that have the effect of making it harder to get a medication abortion. The Planned Parenthood affiliate that provides medication abortions in Minnesota, Iowa and Nebraska told patients from states with bans that they could not pick up the medication and then return home. Instead, they had to take the full dose of the pills at a Planned Parenthood clinic, available only up to nine weeks of pregnancy.

The two-dose policy can mean patients who are traveling have to extend their trips for days. N.A.F. also didn’t want to take any chances. In August, the federation said that all its member clinics must attest that patients from states with abortion bans will take both doses of pills before going home in order to receive funding from N.A.F., The Washington Post reported. The change caused an uproar among some abortion providers. About 20 clinic directors signed a letter asking N.A.F. to reconsider, saying it would hurt the low-income patients, disproportionately Black and Indigenous people and other people of color, who most need their help. “Many patients will have to acquiesce to forced birth even if generous funding is available,” the letter said. It called on N.A.F. to “lead the way at this time in our field” so that other funds and providers can expand their services “rather than further restrict and contract from a place of fear.”

The reason for the two-dose policy, Jones told me, was concern about the legal liability of employees who staff N.A.F.’s patient hotline. “We needed to protect our staff and protect our organization,” she says. “But this has been so hard.” To respond to the directors’ concerns, the federation said it was considering alternative funding models.

Prine didn’t expect large organizations like Planned Parenthood to send pills into hostile states, but she wanted their political support for shield laws that would reduce the risk, she hoped, for providers who wanted to do so on their own. She and her allies see risk aversion, if it’s imposed throughout the abortion rights movement, as a losing strategy. In an August article in The Stanford Law Review, Cohen, Donley and Rebouché argued that abortion rights advocates should expect internal tumult in the wake of Dobbs. “People who care about the same ultimate goal of restoring abortion access will have principled, intense disagreements,” they write. “There are benefits to taking calculated risks that break new ground, even if otherwise allied people disagree.”

Abortion opponents are figuring out their own legal strategy. They are relying, for their own purposes, on the reluctance of abortion rights organizations to take chances. Last year, after Texas passed a law permitting anyone to sue an abortion provider (or someone who “aided and abetted” one), clinics in the state stopped procedures after six weeks of pregnancy, even though few suits were actually filed. “The second-largest state in the union essentially banned abortion, before Dobbs, and folks in Texas just continued their lives,” says Peter Breen, vice president and senior counsel for the Thomas More Society, a conservative law firm that often represents anti-abortion clients.

Breen, who advises Republican state legislators, is urging them to try to stop abortion clinics in blue states from treating out-of-state patients either in person or through telemedicine. He claims enforcing such laws won’t require surveilling women’s online searches or prosecuting them. Putting a stop to the flow of pills inside

the United States, in his view, will largely be a matter of bringing a few lawsuits and winning damages against abortion providers in states like Massachusetts or New York. “We recommend civil enforcement,” he says of his advice to legislators. “Put a stop to the illegal activity. It’s cleaner and easier.”

Breen doesn’t anticipate acts of mass civil disobedience by doctors or other medical professionals. They aren’t inclined in that direction, he surmises, and the abortion rights movement’s lawyers will stop them anyway. “Licensed professionals are not in the business of violating the law,” he says. “You have too much to lose.”

Other abortion opponents see potential political controversy in using lawsuits to crack down on providers who prescribe abortion pills across state lines. “If you want to have a regime that actually is effective in reducing abortion, you’re going to have to do something like that,” says Jonathan Mitchell, a former Texas solicitor general who drafted the state’s 2021 law broadly permitting private lawsuits. “But I don’t know if there’s the political will to do that.” The initial answer may depend on the lesson Republicans take from the November elections.

Abortion opponents have other legal tactics in mind as well. A model bill for the states, for example, proposed by the National Right to Life Committee and introduced in South Carolina over the summer, would make it a crime to give “information to a pregnant woman or someone seeking the information on her behalf” about “self-administered abortions or the means to obtain an illegal abortion.”

Such a law seems to violate the right to free speech. Still, over their weekend outside Toronto, the providers worried about a chilling effect at a moment when it’s crucial, from their point of view, to educate the public about abortion pills. Only about half of American adults have ever even heard of a medication abortion, according to a survey by the Kaiser Family Foundation last year. In July, a new health education nonprofit called Mayday Health put up three billboards in Mississippi, where abortion is banned, with the message “Pregnant? You still have a choice” and the link to its website, which shares information about ordering abortion pills online with a prescription. When the state attorney general sent Mayday a subpoena, the group put up more billboards.

In September, abortion opponents made another move. Twenty-two Republican state lawmakers in Utah wrote a letter to N.A.F. citing two arcane federal statutes enacted in 1873. Known as the Comstock laws, they sweepingly make it a crime to use the mail or other “interstate carriers” to send any drug, “article” or “thing” that produces an abortion. The statutes (which also make it a crime to send “indecent” publications through the mail) were challenged when Margaret Sanger opened the country’s first birth-control clinic in 1916 and haven’t been enforced since the 1960s. “We will do everything in our power,” the Utah lawmakers wrote, “to ensure that the U.S. attorney in the next Republican administration holds N.A.F. and its members accountable for every criminal act they commit in violation of these federal statutes.” In response to the letter, Jones said that N.A.F. was “supporting our members in Utah.”

Perhaps the hardest question for leaders in favor of abortion rights is how to evaluate the legal risk for *patients* who break their states’ abortion laws by taking abortion pills. No state explicitly makes it a crime to receive the pills through the mail. Only South Carolina and Nevada criminalize self-managed abortions. But since 2000, police officers and prosecutors have used other criminal laws in at least 61 cases to investigate or arrest people for supposed self-managed abortions, according to If/When/How, an abortion legal advocacy group.

In other words, though criminal enforcement is rare, it's not unheard-of. And post-Dobbs, it could rise. Black, Latina and rural white women with low incomes are more likely targets, according to National Advocates for Pregnant Women, which tracks pregnancy-related cases. "Abortion rights activists should not be minimizing the legal risk, especially for those who are already criminalized," says Jamila Perritt, president and chief executive of Physicians for Reproductive Health. "We know that sourcing pills outside the medical system has resulted in prosecution."

The Aid Access providers think their patients can weigh the risks and benefits. "People have a right to make choices about what's best for their own lives," Remen says. More than half of Aid Access patients are women of color, and more than 60 percent have children at the time of their abortions. Remen sees informing pregnant people of their full range of options as a tenet of reproductive justice, a Black-led movement that began in the mid-1990s and focuses on people from vulnerable communities. Reproductive justice places access to abortion in the context of "the human right to maintain personal bodily autonomy, have children, not have children and parent the children we have," as the organization SisterSong puts it.

One of the abortion-access movement's insights is that marginalized people have always had to go outside the law to be free. "We should talk about self-managing an abortion in every space we go in," says Marsha Jones, a reproductive-justice leader who helped found and runs the Afiya Center in Dallas. The organization, which assists Black women and trans people with H.I.V. and AIDS, offered abortion aid until Dobbs and continues to provide pregnancy and birthing services. "We provide you with the information you need to understand and make decisions for your bodies. Otherwise, we're the people taking the rights away."

In the second week of September, Prine participated in a webinar on state shield laws organized by one of the other Aid Access providers, Christie Pitney. About 60 providers from across the country appeared on Zoom, introducing themselves in the chat.

David Cohen explained how shield laws work, laying out the protections they can and cannot provide. A month earlier, during their weekend outside Toronto, some Aid Access providers joked about taking a last trip to Florida because they knew going out of state could become risky for them. Now the providers had a serious question: How do arrest warrants work — do you know if a state puts one out for you? (Answer: You might not.)

The group was also curious about the politics of the telemedicine abortion shield laws: Why hadn't states like California passed one yet? (Answer: small lobbying effort.) One provider pushing for such a shield law in California is Daniel Grossman, an obstetrician-gynecologist and the lead researcher of two large studies, published by Obstetrics and Gynecology in 2011 and 2017, that helped establish the safety of telemedicine abortions in the United States. This year, The Lancet published a study of about 3,000 Aid Access patients, which found that only 1 percent of them reported seeking treatment for a serious complication. "Telemedicine alone is not a solution to our access crisis," says Grossman, a professor at the University of California, San Francisco. "But we need someone or a group of people to do it in a big way publicly, so they can really make a difference for access. It's just frustrating to not be able to help patients in these places ourselves."

When Massachusetts made a state telemedicine abortion shield law a reality, the political ground began to shift in some other states. "Our view is that what Massachusetts accomplished" is "doable in New York," Donna Lieberman, the N.Y.C.L.U.'s executive director, told me in September, though she wasn't ready to sign off without seeing the details. Prine, who had been trying to connect with the N.Y.C.L.U. for months, finally heard

back about a meeting for late October. “We are asking questions about the mechanics of potential legislation,” a spokeswoman for Planned Parenthood in New York wrote in an email. “We are not opposed to the broader concept of telemedicine shield laws.”

With help from five or six providers in Massachusetts who are willing to test the state’s telemedicine shield law, Gomperts thinks Aid Access could multiply the number of women it serves. Providers could join the network rather than hang out a shingle on their own. Aid Access has found a malpractice carrier who would cover them, one of the doctors says. At the end of September, a founder of Honeybee Health, Jessica Nouhavandi, told me she was exploring setting up a legally separate pharmacy in Massachusetts so that her company could also take advantage of the state’s shield law.

As doctors and nurse practitioners in Massachusetts considered doing telemedicine abortions across state lines, they wrestled with a sobering personal decision, something like sailing into uncharted waters on an untested boat, when everyone is telling you there’s no guarantee it won’t sink. “It’s hard,” a provider in Massachusetts told me. “It’s scary.”

She was thinking about her “abortion heroes” — the doctors and activists who helped women end their pregnancies before Roe. But she was also thinking about her children. What if they traveled to a Southern state and got hurt and needed her? Was she ready to say she wouldn’t go to see them? “It’s keeping me up at night. I’m here. I could do it.” But she was hesitating. Before Dobbs, when she was doing her job, “there was the risk of stalking or harassment. But not being thrown in jail. Now it’s a different world. How much do I want to risk, and what could I lose?”

The ultimate goal, for advocates like Prine and Gomperts, has always been to make the abortion pills readily available. To that end, Gomperts is planning to start an international research project to test mifepristone as a form of birth control. The more uses, the more accessible the medication could become. In the meantime, advocates on all sides expect legal clashes and are gaming out the political implications. The Supreme Court blamed Roe for enmeshing the courts in the country’s abortion fight, but Dobbs could set red and blue states against each other in ways that make the previous era seem peaceful. So much is unknown and unsettled. “Are they really going to round up doctors in blue states and bring them to sit in a Texas jail?” Prine asked. “We have to do this and see if that’s really what it’s come to.”

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Corrected on Oct. 5, 2022: An earlier version of this article misstated the dates of publication for two articles. David S. Cohen, Greer Donley and Rachel Rebouché wrote an August article for The Stanford Law Review; it is not upcoming. And they published a draft article in February for The Columbia Law Review; it is upcoming for official publication.

Corrected on Oct. 7, 2022: An earlier version of this article referred imprecisely to the medication abortion policy of the Planned Parenthood affiliate in Minnesota, Iowa and Nebraska. Patients who travel to those states from states with abortion bans must receive the full dose of abortion medication at a Planned Parenthood clinic; they do not need to take the medication over 48 hours.

We acknowledge mistakes in our reporting with corrections. If you spot an error, please let us know at corrections@nytimes.com. Learn more.

A version of this article appears in print on , Page 26 of the Sunday Magazine with the headline: Abortion Pills Are Medication Contraband