The New French Abortion Pill: The Moral Property of Women

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I. INTRODUCTION

In September 1988 a pharmaceutical firm announced it would begin marketing a pill in France designed to induce abortion in the very early stages of pregnancy. Several weeks later, the company retracted its original announcement. Motivated by vocal anti-abortion activism in France and the United States, which included threats of a boycott of all of the company's products as well as threats on the lives of company officials, the drug company decided to withhold the pill, known as RU 486, from the French market. However, within days of the French company's retraction, the French government—which owns thirty-six percent of the French subsidiary of the German-based company, Hoechst, that markets the pill—ordered the company to sell it in France. The French Health Minister declared that in the few weeks that the abortion pill's existence had become common knowledge, it had become "the moral property of women."1

In the United States, where opposition to the pill is particularly vocal, the story has been different. Hoechst is susceptible to American threats of a boycott because the American pharmaceutical market represents a significant portion of its earnings. Aware of previous boycotts instigated by American anti-abortionists, most notably the extended boycott of products manufactured by the Upjohn drug company, Hoechst, so far, has decided against marketing the pill in the United States.

The pill's introduction into the French market has ignited speculation about whether or not it will appear in the United States. At the same time, the perceived ease of this new form of abortion has heightened moral divisions over the issue of abortion. The U.S. response to RU 486 is deeply divided among those morally opposed to any form of abortion, those discomforted by the apparent ease of chemical abortion, those supportive of an abortion option easier than surgery, and finally, those who

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are unwilling to advocate any form of birth control which alters the chemical structure of a woman's body.

If RU 486 were approved for sale in the United States, though, its legal implications would not at all mirror the moral division that splits American opinion on the pill. Rather, the pill would fit neatly within the federal law of abortion announced in Roe v. Wade. While the Supreme Court's decision in Roe did not anticipate that abortion could be performed by a method other than surgery, chemical abortion by RU 486 would be consistent with the legal scheme Roe devised for surgical abortion. In fact, chemical abortion is more consistent with the privacy holdings on which Roe is based than is surgical abortion, the form made legal in Roe.

While RU 486 is currently thought of and used only as an abortion pill, it may eventually be developed for use as a contraceptive. The pill has the potential to be used monthly, whether or not a woman is pregnant. If it is developed for regular monthly use, it is possible, though unlikely, that it would fit within federal regulation governing contraception. The pill's classification as a contraceptive would insulate it from changes in American abortion law, changes many people believe are imminent since the Court this term is considering the validity of Roe.

Since September, news of RU 486 has been splashed across the front pages of newspapers across the United States, prompting outraged letters to the editor and motivating enthusiastic editorials. The pill has been heralded as having the potential to end the abortion debate by those who accept abortion, and decried for the same reasons by those who do not. Lost in this outpouring is concern about the pill's effects on women's health, which, ironically, is the central concern of Roe.

The immediate side effects of the pill, the dangers arising from the pill's possible failure to induce complete abortion, and the lack of information about the pill's long-term effects have not been given much attention in media reports. But the appearance of the abortion pill prompts a pointed observation with respect to women's health: that birth control technology is directed primarily at interfering with women's reproductive capacities, not men's, and that much of this technology has enjoyed widespread acceptance before new methods have been proven safe. It is troubling that we have been so free to manipulate a woman's body, willing even to alter a woman's chemical structure, yet have spent little time exploring non-invasive forms of birth control or methods designed for use by men. This last view, not adequately represented in popular reaction to the pill, would demand thorough, long-term testing of RU 486, and counsel

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caution before advocating its use or believing in its potential to alter fundamentally the American abortion debate.

II. THE FOOD AND DRUG ADMINISTRATION APPROVAL PROCESS

Before being introduced for sale in the United States on the open market, any new drug must be approved by the Food and Drug Administration, a part of the Department of Health and Human Services. The long process of getting FDA approval for a new drug is triggered by the application of the drug’s sponsor, and can take up to ten years. While the approval process for RU 486 would probably be significantly shorter because of the vast testing data already generated by foreign researchers, the American approval process has not yet begun because no drug company has petitioned the FDA for approval of RU 486. Although a 1988 change in FDA policy allows some Americans to have access to drugs that have not been approved for U.S. sale if the patients import them from foreign countries by mail for their own personal use, importation of RU 486 is specifically excepted from the policy by an unpublished Import Bulletin Directive issued by the agency.

The standards that must be met for FDA approval of a new drug are safety for the recommended use and substantial evidence of efficacy. The FDA does not itself test a drug, but supervises and evaluates for safety and efficacy the drug trials conducted by the drug’s sponsor, by the National Institutes of Health, or by others. Before the FDA will allow a drug to be tested on humans, the drug’s sponsor must submit results from


5. In general, the FDA accepts foreign clinical studies to support an application when, in the judgment of the FDA, the studies are “well designed, well conducted, performed by qualified investigators, and conducted in accordance with ethical principles acceptable to the world community.” See 21 C.F.R. § 312.120 (1988); see also 21 C.F.R. § 314.106 (1988).


I interviewed Brad Stone, press spokesperson for the FDA, by telephone in March 1989 about the FDA’s mail import policy with respect to RU 486. The July 20, 1988 policy directive issued by the Office of Regional Operations allows drugs unapproved by the FDA to be imported by patients under certain conditions. However, the September 26, 1988 directive issued by the Division of Field Investigations specifically prohibits RU 486 from being imported under the earlier directive.

If a woman were able to obtain a prescription from a French doctor, however, she might be able to bring her personal prescription into the United States. See Thomas, New Abortion Method Hit by Safety and Moral Questions, The Christian Science Monitor, Nov. 16, 1988, at 3, col. 1 [hereinafter Thomas]. Though the FDA does not exempt drugs brought in for personal use from the general prohibition on the importation of unapproved drugs, another FDA spokesperson expressed doubt that RU 486 would be seized from a woman attempting to bring it with her from France into the United States: “Whether the agency would confiscate [RU 486] is another story.” Telephone interview with Sandra Westone (Mar. 1989).

non-human studies. If the FDA approves trials using human subjects, the drug is first tested on twenty to eighty people for toxicity and dose ranges, a process which takes about a year. Phase Two testing, for effectiveness and major side effects, involves several hundred subjects and can take about three years. Phase Three testing, involving several hundred to several thousand subjects and lasting several years, is to confirm findings of effectiveness and to discover any long-term side effects. The drug company applies to the FDA for approval to market a new drug when Phase Three testing has been completed.

There is an exception to the FDA regulatory scheme relevant to the discussion of RU 486. American doctors may prescribe an FDA approved drug for a use other than the use approved, an exception relevant to RU 486 because the drug has effects other than inducing abortion and is currently being tested by the National Institutes of Health as a treatment for other conditions. Under existing law, the possibility exists that if the FDA approved RU 486 for use other than as an abortion pill, it would be available to doctors to prescribe as an abortifacient. While the FDA does not have jurisdiction to regulate the administration of a drug by a physician, the potential liability of a physician who chose to prescribe RU 486 for abortions may be sufficient to render this possibility remote.

III. RU 486 AS A POTENTIAL CONTRACEPTIVE

RU 486 is currently thought of as an abortion method, and indeed, that is its only current use outside of investigational research. The developers of the pill, however, indicate that RU 486 may one day be used as a monthly menstruation inducer.

8. See Eigo, supra note 4, at 9; FDA Chart, supra note 4.
9. See 21 C.F.R. § 312.21(a) (1988); Eigo, supra note 4, at 9; FDA Chart, supra note 4.
10. See 21 C.F.R. § 312.21(b) (1988); Eigo, supra note 4, at 9; FDA Chart, supra note 4.
15. The issues raised by this possibility are beyond the scope of this paper, but would require exploration of precedents for malpractice liability for deviational use of approved drugs and of the boundaries of informed consent.
16. "These preliminary results leave open the possibility that RU 486 could be used as a once-a-month fertility control agent, but they indicate that much work still has to be done to achieve this goal." Baulieu, Contragestion by Antiprogestin: A New Approach to Human Fertility Control, in The Ciba Foundation, ABORTION: MEDICAL PROGRESS AND SOCIAL IMPLICATIONS (London: Pitman, 1985), 192, 204 [hereinafter Baulieu].
traception and abortion, and of whether the potential for its use as a contraceptive should influence the legal classification of RU 486. Because our legal framework does not specifically address the question of when contraception becomes abortion, my discussion here is necessarily speculative. To understand how the pill might be considered something other than an abortifacient requires a basic understanding of what the pill does, and how it differs from current methods of what the law treats as contraception.

The chemical effect of RU 486 is not yet clear, but most researchers believe that it ends pregnancy by interfering with the production of progesterone, a hormone required for the lining of the uterus to develop properly into an environment that can nurture an embryo to development. The pill is a synthetic steroid whose chemical structure resembles the hormone progesterone sufficiently to "trick" the progesterone receptors in the uterus, and thus block production of the real hormone. Without progesterone, the lining of the uterus breaks down and is expelled, as in normal menstruation. If a fertilized egg, or what has evolved from a fertilized egg, is present, it is expelled. The effectiveness of the pill has been shown to be limited to the first seven weeks of pregnancy, or up to about three weeks after a woman has missed her period.

The issue which determines whether a method of birth control is considered by law to be abortion or contraception appears to be at what point in the process the outside agent interferes with potential birth. Conception is considered by federal law to be a process, not a single event. Briefly, a sperm fertilizes an egg, creating a zygote. Approximately seven days after fertilization, the fertilized egg develops into a multi-celled blastocyst. About half of fertilized eggs and what develops from them spontaneously drop out of the uterus within two weeks. Implantation of the blasto-

20. See id.; Kovacs, supra note 17, at 400.
21. Couzinet, supra note 17, at 1567-68. "It is possible that the results are better in early pregnancy because progesterone originates mostly from the corpus luteum during this period. . . . After about 49 days of amenorrhea, implantation is better established and the placenta produces a considerable local amount of progesterone, which may be more difficult to antagonize."

Medical researchers agree that while RU 486 administered with a prostaglandin increases its effectiveness in the first 5-7 weeks of pregnancy (up to 95%), it does not prolong its effectiveness. The success rate of RU 486 alone in 8-10 week pregnancies was 50% complete abortion, 35% incomplete abortion, and 15% no effect at all. All women for whom the drug was unsuccessful received surgical abortions. Baulieu, supra note 16, at 198-99.
22. Roe, 410 U.S. at 161.
24. Id. at 7.
cyst—if it hasn’t dropped out—into the uterine wall also begins about a week after fertilization. The implanted blastocyst develops into an embryo, and is called an embryo from about the third to the eighth week.

Forms of birth control recognized as contraception act at many different points in this process. Spermicides and barrier methods prevent fertilization. An oral contraceptive ("the Pill") usually prevents fertilization by suppressing ovulation, but some forms of "the Pill" can also prevent implantation. The IUD, whose efficacy at preventing birth is still not clearly comprehended, is understood to act at several phases. Put simply, the IUD interferes with the uterine environment sufficiently to prevent implantation. The presence of a foreign object within the uterine environment causes white blood cell migration, cells which presumably attack the blastocyst. Many IUD's also contain progesterone inhibitors, which, like RU 486, interfere with the production of progesterone in the uterus. Additionally, some IUDs are copper, which increases their effectiveness because copper ions are toxic to both sperm and blastocyst. The effect of the IUD can also be to disrupt the implanted blastocyst from the uterine lining.

Medical knowledge is not easily translated into legal standards. The chemical effect of RU 486 is medically different from the chemical and mechanical effects of the IUD. However, for the purposes of enacting legal standards, which evolve mainly by analogy, the effects of the two could be considered substantially the same. The principal function of both the IUD and RU 486 is to interfere with the nurturing uterine environment sufficiently to prevent the continuation of pregnancy, and to instead induce menstruation. The IUD can act at any stage up to and including implantation of the blastocyst. If taken monthly, RU 486 would do the same. The woman would take an RU 486 pill a few days before the expected date of menstruation. If there were no fertilized egg, the pill would merely induce menstruation. If a fertilized egg were present, the pill would prevent implantation by flushing it out with the uterine lining. If a blastocyst were in the process of implanting, or if it were implanted, it too would be flushed out in the menstrual flow.

Monthly use of RU 486, still a remote possibility, may fit within federal law governing contraception. Since federal regulation treats the IUD

25. Id. at 8.
26. Id. at 105.
29. The inventor of RU 486, Etienne-Emile Baulieu, objects to the term "contraception" being applied to the pill, since the word's roots suggest action to prevent conception—contra-conception. Instead, he prefers the word "contragestion," since the pill's function is to prevent the gestational environment from developing. Baulieu, supra note 16, at 192.
as contraception, not abortion, and RU 486 taken as a monthly antifertility agent would intervene at roughly the same time in the conception process as an IUD, the pill's monthly use could arguably be contraceptive. While the effects of the two are similar, for the analogy to be coherent, the FDA might also consider the intent of the pill's user to be relevant to its legal classification.

While intent in this context is largely a legal fiction, for the law to comprehend RU 486 as a contraceptive device would require that the intent imputed to the monthly RU 486 user be similar to the intent of the IUD user. The IUD user intends to prevent pregnancy. She is aware at the time the device is inserted by her doctor that it may prevent implantation, or as a back-up function, perhaps disrupt implantation. The monthly RU 486 user would have a conditional intent: she would intend to end her pregnancy, if she were pregnant, or to induce normal menstruation, if she were not. The only difference between the intentions of the two users would be in their understanding of the principal function of the antifertility device. The RU 486 user would know that the pill was designed to disrupt the implanted blastocyst, and that its other effects would be secondary to this principal function. The IUD user, on the other hand, would know that the device was designed to prevent implantation, and would disrupt implantation only on those occasions when the device's principal function has failed. This subtle distinction in the intentions of the users may not be sufficient to justify classification of the pill, when used monthly, as an abortifacient, while at the same time allowing the IUD to be considered a contraceptive.

Should RU 486 be approved in the United States as a monthly antifertility device, the Court's articulations in *Griswold v. Connecticut* and *Eisenstadt v. Baird* of a married couple's or individual's rights to privacy would protect a woman's access to the pill from state interference. If the FDA classified the pill as a contraceptive, its use in the United States, should it be introduced here, could be legally insulated from Supreme Court action on abortion. Federal regulation of contraceptives is limited to their initial entrance into the market, when the FDA approves the drug and its labeling, and to requirements that some contraceptives, such as "the Pill" and the IUD, be prescribed by doctors. The consequences, then, of a decision by the FDA to approve RU 486 as a contraceptive, should it approve the drug at all, would be dramatic.

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30. 381 U.S. 479 (1965).
32. See infra Section V and accompanying notes for a discussion of how privacy doctrine as defined in *Griswold, Eisenstadt, Roe, and Bowers v. Hardwick*, 478 U.S. 186 (1986), would protect access to the pill from state interference should it be approved by the FDA as an abortion method.
34. The inventor of RU 486 hopes that one day women will be able to purchase the pill at supermarkets. Baulieu, *supra* note 16, at 209–10. Though this is not likely to happen in the United
Even if the RU 486 pill were one day developed to be used as a monthly contraceptive device, however, the likelihood of the FDA's considering it to be anything other than an abortion pill is remote. Two interrelated issues would probably distinguish the pill from existing methods of contraception: timing and intent. While the pill may be prescribed by a doctor with instructions to the woman to take it monthly, the FDA might be motivated to classify the pill as an abortifacient because of the possibility that the woman might take it less frequently, i.e., only when her period was late, and she feared pregnancy. In short, given RU 486's potential to be used as an abortifacient, the FDA, in the current climate, would probably consider it to be nothing but an abortion pill.

The timing of the pill's ingestion implicates the second factor militating against its classification by the FDA as a contraceptive, the woman's intent. If taken at the time prescribed, which is several days prior to the expected onset of menstruation, her intent is at best ambiguous: to cause menstruation whether or not she is pregnant. But the possibility that the pill could be taken subsequent to the prescribed time means that she would be able to form and act on an intent to abort, under the guise of contraception. Despite the possible factual similarity of the effects of RU 486 and of an IUD, the pill's potential to be used intentionally as an abortifacient would probably be dispositive. Use of RU 486, even if approved as a monthly antifertility agent, would most likely be governed by federal abortion law, rather than the less intrusive law which governs contraception. The more relevant inquiry, then, is how the federal law of abortion would apply to RU 486.

IV. RU 486 AND EXISTING ABORTION LAW: Roe v. Wade

The new French abortion pill, if used as a chemical inducement of early abortion, fits easily within current federal law guiding the states' legislative regulation of abortion. The Court's historic 1973 opinion, Roe v. Wade, set maximum levels of permissible state intrusion on a doctor's right to decide with his pregnant patient whether to terminate her pregnancy. The pill's introduction within the United States for use as an abortifacient presents no legal difficulties within the Roe scheme.

The Roe decision identified three interests which are present at all stages of a woman's pregnancy: maternal privacy, maternal health, and potential life. The Court held that a state's choice of when and how to regulate a doctor's freedom to recommend abortion to his pregnant patient...
should be guided throughout her pregnancy by the state’s interest in preserving the woman’s health. The Court limited the additional factors that a state can rely on, should the state decide to regulate abortion. All state schemes for regulation of abortion must first respect the woman’s right to privacy within the doctor/patient relationship as it pertains to her decision to abort. The second additional factor, not mandatory but at the state’s option, is a permissible state interest in protecting potential human life.

The state’s interest in the woman’s health is paramount through all stages of the woman’s pregnancy. According to the logic of Roe, the two factors of privacy and potential life are subordinate throughout a woman’s pregnancy to the state’s interest in preserving the woman’s health. Each of the three factors is nevertheless recognized as being present at all stages of pregnancy. To state the Court’s decision in crude adversarial terms, the factor presumed to “trump” the others, privacy or potential life, is the state’s interest in the pregnant woman’s health. Since the interest in the woman’s health dominates throughout, actions taken by the woman, predicated on her right to privacy, or actions taken by the state, predicated on its interest in potential human life, are permissible only when they coincide with the state interest in her health, a determination made by her doctor.

According to the Roe balance of permissible interests, the state’s interest in the woman’s health is served by her doctor’s decision to recommend abortion in the first thirteen weeks of pregnancy because the Court found that surgical abortions during that period were safer for a pregnant woman than carrying the pregnancy to term. Accordingly, during the first trimester, the woman’s decision to abort her pregnancy is protected from state regulation by the alignment of the state’s interest in her health with her right to privacy. Because surgical abortions in the second trimester were not necessarily safer than giving birth, Roe held that the state’s interest in protecting a woman’s health was furthered by allowing state regulation, but only when reasonably related to preservation of her health. In the third trimester, the state’s overriding interest in the woman’s health can be served by no regulation, or by regulation to the same extent as the state has legislated for the second trimester, such as limitations on abortion facilities or medical personnel. It is only in the third trimester that the Roe balancing of interests allows a state to enact into law its cognizance of the third possible concern, the state’s interest in potential life, an optional interest which only at fetal viability is sufficient justification to

36. 410 U.S. at 163–66.
37. Id. at 164.
38. Id. at 150.
39. Id. at 163.
40. Id.
limit a woman's fundamental privacy right. Interest in the pregnant woman's health, however, remains the dominant state interest. Even in the third trimester, if the state's interest in protecting potential life conflicts with its interest in preserving the woman's health, a determination made by her doctor, the state cannot prohibit access to abortion.

In terms of abortion law, the strongest legacy of the reasoning of the Roe decision is that throughout a woman's pregnancy, the state's primary interest is in preserving the woman's health. The decision did not prescribe any regulation of abortion during the second and third trimesters, but merely located the interests a state could rely on should it choose to enact a regulatory scheme at all. The final mandate of the Roe decision is defined in negative terms: no state may interfere with the freedom of a physician to decide with a woman that she should abort her pregnancy in the first trimester.

The new French abortion pill fits comfortably within both the positive and negative mandates of Roe. If taken orally as an abortifacient, use of the pill should be protected from state interference because it fulfills the state's interest in protecting a woman's health: abortion induced chemically by RU 486, taken in conjunction with a prostaglandin, is tentatively considered by medical researchers to have some side effects, but to be a safer procedure than surgical abortion for terminating early pregnancy. Use of the pill may prove to be more effective than surgical abortion in fulfilling the state's interest in a pregnant woman's health because it does not carry the attendant risks of surgery, including anesthesia.

Introduction of RU 486 to induce abortions would not require states to adjust existing regulations of abortion because the privacy interest which prevails in the first trimester of abortion would protect a doctor's discretion to prescribe RU 486. Use of RU 486 is for medical reasons limited to well within the first trimester of pregnancy. In clinical trials, the effective-

41. Id.
42. Id. at 163-64.
43. Id. at 164.
44. Kolata, Boycott Threat Blocking Sale of Abortion-Inducing Drug, N.Y. Times, Feb. 22, 1988, at A1, col. 3 [hereinafter Kolata]. According to Chinese and European researchers, prostaglandins taken together with RU 486 reduce the side effects that either drug has when given alone. Prostaglandins alone, used in the United States for later than first trimester abortions, can cause nausea, vomiting, diarrhea and severe abdominal cramps. RU 486 alone has caused severe bleeding and incomplete abortion, which increases the risk of infection. Because the prostaglandin dosage is much smaller when taken in conjunction with RU 486, most of its side effects are eliminated. Id.

In an article published in 1985, the pill's inventor reported that there had been excessive bleeding in three of 200 women given RU 486 alone, but in none when it was administered in conjunction with a prostaglandin. Balieu, supra note 16, at 209.
45. Couzinet, supra note 17, at 1569. In this recent study of RU 486, the researchers cautioned that the current form of the drug should only be used under close medical supervision because of the possibility of failed abortion (about 15% when RU 486 is used alone) and prolonged uterine bleeding. They wrote, "Even with these reservations, however, RU 486 offers a reasonable alternative to surgical abortion, which carries the risks of anesthesia, surgical complications, infertility and psychological sequelae."
ness of the pill has been shown to be limited to the first seven weeks of pregnancy, or up to three weeks after a woman has missed her period. It is coincidental that the pill’s temporally limited usefulness corresponds with the phase of pregnancy least regulated by the prevailing American law of abortion. Because the pill can currently only be used in the first trimester, the decision to opt for a chemically induced abortion would be protected by the alignment in the *Roe* decision of the state’s interest in the woman’s health and the woman’s right to privacy.

But use of RU 486 would fall even more particularly within the conception of privacy that is unique to *Roe*. In *Roe*, the Court announced that the previously articulated right to privacy was broad enough to encompass a woman’s decision to abort her pregnancy. But the language of the *Roe* decision is fraught with limitations. Throughout the decision, Justice Blackmun emphasized the essential role to be played by the doctor in the decision to abort, so that the right to privacy inheres not just in the woman, but rather in her relationship with her doctor. Because she is pregnant, “the woman’s privacy is no longer sole.” The Court deliberately circumscribed the privacy right so it was contained within the realm of medical judgment by holding that “the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated.”

The privacy that the decision protects is reminiscent of the privacy that cloaks the attorney/client relationship, a model which surely resonated with the Court. In the ideal attorney/client relationship, the client presents a problem, to which the attorney responds with all available legal courses of action. *Roe* protects the right of physicians to make an exhaustive medical recommendation, i.e., to provide a pregnant patient with both available medical options: medical treatment needed to carry the baby to term, or medical treatment needed to abort. While the client/patient makes the decision, the professional shapes the choices and carries some of the responsibility for the ultimate decision. In fact, the Court in *Roe* exceeded the limits of this model by allocating near total responsibility to the physician. The Court held that “the abortion decision, in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.” The *Roe* decision is built on the legal fiction of a close and confidential doctor/patient relationship, and the pri-

48. This conception of the privacy right deviates from prior privacy holdings in which the right to privacy was found to inhere in the individual. See, e.g., *Eisenstadt*, 405 U.S. at 453; *Stanley v. Georgia*, 394 U.S. 557, 564 (1969).
50. *Id.* at 163.
51. *Id.* at 166.
vacy right that the decision protects reflects this, since it is shared by the physician and the woman.\textsuperscript{52}

Nonetheless, the legal fiction of the close association of doctor and patient upon which \textit{Roe} bestows the protection of privacy comports with the reality of the most probable use of RU 486. The pill's current use in France is a reliable guide to its use in the United States, should it be introduced into the U.S. market. In France, the pill is prescribed by a doctor, and ingested within the hospital.\textsuperscript{53} Following her ingestion of the pill, the pregnant woman is treated as an outpatient. Doctors monitor the effects of the pill, and perform a follow-up check-up for tissue remaining in the uterus. If the pill does not affect the woman's pregnancy, or if it does not induce a complete abortion, as it sometimes does not, a doctor performs a surgical abortion.\textsuperscript{54} Under current use of the pill, then, doctors remain integrally involved in the decision to use the pill, since they must prescribe it and remain in close contact with their patients after they take it because of the possibility of its failure to induce a complete abortion.\textsuperscript{55}

The \textit{Roe} concept of privacy, because it protects the doctor/patient relationship from state interference when, in the doctor's opinion, abortion is a medically responsible course of action, easily encompasses the use of the pill as a doctor-prescribed abortifacient. The \textit{Roe} concept of privacy protects the doctor's right to recommend to his patient any of the treatment options which he knows to be available. If RU 486 were available in the United States, the use of the pill would, if current practices in France are a guide, necessarily include the medical decision \textit{Roe} envisioned.\textsuperscript{56}

While the \textit{Roe} concept of privacy is broad enough to encompass use of the new pill, the decision protected by the woman's privacy right would be different. In the image which motivated the \textit{Roe} decision, the doctor is free in the first trimester to make a medical judgment that either abortion or birth is more appropriate for the patient. With RU 486, the privacy concept would protect the doctor's freedom in the first trimester to make a medical judgment that either surgical or chemical abortion (or birth) was

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\item \textsuperscript{52} Whether this notion of the physician/patient relationship corresponds with the reality of women outside the middle and upper class is extremely doubtful. More likely, it reflects the relationships of the Justices with their doctors.
\item \textsuperscript{53} \textit{Langone, After-the-Fact Birth Control: Abortion Pills, Approved Abroad, Are Doubtful for the U.S.}, \textit{Time}, Oct. 10, 1988, at 103.
\item \textsuperscript{54} \textit{Id.}
\item \textsuperscript{55} As noted earlier, \textit{supra} note 21, RU 486, even when taken in conjunction with a prostaglandin, is at best 95\% effective in terminating pregnancies of 5-7 weeks.
\item \textsuperscript{56} Clearly, doctors may be involved for a longer period of time when a woman chooses to have a chemical over a surgical abortion. Use of RU 486 in France has been limited until recently to clinical experiments. While under clinical conditions medical surveillance probably exceeds the medical involvement necessary for non-experimental use, a woman's contact with the clinic was at minimum six visits: four times to ingest the RU 486 dosage, once to have a prostaglandin administered, and once to follow up on the effects. Much depends on the dosage of RU 486; in some tests, it has been administered for as little as two days, in others up to four days, in either one or two doses per day. Finally, some women have required surgical abortion. \textit{See generally} Baulieu, \textit{supra} note 16; Couzinett, \textit{supra} note 17; Kovacs, \textit{supra} note 17.
\end{itemize}
more appropriate for the patient. Because the decision to use a chemical abortifacient would involve a doctor, and because availability of chemical abortion would be a treatment option which the doctor should be able to prescribe where appropriate, use of the pill parallels the motivating image of Roe.

V. Home Use of RU 486 and the Griswold Right to Privacy

The Court's decision in Roe expounded, but did not create, the constitutional right to privacy. In a more recent case, Justice Blackmun has explained that the privacy right developed by the Court has two distinct strains: a decisional aspect, and a locational aspect.\(^\text{67}\)\(^\text{67}\) Roe, as I have explained, is an example of the first.\(^\text{68}\)\(^\text{68}\) The woman's decision to abort, made with her doctor, is a private decision, not to be touched by state regulation in the first trimester. Like the decision to abort surgically, the decision to use RU 486 fits within the decisional aspect of the privacy right. The locational aspect of the privacy right, which informed the Court's original announcement of a constitutional right to privacy in Griswold v. Connecticut, is the Court's recognition that a person's home, and the activities within the home, deserve special protection in constitutional law. Unlike surgical abortion, however, the anticipated use of RU 486 fits also within the Court's locational aspect of privacy because of the possibility that a woman could take the pill as an outpatient within her own home.

The constitutional right to privacy, as it was first articulated in Griswold, was invoked to protect a married couple's access to contraception.\(^\text{59}\)\(^\text{59}\) The Griswold Court held that the Constitution contains a right to privacy, located in any or all of several different provisions, including the First, Third, Fourth, Fifth and Ninth Amendments, and particularly in the penumbra of peripheral rights without which those specifically granted by the Bill of Rights would be less secure.\(^\text{60}\) While the textual grounding of the right to privacy is not precisely pinpointed in Griswold,

\(^{57}\) Bowers, 478 U.S. at 203-04 (Blackmun, J., dissenting).
\(^{58}\) The Court's most recent decisional privacy holding, Bowers, declined to extend the right to privacy to the decision made by homosexuals to engage in consensual sodomy. The Court held that that decision by homosexuals did not implicate the traditional activities to which privacy extends, a list which includes family, marriage, and procreation. While the Court discussed the special protection that one's home has had in constitutional doctrine, it held that because homosexual relations have "no connection" to traditional privacy concepts, the occurrence within the home was not sufficient on its own to immunize otherwise illegal conduct. Id. at 191.

The Court's holding, as Blackmun pointed out in his dissent, misapplied earlier privacy decisions by dismissing the locational aspect of privacy. Id. at 206. In his powerful dissent, Blackmun also criticized the Court for skirting the reasons why we protect family-related decisions—because these decisions "form so central a part of an individual's life." Id. at 204.

Despite Bowers' limited conception of privacy, use of RU 486 would nonetheless be consistent with the Bowers holding. Unless use of the pill were specifically made illegal, which would require a change in the law not yet proposed, the pill's use would be within the decisional aspect of privacy, which Bowers reaffirmed to include decisions relating to procreation.

\(^{59}\) Griswold, 381 U.S. at 485.
\(^{60}\) Id. at 484.
the state invasion of that right, against which the Court sought to protect private citizens, is graphically sketched. The image which motivated the Court's holding is the specter of the state invading the privacy of the marital bedroom. In what could be called a fear of the enforcement possibilities, the Court struck down the state law prohibiting possession of contraceptives to protect the marital bedroom from unreasonable searches. The Court recoiled collectively at the nightmarish possibility of the law's enforcement: "Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship." While the Court grounded the right to privacy variously in Constitutional provisions, the motivating image is grounded firmly in the Fourth Amendment protection from unreasonable searches: a state search for contraceptives would be unreasonable because the marital relationship is private and the location in which the marital relationship takes place, the home, is private.

Researchers involved in the study of RU 486 project that the pill may soon be available for use in the home. Use in the home is anticipated to take either or both of two forms: monthly, as a menstruation inducer, or periodically, also as a menstruation inducer, but only when the woman thinks she might be pregnant.

Periodic home use of the pill, still just a possibility, is envisioned to be similar to use of other prescription medicines. Within one to three weeks of a missed period, the woman would get a doctor's prescription for RU 486, and most likely a prostaglandin, which she would fill at a pharmacy. It is also possible that she would have the prescription on hand, having earlier received a supply prescription. She could then return home, or remain home if she were using a supply prescription, and take a single pill. Approximately two days later, she would either return to her doctor for a prostaglandin injection, or insert a prostaglandin suppository. Within a few days of ingesting the pill, she would begin bleeding as if she had a heavy menstrual period, and would continue bleeding for seven to

61. Id. at 485.
62. Id. at 485-86. While the Connecticut law which the opinion struck down was not in fact enforced in this way, the image of police in the marital bedroom is central to the Griswold holding.
63. Id. at 484.
64. Baulieu, supra note 16, at 209. In his 1985 report, the inventor of the pill said, "I believe that we will have a successful recipe for a safe, self-administered compound in a few years, but we haven't got it yet."
65. Id. at 198. Research results have been more successful for 5-7 week pregnancies than for 8-10 week pregnancies. See supra note 21.
66. See Baulieu, supra note 16. Prostaglandins are already on the market in the United States, approved by the FDA for inducing abortion after the first trimester. Kolata, supra note 44.
67. Couzinet, supra note 17, at 1569. Though in many studies of RU 486 researchers have used multiple doses of the drug, in this recent article the researchers stated, "[A] single dose may be sufficient. . . . This would make treatment with RU 486 more convenient."
68. Baulieu, supra note 16, at 209; Kolata, supra note 44.
fourteen days, after which she would require a follow-up visit to her doctor to ensure that her uterus was empty.\textsuperscript{69}

As mentioned above, the effectiveness of RU 486, even taken with the addition of a prostaglandin, is limited to approximately the first seven weeks of pregnancy, or up to three weeks after the woman’s period was due.\textsuperscript{70} In the scenario for periodic home use sketched above, the woman who had the prescription on hand would have to know that she should not use the pill after seven weeks. The above example also leaves open the possibility that the woman is not actually pregnant. If the pill is self-administered when the woman’s period is up to a few weeks late, it is possible that the physical circumstance is not pregnancy, but simply that her period is late, although the availability of home pregnancy test kits makes such a mistaken assumption less probable.\textsuperscript{71}

The projected home use of the pill is consistent with the \textit{Griswold} concept of privacy, which grants special protection under the Constitution to certain activities that take place within the privacy of one’s home. Used either as a periodically prescribed pill, when a woman’s pregnancy is confirmed, or as a prescribed pill periodically ingested when a woman believes pregnancy is a possibility, the woman could take the pill on her own, in her own home. This anticipated use of RU 486 comports with the spatial aspect of the \textit{Griswold} privacy right. The woman need not travel to a clinic for the actual abortion, or undergo anesthesia or surgery.\textsuperscript{72} The precipitating act would be a spatially private one.

Abstract legal concepts are more easily integrated into our common understanding when they can be visualized. The image of a woman taking a pill is easy to visualize because it is an experience that is shared by anyone who has ever taken an aspirin. Psychologically, then, the use of RU 486 is more easily placed within common notions of privacy than is surgical abortion, since the physical act of taking a pill within one’s own home is within the common understanding of private acts performed at home. Though doctors remain indispensable to the RU 486 process, the scenario has the hallmark of \textit{Griswold}’s locational privacy because it can take place in the home.\textsuperscript{73} Doctors might have been involved in \textit{Griswold} in a similar

\textsuperscript{69} Kovacs, \textit{supra} note 17, at 402.
\textsuperscript{70} Baulieu, \textit{supra} note 16, at 198. The prostaglandin dosage would cause uterine contractions. Taken in conjunction with RU 486, prostaglandins both increase the probability of the woman’s expelling all of the abortive material, and decrease the possibility of excessive bleeding. Kolata, \textit{supra} note 44.
\textsuperscript{71} See \textit{supra} Section III and accompanying notes for a discussion of the role of intent in the legal classification of the pill.
\textsuperscript{72} Cousinet, \textit{supra} note 17, at 1569; Baulieu, \textit{supra} note 16, at 198. This is obviously not true for every potential RU 486 user. Some women’s pregnancies have not been affected by RU 486, and others have required surgical abortion as a back-up to fully evacuate the uterus.
\textsuperscript{73} See generally \textit{Griswold}, 381 U.S. 479 (1965). \textit{Griswold} locational privacy certainly does not protect all activities that might take place in the home. In \textit{Griswold}, the privacy of a married couple’s decision and the privacy of its site reinforced one another as reasons to proclaim the couple’s use of contraceptives to be free from government interference. The couple would not be free to have sex in
manner by prescribing the contraceptives in question. The presence of doctors in the RU 486 scenario, both to prescribe the pill, and to perform a follow-up medical check-up, does not then mitigate its association with the privacy of one's home.

Importantly, the pill's use in the home would conjure the same enforcement nightmare that motivated the Court's holding in *Griswold*. In *Griswold*, the Court reacted to the possibility of state enforcement of a law prohibiting married couples from possessing contraceptives via state searches of marital bedrooms by invalidating the state law. The Court made it clear in a subsequent decision which extended *Griswold* on equal protection grounds, *Eisenstadt v. Baird*, that an unmarried person's possession of contraceptives was also protected by her privacy rights. It was not the contraceptive possessor's concurrent possession of a marriage certificate that elevated the scenario into the constitutional sphere. Rather, the privacy that the Court was protecting was based on the decision and the place itself, the person's home.

VI. THE POSSIBILITY OF INDIVIDUAL STATE INTERVENTION

Should RU 486 be federally approved for sale in the United States, a state probably could not limit a doctor's decision to prescribe it. Once the federal government approved the pill, if a state wished to pass laws prohibiting possession of the pill, the motivating image which the *Griswold* and *Eisenstadt* decisions cloaked with privacy should protect home use of RU 486. Enforcement of the anti-contraceptive laws violated the person's privacy rights because the laws invited the state into the intimate realm of procreation and the private space of the home. State intrusion on a woman's private act of taking the pill would constitute a similar violation.

Nor could a state, once RU 486 were approved by the FDA, prohibit prescription or use of the drug on the basis of the state's interest in maternal health, despite its being the dominant interest throughout all stages of a woman's pregnancy. It is only once the pregnancy progresses to the second trimester that federal abortion law permits the state interest in maternal health to be enacted into law, allowing regulation of abortion only if it "reasonably relates to preservation and protection of the pregnant woman's health." The uses of RU 486 would, for medical reasons, be limited to the first trimester—that stage of pregnancy insulated from state regulation that infringes on the woman's privacy-based right to choose abortion.

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74. 405 U.S. at 453.
A state might attempt to elude the federal proscription of regulation for safety until after the first trimester by arguing that the health risks associated with chemical abortion are different from those involved in surgical abortion, and that therefore, the scheme devised by Roe to deal with surgical abortion should be expanded to allow health regulations in the first trimester. The Court allowed state regulation of second trimester abortions because at the time Roe was decided, the mortality rate of abortion was less than the mortality rate of childbirth only until the end of the first trimester.\textsuperscript{76} The significant comparison, then, would be the safety of an RU 486 abortion to the safety of childbirth, measured by mortality rates. Since the state law posited here would not arise until the FDA had approved use of RU 486, the exhaustive FDA determination of the pill’s safety would probably be dispositive in that it is unlikely the FDA would approve a first-trimester abortion method demonstrated to be less safe than childbirth. The assessment of safety, then, would already have been made at the federal level.

The Court’s holding in Planned Parenthood v. Danforth\textsuperscript{77} supports the conclusion that the safety of a form of abortion is not presumed to be a single state’s determination. The Court in Danforth struck down a Missouri law which had prohibited the performance of one form of abortion on the basis of the state’s interest in maternal health.\textsuperscript{78} The Supreme Court found that the state had deviated from national norms of safety by prohibiting saline abortions, “an accepted medical procedure in this country,”\textsuperscript{79} and that saline abortions were safer for a woman than giving birth.\textsuperscript{80} The Danforth language, in dicta, leaves open the possibility that if a state could show that the abortion method it wished to prohibit were not as safe as other forms of abortion used at the same stage of pregnancy, and could show that the other forms were available within the state, such a prohibition might be constitutional. Under Roe, however, this possibility of prohibiting a relatively less safe abortion method would probably not be an option for a state wishing to prohibit RU 486 because the state would have to show that the mortality rate of an RU 486 abortion in the first trimester was higher than that of childbirth—an issue which presumably would have been resolved in the FDA approval process.

Nor would a state prevail by arguing that its attempt to prohibit RU 486 was merely a minor health regulation which did not interfere with a woman’s right to abortion, akin to the record-keeping requirements found permissible in Danforth for the first trimester.\textsuperscript{81} Considering the state’s

\textsuperscript{76} Id.
\textsuperscript{77} 428 U.S. 52 (1976).
\textsuperscript{78} Id. at 79.
\textsuperscript{79} Id. at 77.
\textsuperscript{80} Id. at 76–78.
\textsuperscript{81} Id. at 81.
prohibition of RU 486 against the backdrop of the federal determination of safety, the Court could, as it did in Danforth, look beyond the proffered state justification to discern its genuine intent, i.e., to see if the state really intended to impermissibly burden a woman’s right to abortion. 82

VII. RESISTANCE TO AND SUPPORT FOR RU 486 IN THE UNITED STATES

If the law were our moral guide, resistance to the abortion pill’s introduction into the United States would be minimal. Yet it is not. Vocal opposition to the pill has been heard from people who are opposed to any form of abortion. While feminists are supportive of new birth control developments, 83 some, among them those who are reluctant to endorse chemical forms of birth control, have reservations about the long-term dangers of this new form. 84

It is the dream of Etienne-Emile Baulieu, the inventor of RU 486, that his pill will remove the word “abortion” from common usage by eliminating the need for the things we currently associate with abortion: the clinics, surgery, anesthesia. 85 Many anti-abortionists share with Baulieu the belief that widespread use of his pill could remove abortion from the clinics to the home, but what is a dream for the pill’s inventor may be an anti-abortionist’s nightmare, for abortion in the home might well be beyond the reach of the pro-life movement.

Anti-abortionists recoil at the potential trivialization of abortion if it can be had in a pill. It is too easy. Their fear is that the ease of the instigating action, swallowing a pill, would dilute the moral significance of the act. 86 A pro-life Congressman sent a “Dear Colleague” letter in 1986 urging support for a limitation on federal funding for testing of the pill: “The proponents of abortion want to replace the guilt suffered by women who undergo abortion with the moral uncertainty of self-deception. Imagine, with the ‘death pill,’ the taking of a pre-born life will be as easy and as trivial as taking aspirin.” 87 In the minds of the anti-abortionists, if abortion can be had in a pill, a woman would no longer need to

82. Id. at 79.
83. I interviewed 15 women who work in the reproductive health field and describe themselves as feminists for their views on RU 486. Janet Gallagher, an expert on reproductive health law, emphasized the sobering effect of seeing contraceptive research slow down in the wake of successful products liability litigation against some manufacturers of contraceptives, an unfortunate byproduct of such litigation. Telephone interview (Feb. 1989).
84. Telephone interview with Lynn Paltrow, staff attorney for the ACLU Reproductive Freedom Project (Nov. 1988).
85. Kaye, supra note 27, at 14. The executive vice president of Planned Parenthood said recently, “This drug or some similar compound will be available here someday, and when it is, it will usher in the end of the abortion debate in America.” Abrams, Politics, Profits and a Pill, N.Y. Newsday, Dec. 13, 1988, Discovery section at 1.
86. Thomas, supra note 6, at 3.
travel to a clinic for surgery, to wait surrounded by other anxious women, some crying, some changing their minds. The anti-abortionists fear that the act in the home could follow the formation of intent too quickly to give the act its moral significance. They fear that women would no longer risk traversing the moral barriers of their picket lines, with their graphic literature and photographs, to get an abortion.

Anti-abortionists may also fear that there would no longer be sites for their picket lines. In recent years, the pro-life movement has adopted civil disobedience, the morally compelling tactic of the American civil rights movement, to protest abortion at clinics where it is performed. The potential for RU 486 to decentralize the act of abortion from clinics to homes would deprive the right-to-life movement of its most concrete rallying points. Women who go to clinics for abortions often have to face chanting demonstrators who decry their actions. Women who abort in the home would not.

Anti-abortionists fear that the decentralization of abortion would increase its identification with privacy. Abortion in the home, even with medical supervision, would carry the special status that we attach to activities within home. While the identification of surgical abortion with privacy may be an elusive concept for many people, connecting home pill-abortion with privacy is less difficult, since we consider our homes to be private spheres.

Most significant from a political standpoint, anti-abortionists fear that the introduction of RU 486 would erode the strength of their movement. Opposition to abortion increases as pregnancy progresses, and many who oppose surgical abortion are less sympathetic to the moral claims of right-to-lifers when termination of pregnancy is closer to fertilization. The significant proportion of people whose views on abortion do not fall into either camp may respond positively to early abortion in the home, potentially marginalizing a polarized right-to-life view from mainstream debate.

Both the pill’s researchers and anti-abortionists believe the pill has the potential to reshape the abortion controversy. It is the researchers’ hope, and the pro-lifers’ fear. But many feminists doubt that RU 486 would

89. John Wilke, president of the National Right to Life Committee, has acknowledged that the photographs of aborted remains which have been a galvanizing tool for right-to-life activists would be less compelling if use of RU 486 became widespread because early embryos are not visually identifiable as human. Halpern, RU 486: The Unpregnancy Pill, Ms., Apr. 1987, at 56, 58 [hereinafter Halpern].
90. Richard Glasow, education director for National Right to Life, has predicted that if proponents of RU 486 are successful in identifying the drug with contraception, rather than solely with abortion, right-to-life opposition could be seen as reactionary. Id.
significantly alter the lines of the abortion controversy since surgical abortion would still be a necessary alternative to the pill. For some who chose to use RU 486, it might not work completely, and for a few, not at all. It is significant that every woman who has participated in the clinical studies of RU 486 has been required to agree to a surgical abortion should the chemical not work, and that some have indeed had to use the surgical back-up. Moreover, the pill would only be useful for very early abortions, up to seven weeks, and undoubtedly some women would fail to seek an abortion in time to take the pill. Surgical abortion would remain their only choice. Finally, even given the choice, many women would probably choose surgical abortion over a new chemical form of abortion since surgical abortion has proven to be both safe and effective.

Most critical to a number of feminists is the pill's safety. The optimism of researchers may be understandable, but it is suspect because of their vested interest in seeing their ideas and inventions accepted. Feminists concerned with the health of women fear a replay of the overly enthusiastic response which greeted oral contraceptives, an enthusiasm which led millions of women to use "the Pill" without knowledge of its consequences. Like RU 486, "the Pill" was marketed before adequate research had been done to discover its long-term health consequences.

We should approach RU 486 with the precedent of the oral contraceptive's rapid endorsement by the medical profession in mind, and the more general observation that women's bodies in our society are not as valuable as men's. To date, research on RU 486 has been limited to tests of its toxicity and efficacy. Some women have experienced side effects researchers may not consider serious, but should not be lightly dismissed. Several women have bled excessively when given dosages first thought to be safe, and some have hemorrhaged even with lower doses. Several have experienced pain from uterine contractions, and others have experienced dizziness.

91. See supra note 21.
92. Id.
93. "In 1965, nearly one third of all American women who ever used any method of contraception reported having used the pill, consuming progestogen and estrogen tablets at the rate of 2660 tons yearly. . . . By early 1969, 20 preparations differing in chemical composition, absolute quantity, and proportion of ingredients were being distributed in the U.S. at the rate of 8.5 million cycles per month." Harry W. Rudel, Fred A. Kind & Milan R. Henzl, BIRTH CONTROL: CONTRACEPTION AND ABORTION (New York: The Macmillan Co., 1973), 90. Among the side effects already known to researchers by 1973 were anxiety, amenorrhea, acne, changes in libido, backache, breast enlargement and tenderness, delayed menses, depression, dizziness, headache, leg cramps, nausea, pelvic cramps, fatigue, and weight fluctuations. Id. at 130. Recent federal regulations require that patients be warned about known dangers of oral contraceptives, including thrombophlebitis, stroke, links to cancer, and the specific dangers to smokers. See 21 C.F.R. 310.501(a)(2)(iv)-(vii).
95. See Kaye, supra note 27, at 14; Pearson, RU 486: What Will It Mean for the Women's Health Movement?, Unpublished Discussion Paper Presented at National Women's Health Movement Board Meeting (Nov. 12, 1989) (on file with author). However, researchers have reported that fewer women experienced excessive bleeding when RU 486 was used in conjunction with a prostaglandin. Baulieu, supra note 16, at 209.
ness, fatigue and nausea. Nor is the pill entirely successful in effecting a complete abortion in all women. While the efficacy of RU 486 is increased significantly when used in conjunction with a prostaglandin, there remains the possibility of incomplete abortion, dangerous because of the potential for the tissue remaining in the uterus to cause infection.

Though RU 486 is quickly flushed from a woman's system, making long-term effects less likely, feminists emphasize that a lack of long-term effects must be proven, not assumed. The pill has only been tested for toxicity and efficacy in the last few years, and I have not found any research reporting on the pill's long-term effects. Many medications, oral contraceptives among them, have had unforeseen long-term effects, and feminists tend to be skeptical of the long-term safety risks of hormone-related drugs. There may be special dangers for particular populations that would come to light only after those populations had been administered the drug. Questions that should be but have not been answered include: how does the pill affect other parts and systems of a woman's body? How would RU 486 interact with other oral contraceptives? With other medications? Will a woman who has had an RU 486 abortion have difficulty becoming pregnant again? If she is able to become pregnant again, and wishes to carry the baby, will the child be affected by the pill? These questions should be answered before the pill is marketed.

Some feminists discern a more abstract reason to hesitate before endorsing RU 486, centered, ironically, on the very privacy that other feminists celebrate. While some feminists believe the increased privacy of chemical abortion is "wonderful," others are concerned that the long feminist struggle to identify private lives as political may be undermined by the decentralization of abortion services. A corollary of privacy may be induction or exacerbation of feelings of guilt or shame. A woman who aborted at home would not benefit from the supportive counseling offered

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96. Halpern, supra, note 89, at 58; Cahill, supra note 88, at 5.
99. One published study included a follow-up checkup a month after the administration of the drug, but limited the examination to testing for efficacy and infection. Couzin, supra note 17, at 1566.
100. Telephone interview with Cindy Pearson, program director of the National Women's Health Network (Feb. 1989).
101. One woman who participated in an RU 486 study got pregnant again soon after her RU 486 abortion, and returned to the researchers for a second dosage of the drug. Couzin, supra note 17, at 1567.
102. While formal research in this area should be conducted, informal reporting to the drug's manufacturer has shown that some women who chose to carry a subsequent pregnancy after having an RU 486 abortion have had normal pregnancies. Bass, supra note 97, at 20.
103. Telephone interviews with Alice Kirkland, National Abortion Federation (Feb. 1989), and Deborah Pastor, Chair, Reproductive Freedom Project of N.Y.C. NOW (Feb. 1989).
at some clinics, counseling which can lead to the politically significant realization that she is not alone in needing an abortion. While the picketers who line the sidewalks in front of abortion clinics can intimidate women, they also politicize the private act of seeking an abortion. Abortions in the home, out of sight of the public eye, may allow society to avoid the fundamental role of reproductive autonomy in the "intensely public question of the subordination of women to men through the exploitation of pregnancy."\(^{106}\)

The level of ignorance about the long-term effects of RU 486 make it premature to apply the adjective "safe," and the privacy that the pill promises may not be wholly beneficial. The possibility of U.S. use of RU 486, however, must finally be considered in light of the political realities of the current abortion debate, for anti-abortionists have not limited their opposition to RU 486 to public statements and threatened boycotts, but have also attempted through Congressional legislation to alter the allocation of federal funds in order to impede the FDA approval process.

A right-to-life congressman, Robert Dornan, has attempted to expand the general ban on Department of Health and Human Services ("HHS") funds being expended for the performance of abortions to prevent FDA consideration of RU 486 as an abortifacient, and has attempted to prevent private research on its use as an abortifacient.\(^{107}\) Congressman Dornan attempted unsuccessfully to amend the 1988 HHS appropriations bill to prohibit the agency from using federal funds to consider a new drug application for the abortifacient use of RU 486.\(^{108}\) His attempt, likely to be repeated, to limit a federal agency's congressionally-mandated role with regard to a single drug points to unresolved constitutional questions analogous to those raised by the withdrawal of public facilities as places to perform abortions, a question currently before the Supreme Court.\(^{109}\)

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105. These insights were shared by several women, none of whom wished to be quoted.


107. While divisions of HHS can fund drug testing, none can currently test RU 486 for use as an abortifacient. This is due to the general ban on HHS funds being used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term, a restriction embodied in the "Hyde Amendment" that is added to the HHS appropriations bill each year. See Act of Sept. 20, 1988, Pub. L. No. 100-436, 102 Stat. 1680 § 204 (1988). Additionally, under HHS policy for research involving human subjects, no federal funds may be used for research involving pregnant women unless the risk to the fetus is minimal. See 45 C.F.R. § 46.207(a) (1988). These general bans do not prohibit HHS funds from being used to test RU 486 for purposes other than abortion.

The FDA decision to exempt RU 486 from its recently enacted policy allowing the mail importation of some unapproved drugs provides additional evidence of anti-choice activism targeted at federal administrative bodies. See supra note 6.


109. One question presented by the abortion case scheduled to be heard this term by the Supreme Court is the constitutionality of Missouri's termination of the use of public facilities for the performance of abortions. See 57 U.S.L.W. at 3441–42. Dornan's proposal raises a similar question because it threatens to curtail indirect government support for abortion, as opposed to direct government funding. The withdrawal of direct government funding for abortion was held to be constitutional in Harris
Congressman Dornan's unsuccessful amendment would also have prohibited HHS funds from being used to administer the FDA exemption process that allows private research on the drug as an abortifacient to take place within the United States. If the amendment had passed, the only U.S. testing of RU 486 as an abortifacient, currently being conducted by the Population Council, a privately funded non-profit organization, would have been prohibited.

Against the background of right-to-life activity targeted to prevent RU 486 from reaching the United States, feminist concerns about autonomy and choice become more urgent. Women’s autonomy is founded on increased control over our bodies, and the option of another form of abortion gives us more control. Alice Kirkland, of the National Abortion Federation, stressed that we should trust women to make their own decisions, a trust sometimes lacking even in feminist circles. The remaining unknown safety risks of RU 486 justify a feminist endorsement of further testing before releasing the drug to the open market, but the possibility that the American regulatory system could be prevented by anti-choice activism from even considering the pill spurs a more immediate concern for autonomy. The potential RU 486 holds to be developed as a safe alternative to surgical abortion should not be foreclosed by anti-abortionists' pressure on those who determine the federal regulatory scheme. If the pill proves to be safe, women should be given the choice to use it.

VIII. Conclusions

Current federal abortion law, with its trimester structure, is directly threatened by the abortion case pending before the Supreme Court, Webster v. Reproductive Health Services. Assuming, however, that the Court reaffirms the fundamental tenet of Roe, that abortion in the first trimester should remain free from intrusive regulation by the state, the most likely projected use of RU 486 in the United States, as an abortifacient to be administered under close medical supervision after a pregnancy is confirmed, is well within the embrace of the constitutional framework. The remote possibility of RU 486's introduction as a monthly antifertility drug would also be well within abortion law, and perhaps would allow RU 486 to be treated under law as a contraceptive.

The controversy over RU 486 highlights a common but disquieting observation about existing abortion law, even as one can see how the pill would easily fit into that law: it does not satisfy either side. Roe was a political decision, in the sense that politics is a balancing of interests and

110. Telephone interview with Deborah Pastor, Chair, Reproductive Freedom Project of N.Y.C. NOW (Feb. 1989).
111. Telephone interview with Alice Kirkland, National Abortion Federation (Feb. 1989).
112. See 57 U.S.L.W. at 3441–42.
beliefs. The balance achieved by Roe was an attempt to reconcile two irreconcilable moral principles, that reproductive choice is essential to women’s autonomy, and that abortion is murder. The abortion controversy, because it required the Court to address two incongruous principles of social and moral order, is analogous to the segregation controversy. In Brown v. Board of Education, the Supreme Court dealt with segregation, which like abortion continues deeply to divide American opinion, by announcing unequivocally that segregation was morally wrong. Unlike the Brown decision, Roe did not endorse the moral beliefs of either the feminist or pro-life positions. Roe explicitly denied the argument made in an amicus brief submitted to the Court, that a woman’s right to abort her pregnancy should be grounded in her right to control her own body.

The Court also explicitly addressed, but ultimately declined jurisdiction on, the issue of when life begins in order to avoid the pro-life argument that a fertilized egg is a human being.

Roe’s political balance is both its triumph and failing. It was this balancing that enabled the decision to command sufficient assent to preserve the authority of the Court. The moral compromise is also a failing, because sixteen years after Roe, the trimester theory of pregnancy is misinterpreted both by popular opinion and by the courts. Roe is popularly believed to support a woman’s access to “abortion on demand.” The opinion has also been cited by courts for the contradictory proposition that the state may act, and may even be obligated to act, on its “compelling interest” in third trimester fetal life to subject a woman to court-ordered surgery, overriding her interest in her bodily integrity and the state’s interest in her health.

The Roe political compromise, placing maternal health above other state interests, did not dispose of the abortion controversy, but shifted the political ground to the arena of maternal health. In the abortion cases decided in the wake of Roe, the political weapon used by state legislatures to justify limits on access to abortion has been the state’s interest in preserving maternal health. In these cases, the Court has been called upon

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114. 410 U.S. at 154.
115. See, e.g., In re A.C., 533 A.2d 611 (D.C. 1987), rek'g granted, 539 A.2d 203 (1988). In this case it was held that a terminally ill woman could be forced by hospital authorities to undergo a caesarean delivery of a 26-week-old fetus, against her wishes and despite her own doctors’ recommendations. The holding in A.C. ignores Roe’s mandate that the state’s interest in maternal health be paramount; in Roe the Court held that even if a state is interested in protecting fetal health, if this interest is at odds with the state interest in preserving the woman’s health—a determination to be made by her doctor—the state cannot prohibit access to abortion. See 410 U.S. at 153. The Court’s holding requires states always to leave the abortion option open when a doctor finds it is necessary to protect a woman’s health: subsequent to viability, a state “may, if it chooses, regulate, and even proscribe, abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” Id. at 165.
to delineate the evolving perimeters of the current political battlefield—to define permissible state interest in maternal health. The dramatic change promised by RU 486, should it be approved by the FDA as a first-trimester abortion method, is that it would render one form of abortion nearly invulnerable to limitations premised on the state’s interest in maternal health, thereby removing from a state legislature’s hands its most potent weapon against abortion rights.117 Since RU 486 is only effective and could only be administered in the first trimester, and the FDA would already have determined its safety, the maternal health argument could no longer be easily marshalled by states hostile to abortion. In this sense, the right-to-life movement’s perception of the threat to its position posed by RU 486 is accurate. At the same time, the potential foreclosure of continued maneuvering within the field of maternal health reinforces the potentially dispositive role of the FDA in the event it is called upon to rule on RU 486.

No drug company has yet petitioned the FDA to commence its safety testing process, a process which can last several years. The reasons for drug companies’ reluctance to market the pill in the United States are most likely the uncertainty that abortion will remain legal, the anti-abortion stance of the current Administration, and the opposition of anti-choice activists. Pro-choice forces, for their part, must address, in the arena of administrative law, how to safeguard the FDA regulatory process from the undue influence of organized anti-choice pressure, and uncover the boundaries of the legitimate exercise of federal regulatory power.118

Paradoxically, we are most likely to witness the appearance of RU 486 in the United States if Roe is overturned, and abortion is again illegal. While the prospects for an as yet undeveloped contraceptive form of RU 486 being approved by the FDA are very low,119 a black market in the pill might well spring up to meet the need for illegal abortions. In this scenario, the pill might pose very serious health risks for women, since many could suffer side effects, especially in the absence of medical supervision. Still more frightening is that women ingesting the pill illegally would no longer have access to the back-up of safe surgical abortion.


117. For a discussion of the Supreme Court’s historical deference to FDA actions, see generally Buc & Neipris, FDA and the Supreme Court in The Food and Drug Law Institute, ed., Seventy-Fifth Anniversary Commemorative Volume of Food and Drug Law (Washington, D.C.: The Food and Drug Law Institute, 1984), 114.

118. In recent years, AIDS activists have shed light on the critical role played by the FDA in defining the nation’s health priorities, particularly as manifested by the agency’s broad discretionary power in the drug approval process. Feminists interested in the fate of RU 486 will need to monitor the FDA’s actions with respect to RU 486 carefully in order to ensure the FDA’s responsiveness to women’s health needs, just as AIDS activists now monitor the agency to ensure its accountability to the concerns of people affected by AIDS.

119. See supra Section III and accompanying notes for a discussion of why it is unlikely that the federal government would approve RU 486 as a contraceptive.