Revisiting Relational Pandemic Ethics in Light of the COVID-19 Abortion Bans in the United States

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Abstract: The experiences of working-class people and those from communities of color seeking abortions in the United States before and during COVID-19 call for feminist, relational pandemic ethics. Françoise Baylis and colleagues argue for public health ethics that emphasize relational personhood, relational autonomy, social justice, and solidarity. COVID-19 abortion bans in the United States require vigilance against powerful actors who abuse these values—particularly that of solidarity—to further their political, religious, and/or economic agendas in harmful ways. Thus, efforts to promote solidarity during a pandemic must attend to social injustice and systemic oppression and provide resources to vulnerable people.

Keywords: pandemic ethics; social justice; solidarity; abortion; public health; COVID-19

1. Introduction

As the United States Congress began exploring options for a COVID-19 aid package, antiabortion politicians and activists started using pandemic response efforts to undermine the availability of abortion care. Republican lawmakers initially stalled discussions for the multi-billion-dollar relief bill, arguing that it must include the Hyde Amendment, which forbids the use of federal funding for abortions (Washington 2020). At the state level, Alabama, Arkansas, Oklahoma, Ohio, Iowa, Lousisana, and Tennessee attempted to ban abortions by deeming them "nonessential," but judges prevented them from doing so. Texas Governor Greg Abbott banned abortions in Texas, arguing that abortion care diverts medical equipment from COVID-19 patients (he was later required to lift the ban by the United States Court of Appeals for the Fifth Circuit) (Palacio 2020). Alaska took steps to "delay" abortion care until June 15th, 2020, and Mississippi's state government attempted to ban abortion access on the grounds that it was "nonessential." healthcare, which, officials argue, includes abortion. Meanwhile, a coalition of antiabortion activists has been lobbying the federal government to

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otherwise pressure abortion providers to close their doors during the pandemic (McCammon 2020).

These "COVID-19 abortion bans" have placed considerable burdens on pregnant people seeking abortions in the United States. The Guttmacher Institute estimates sharp increases in the distances that pregnant people from states with COVID-19 abortion bans must travel for abortion care (Bearak et al. 2020). *TIME* magazine reported that "with all Texas clinics now blocked from offering abortion, 94 percent of the state's counties are more than 100 miles from a provider, and nearly three quarters are more than 200 miles away" (Abrams 2020). There are also concerns that traveling for abortion care could further spread the virus. The Guttmacher Institute stated that "extended travel, or any travel, during the COVID-19 crisis flies in the face of basic public health recommendations and, in some cases, legal orders" (Abrams 2020). And a reporter for *The Nation* wrote that "in the months to come, outlawing abortions will likely exacerbate the strain on the healthcare system," while "people who lack access to abortions will travel to neighboring states, potentially contributing to the pandemic's spread" (Rebouché 2020).

Equally worrisome is the fact that the new abortion restrictions "are all exacerbated by unprecedented financial constraints, school closures and limited childcare options," while "for some populations, like young people or those who experience violence in their home, extended travel may be impossible now that family members and housemates are at home full time" (Rebouché 2020). Reporting on the bans, *The Guardian* quoted a pregnant Texas woman who wanted an abortion: "I am scared to go outside," she said, "I just saw the news about Ohio and that scared me that I can't get an abortion in time. . . . Now, they did it in Texas. I don't know what to do" (Glenza 2020).

Reading about the COVID-19 abortion bans transported me to the summer of 2017, when I conducted ethnographic research at two abortion clinics in Albuquerque, New Mexico: Southwestern Women's Options and the University of New Mexico Center for Reproductive Health. My research focused on pregnant people's experiences crossing state and national borders and traveling long distances for abortion care. I had selected Albuquerque as my research site due to New Mexico's comparatively "liberal" abortion laws, as well as the fact that two of the only four physicians who practice third trimester abortions in the United States work in that city, making it a key destination for people across the globe seeking abortions later in pregnancy.

I spent the summer shadowing several abortion providers at both clinics as they performed abortions at various stages of pregnancy and otherwise interacted with patients. I also conducted ten semi-structured interviews and dozens of informal interviews with women who had traveled to Albuquerque for abortion care due to restrictions on abortion in their hometowns, as well as a cluster of interviews with Albuquerque-based abortion care providers. My research demonstrated that long before COVID-19, widespread restrictions on abortion care placed significant financial, travel, emotional, and health burdens

on pregnant people, particularly those who are working class and from communities of color.

As I explore in this essay, the consequences of the COVID-19 abortion bans need to be understood in connection to years of increasing abortion restrictions that have long compelled pregnant people to endure onerous travel and other burdens in order to access reproductive health care. It is clear, however, that the recent bans have made things considerably more difficult for abortion-seekers and those heath care providers trying to serve them. Brenda Pereda, an Albuquerque-based abortion provider with whom I conducted a follow-up telephone interview in May 2020 (having shadowed her at the UNM Center for Reproductive Health in the summer of 2017), told me that in the midst of the COVID-19 pandemic:

> People are coming in [to the abortion clinic] with no money. No food or medication. How do we mobilize our foodbanks—at least give them a little bag of food so that they can cook for their family? These are the sorts of things that are outside the norm. . . . People are waiting a month [to get their abortions]. People are nervous. People are still deciding. Because of fear of the virus, they may change their mind. We have to think about provider availability, if they go into the second trimester. A lot of providers travel, and if there is a traveling restriction, providers aren't going there.

Pereda then explained:

> These stories [of people seeking abortion care during the COVID-19 pandemic] are exacerbated 15 percent from their baseline. I want healthcare providers and the world to understand that we take care of women from the margins … People live on the edge, and COVID took the safety net off, and people just fell over.

In this paper, I employ methodological tools of ethnography and philosophy to argue for two claims. First, I argue that experiences of many people, particularly those who are working class and from communities of color, seeking abortions in the United States before and during COVID-19 underscores the need for a feminist, relational pandemic ethics that attends to social injustice and systems of oppression. In making this argument, I engage Françoise Baylis et al.'s (2008) article "A Relational Account of Public Health Ethics," in which the authors argue that "pandemic planning must be squarely situated in the larger realm of public health and that an ethics framework for public health with be one that recognizes the need to pay particular attention to the vulnerability of subpopulations lacking in social and economic power" (196). The authors argue for a pandemic and public health ethics that emphasizes that values of relational personhood, relational autonomy, social justice, and solidarity.

Second, while I employ Baylis et al.'s (2008) framework, I also argue that the COVID-19 abortion bans in the United States illustrate a need for heightened vigilance in terms of how these values—particularly that of solidarity—can be abused by powerful actors. I explore how social actors can actively use

pandemics to further their own political, religious, and/or economic agendas in ways that harm members of vulnerable groups. In light of this, efforts to promote solidarity during a pandemic must explicitly acknowledge this and even provide conceptual resources for vulnerable people who wish to call attention to ways in which a public health crisis has been exploited to harm them.

This paper is organized as follows. In section 2, I explore in greater detail how the oppression endured by many abortion-seekers under the COVID-19 abortions bans is connected to a broader system of social injustice. In so doing, I call upon my 2017 ethnographic research and a brief follow-up study on abortion care during COVID-19 that I conducted over the phone in May 2020. This empirical data on abortion access in the United States before and during COVID-19, I argue, helps to illustrate the need for a feminist, relational pandemic ethics such as that of Baylis et al. In section 3, I outline and assess Baylis et al.'s feminist account of pandemic/public health ethics. I show how several features of their account—namely, the values of relational personhood, relational autonomy, and social justice—can help us unravel productively the ethical challenges of abortion care under COVID-19. In Section 4, I argue, using the group of COVID-19 abortion bans as a case study, that a commitment to attending to the "vulnerability of subpopulations lacking in social and economic power" compels us to build upon their account. In particular, we should draw attention to the ways in which values like "solidarity" can be abused by powerful social actors seeking to use a public health crises to further their own political agendas under the rubric of the "common good."

Prior to beginning, a note on methodology. While it remains somewhat unusual (although not entirely unusual) for philosophers to do ethnography, I undertook an ethnographic research project because of a lack of scholarly work, both empirical and normative, on the phenomenon of traveling for abortion care. Since I completed my research, a few other empirical studies were published on this subject, and I engage them alongside some of my own findings in this paper. I should also note that this is, in the main, a U.S.-focused case study. However, it has some implications beyond the United States, given that, as I explore later in this paper, women/pregnant people from across the globe regularly travel to the United States, and particularly Albuquerque, to access third trimester abortion care given due to a widespread shortage of providers (legally) performing this type of medical care. In this sense, then, the COVID-10 abortion bans are of international significance.

2. Traveling for abortion care before and during COVID-19

Pregnant people across the globe have long been traveling long distances, crossing borders, and enduring serious financial and emotional hardships to end unwanted pregnancies. The Guttmacher Institute reports that "in 2014, some 90 percent of U.S. counties lacked an abortion clinic, and five states had only one" (Jerman et al. 2017). In that same year, approximately 57 percent of reproductively aged women lived in states deemed "hostile" to abortion rights"

(Jerman et al. 2017). Pregnant people from Texas and Ohio, two such states, faced particularly daunting challenges in the aftermath of anti-choice legislation passed there. For instance, after the state of Texas passed HB2, which resulted in the closure of nearly of that state's abortion facilities, researchers found a 747 percent proportional increase in women from Texas seeking abortions in New Mexico, as well as a greater number of women seeking abortions in the second, as opposed to the first, trimester of pregnancy (Bhardwaj et al., 2017). On a global scale, it was reported in 2017 that 45 percent of the world's reproductively aged women live in one of the 125 countries in which abortions are either illegal in all cases or permitted only when the pregnant person's health is at risk (Singh et al. 2017).

All of the women I interviewed in the summer of 2017 reported that traveling for abortion care placed significant burdens on them. Most interview participants from the group of women who were seeking/had received abortions in Albuquerque reported that they turned to abortion funds like that of the National Abortion Federation (NAF) and WestFund for financial assistance to pay for their travel for abortion care. Some participants who could not afford to stay in a hotel room (which must often be booked for a full week in the case of a third trimester abortions, which require the delivery of a deceased fetus) stayed at the homes of volunteers from the New Mexico Religious Coalition for Reproductive Choice. "Samantha," who traveled to Albuquerque from Toronto alongside her brother and his wife for a third trimester abortion due to a fetal anomaly, while her husband stayed home to care for their toddler, said the following to me in an interview about her experience:

> Yeah, so, flight: we also paid for the flights for my family members, because they work full time and we want to cover their expenses as well. So, the three of us, together, it was like $2,500, and the food for a week probably is going to be like $500. Accommodation here: So, I think it's like $1,600. So altogether it's going to be like $4,450 dollars for a week to travel here. It's expensive and emotionally. . . . Everyone wants to be with their own partners, because…I can't share every single thing with my brother and his wife because they're about to have a kid. I can't just share how I feel about giving birth to a dead baby anyway. So, I'm trying to skip all the sadness about this travel and also. . . . Emotionally it's hurtful, financially it's hurtful.

"Lorena," who traveled from El Paso, Texas, to Albuquerque for a second trimester abortion she attributed to serious financial difficulties that made it impossible for her to support another child, said the following:

> We weren't expecting the high cost. I know it's not a big cost compared to having a child, but still, it's a lot. . . . We did receive some help. I received some help from two [abortion funds]: they gave me $150 from one and $65 from the other. I paid $445.

To avoid the costs of a hotel room, Lorena, her husband, and their infant left their home in El Paso at 3:30 a.m. to make the four- or five-hour drive to

Albuquerque, and they initiated their travel home late in the evening right after her abortion. That same day, I interviewed "Casey," a very young woman from rural New Mexico, who told me: "I had some rent money saved up so I had to take out of that to get over here."

Apart from financial and emotional difficulties like these, which are often associated with traveling for abortion care, some women reported safety concerns associated with travel. For instance, "Yolanda," who traveled to Albuquerque from California for a third trimester abortion, and who could not afford a hotel room, said that she was initially fearful of staying in the home of a volunteer she did not know from the New Mexico Coalition for Reproductive Choice. But she was even more fearful of being alone in a new place:

> At first, I was wondering—am I going to be safe? I am staying with a volunteer from the RCRC program, which I'm thankful for. Because if I stayed in a hotel, that would've been, like, $250 for four nights . . . and just being alone . . . I mean flying out…I'm already scared, and just being alone adds onto it. But I'm not alone, so good. They picked me up at the airport and I got in at like 12:30 am. They picked me up and took me home, and I was really grateful.

While shadowing abortion providers at the UNM Center for Reproductive Health, I observed a patient-physician interaction in which the patient—a teenager who had just driven for fourteen hours with her boyfriend from eastern Texas to Albuquerque—revealed that she did not actually want an abortion but was being pressured to get one by her partner. She feared the consequences of not getting an abortion, in part because she would have to drive home with her boyfriend for another fourteen hours. Her physician told her that she would not give her an abortion if she did not want one and tried to figure out a safe way to get the patient home.

Meanwhile, long before COVID-19, abortion providers working with patients who travel long distances for abortion care altered and adapted their care strategies to the challenging sociopolitical contexts in which they work. For instance, an Albuquerque-based abortion provider (who asked that her name not be used) told me:

> We deal with additional health risks in the sense that a lot of times, these are women who have kids that are getting up at 2:00 a.m. to drive—some of whom are alone and don't have anyone to come with. We had a woman who rolled [her car] on the way from Texas and was taken to UNM trauma. She fell asleep while driving. So occasionally, yes, if you're going back [a long distance] we worry that you're going to bleed too much or have a complication. How are you going to get to a hospital that will take care of you in the way that you should be taken care of?

Abortion care providers also reported in interviews that they have tried to counsel undocumented patients who must drive long distances for abortion care about what to do if they are pulled over by police officers. They also noted that, for financial reasons, some patients are not able to attend recommended

follow-up visits after their abortions, including third trimester abortions. In addition, abortion providers interviewed for this study reported that they must be vigilant about their patients possibly developing blood clots following their abortions, given heightened postpartum risks for blood clots and the fact that patients traveling long distances must often remain seated for extended periods of time.

As we can see, traveling for abortion care has long been a struggle for pregnant people in the United States (and beyond), as it can present very serious financial, emotional, safety, and health risks, including the threat of deportation for undocumented people. However, the COVID-19 abortion bans exacerbate these burdens. Shelley Sella, an abortion provider at Southwestern Women's Options in Albuquerque, described how operating procedures at Southwestern Women's Options have been impacted by COVID-19:

> When they call for the appointment, we will screen them for any symptoms of COVID-19. If they are fine, we will make the appointment. We encourage them not to fly. We encourage them to come by themselves. We tell them that if they are flying, they have to be in quarantine the entire time [in Albuquerque] except when they enter the clinic. If they drove, and the partner drove with them, the partner must stay in the car and drop them off at the clinic and leave. In the waiting room, the seats are six feet apart. When the patient checks in, she gets a mask. And we're wearing masks at all times when we are caring for patients. . . . And we are trying to minimize the time that people are in the clinic. In the recovery area, people are six feet apart, and it's challenging for patients and the staff.

In this quote, we see that that pre-COVID financial, emotional safety and health risks are enhanced in many ways. People getting abortions during COVID-19 have faced additional unwanted separations from family and friends during their "abortion journeys" due to quarantine and social distancing requirements, which generate greater emotional burdens. Patients who cannot fly or do not feel comfortable flying during a pandemic face additional financial obstacles if they must drive and stay in hotels while driving across many states. Meanwhile, those who chose to fly for abortion care take on additional emotional and health risks. In the midst of all this, already-overburdened abortion clinics struggle to meet patient demand for abortion access while keeping patients and staff as safe as possible.

In another phone interview, I spoke with Carmen Landau, another abortion provider at Southwestern Women's Options who highlighted additional burdens faced by people who must travel for abortions in the face of the COVID-19 abortion bans:

> We've seen with patients from Texas, Oklahoma, Arkansas—many people ended up having their abortions much later in gestation than they would otherwise because when they tried to access abortion care locally it wasn't available. There was so much judicial back-and-forth, and it caused unnecessary delays, and more second and third trimester abortions. . . . We have also seen some patients with fetal anomalies have later access to care because a lot of screenings have been delayed during to the pandemic, so patients didn't have

> results back or follow up information, and that delayed the final prognosis. . . . And obviously a lot of people have lost their jobs, and so patients who are no longer working, or if they have a partner, their partner is no longer working . . . suddenly their life circumstances are [more difficult], and they see that it's not a good time to bring a child into their family. The pandemic, and the financial repercussions, are the determining factor [in getting an abortion]. Certainly, there is a level of anxiety. What does the future bring to us as humans? Or to me and my family? Or to me and my community?

Here, Landau emphasizes how delays in prenatal screenings resulted in pregnant people seeking abortions later in pregnancy, which, in and of itself, poses both financial and health risks (first trimester abortions are cheaper and extremely safe, while third trimester abortions are not only more expensive, but also require pregnant people to endure the health risks associated with labor and delivery). Furthermore, she suggests that the economic, financial, and health burdens of the pandemic may have led to more people seeking abortions at a time when it was even less accessible to them.

Abortion providers interviewed for this study also emphasized that many abortion-seekers were angry about their experiences. One source of their anger was the fact anti-abortion protestors continued to show up at clinics like Southwestern Women's Options in violation of shelter-in-place guidelines. Shelley Sella also explained that patients with whom she spoke about the COVID-19 abortion bans, particularly in Texas, were "pissed off—angry that they had to drive fourteen hours for a pill [for a medication abortion before eleven weeks]." Other abortion providers spoke of shortages of masks, gloves, and space.

In sum, the COVID-19 abortion bans have made things considerably more difficult for many pregnant people seeking abortion care. Patients have experienced additional financial obstacles associated with travel; greater emotional burdens associated with separating from their "support units" of family, friends, and partners; increased health and financial risks as they were compelled to get abortions later in pregnancy; and anger at being confronted with protestors violating shelter-in-place guidelines along with legal restrictions that seemed overtly burdensome during an already-burdensome pandemic. Note, however, that while some of the difficulties experienced by people seeking abortions during COVID-10 are entirely unique to the pandemic (e.g., worries that traveling for abortion care can contribute to the pandemic's spread), most of them existed before COVID-19, albeit in somewhat less egregious forms. As we have seen, well before COVID-19 abortion seekers in the United States were navigating significant emotional, financial, safety, and health barriers associated with travel for abortion care.

It is appropriate, I submit, to view the burdens endured by pregnant people seeking abortions during the COVID-19 as part of a larger pattern of structural injustice, defined by Iris Marion Young (2003) in terms of "harms that come to people as a result of structural processes in which many people participate" (7). She further explains that "these participants may be aware that their actions

contribute to the processes that produce the outcomes, but for many it is not possible to trace the specific causal relation between their particular actions and some particular part of the outcome" (7). In certain respects, the harms experienced by people seeking abortions during COVID-19 can be attributed to the actions of particular individuals, such as those who had final authorization on the abortion bans. However, most of the associated injustices are, in fact, structural harms, like a widespread unavailability of affordable childcare, high rates of unemployment, low wages, social stigma, and years of antiabortion legislation leading to the closure of great numbers of abortion clinics. Furthermore, these injustices disproportionately affect women/people with gestational capacity—an oppressed social group.[1]

It is clear that if we want a pandemic ethics that can provide guidance about abortion care, then we need it to take structural injustice and oppression seriously. In the next section, I outline one account that, in many ways, does precisely this.

3. Toward a relational pandemic ethics

In "A Relational Account of Public Health Ethics," Françoise Baylis, Nuala Kenny, and Susan Sherwin (2008) argue that a great deal of governmental pandemic planning—evinced in documents such as the 2006 *Canadian Influenza Plan for the Health Sector*, the 2005 proposal *Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza* (also from Canada), and the CDC's *Ethical Guidelines in Pandemic Influenza*—ought to transcend its current, narrow focus on individual rights and liberties in order to account for the needs of particularly vulnerable social groups, such as those "lacking in social and economic power" (196). They argue that pandemic planning needs a public health ethics that is "firmly grounded in our shared interest in preventing illness, building physically and socially healthy communities and eliminating health inequities," (196) as well as the "common good" (197). Let us explore the particular values advocated by the authors.

First, note that a largely individualistic ethics for pandemic planning focuses disproportionately on (uncontroversially important) concerns such as whether social distancing measures and quarantine are justifiable infringements on individual liberties, appropriate distributions of vaccines and antivirals, the protection of privacy, the ethics of travel advisories, and the duties of health care workers to provide medical assistance during a pandemic. It also (again, appropriately) recognizes the unique needs of public health workers and their families during a pandemic. However, it fails to focus on the "vulnerable and the historically marginalized" as "persons likely to face a disproportionate burden" (Baylis et al. 2008, 198).

Baylis and colleagues (2008) argue for a public health ethics that acknowledges the "social and political context" at hand, and in which relational considerations such as "trust, neighborliness, reciprocity, and solidarity [are] made central" (198). Making pandemic responses more relational, they argue, will increase the likelihood that public health measures will succeed, particularly

during times of widespread social distrust. In addition, they contend that pandemic planning must be particularly attentive to the needs of at-risk populations. The feminist, relational pandemic ethics they propose includes the values of *relational personhood*, *relational autonomy*, *social justice*, and *relational solidarity*.

Relational personhood can be contrasted to individualistic conceptions of the person that feature individuals as self-interested, rational, and autonomous units that can be isolated from their surrounding communities and relationships. It recognizes that our "selves" are, in fact, constituted by our social relationships, and that "patients are not self-contained persons in terms of their health needs, for their health status is inevitably affected by their particular historical, social, and economic position" (Baylis et al. 2008, 201). It also connects concerns of social justice to identity by considering how social identities and oppression often shape how one sees oneself and is treated by others. This is particularly important for pandemic planning, given that, as the authors point out, "the well-being (or disadvantage) of some is likely to result in the well-being (or disadvantage) of others" (201).

Relatedly, *relational autonomy* uses and builds upon a conception of relational personhood by highlighting how what may appear to be purely individual choices are at least partial products of the webs of social relations in which one is situated. One's social context—which includes the material options available to one—can help or hinder one's autonomy. For instance, the authors point out that one's ability to take action to prevent the spread of infection is at least in part determined by one's access to disinfecting soap. Being a member of a disadvantaged group may have a deleterious effect on one's personal autonomy.

The value of *social justice*, meanwhile, requires "that particular attention . . . be to unraveling patterns of advantage and disadvantage" (Baylis et al. 2008, 203). It differs from distributive justice, which focuses on how finite social goods like public funds, hospital beds, and vaccines are justly to be distributed among individuals. Instead, social justice is concerned with "fair access to social goods such as rights, opportunities, and self-respect," paying attention to how particular social groups are systematically impacted by public policies, social practices, and distributions (203). This account is similar to Young's theory of structural injustice, in its focus on, in Young's (2003) words, "harms that are the outcome of processes in which many people participate" (7).

Finally, the authors theorize a conception of *relational solidarity* that, they argue, emerges from public health ethics itself. They first acknowledge the difficulty of achieving solidarity during a pandemic, when social trust becomes diminished and strained. Then, they develop a conception of solidarity that focuses on the particular disadvantages that members of marginalized groups face during public health crises. Relational solidarity should not, they argue, require a shared sense of identity or "us versus them" mentality, and it should be able to transcend geopolitical boundaries. They argue that "relational solidarity values interconnections without being steeped in assumptions about commonality or shared collective identity," and that "what matters is a shared interest in

survival, safety, and security—an interest that can be effectively pursued through the pursuit of public goods and through ongoing efforts to identify and unravel the complex web of privilege and disadvantage that sustain the 'us' versus 'them' divide" (Baylis et al. 2008, 205).

To achieve relational solidarity in the midst of a pandemic or other public health crisis, they argue, we should focus on our collective need for public health goods, such as vaccines, other forms of disease control, and scientific knowledge. Members of relatively privileged groups should concentrate on the fact that disease control is a truly collective enterprise and that pandemics tend to emerge in areas of comparative disadvantage (for instance, in their discussion of relational solidarity the authors note that "avian influenza, and possibly severe acute respiratory syndrome, arose in the live-animal markets of China where the poor living conditions for humans and animals make this a ripe area for zoonotic infection") (Baylis et al. 2008, 205). A similar point is made by Singer et al. (2003) (whom the authors cite), who argue that the SARS demonstrated the need to cultivate solidarity "for both self-interested and altruistic reasons" (1343).

The realities of traveling for abortion care before and during COVID-19, I argue, illustrate the importance of adopting a feminist, relational pandemic ethics, including several of the values advocated by Baylis et al. First, traveling for abortion care before and during the abortion bans underscores the need for a pandemic ethics that is attuned to considerations of social justice and the unraveling of patterns of advantage and disadvantage. Once again, those most affected by abortion restrictions are an oppressed social group, while those who issue abortion restrictions generally have more social power. Furthermore, it reveals the importance of attending to both distributive and nondistributive concerns in assessing abortion care access during the pandemic. While abortion access itself is a concern of distributive justice, we have also seen that traveling for abortion care generates fear for one's safety, anger, anxiety, and stigma, which are nondistributive justice concerns. Finally, we have seen that the burdens endured by those traveling for abortions before and after COVID-19 raise concerns of structural injustice, as they are connected not only to particular abortion restrictions authored by particular individuals but also to issues such as unemployment rates, the availability of affordable childcare, and more.

Second, the case at hand reveals the importance of employing relational conceptions of personhood and autonomy. As we have seen, we can only understand the health needs of people seeking abortion care under COVID-19 if we consider how, in the authors' words once again, "their health status is inevitably affected by their particular historical, social, and economic position" (Baylis et al. 2008, 201). We cannot develop an adequate pandemic ethics that regards abortion care as morally important if we represent people and their health needs as "self-contained" and separate from the sociopolitical context that determines the availability of reproductive healthcare. Relatedly, a person's "autonomous choice" to get an abortion, or to not get one, is clearly conditioned by various

sociopolitical forces—the economy, social stigma, the availability of childcare, etc.—that may or may not make such health care available to one. This requires an approach to pandemic ethics that differs from concerns over whether, say, shelter-in-place orders are unjust violations of individual liberty, as the former issue, but not the latter, demands that we consider people and their "free" choices as socially conditioned.[2]

I submit, then, that the phenomenon of traveling for abortion care—the associated burdens of which have been exacerbated by the United States COVID-19 abortion bans—illustrates the need for a feminist, relational pandemic ethics. Furthermore, the values of relational personhood, relational autonomy, and social justice, as articulated by Baylis et al. (2008), are useful for this purpose. However, in the next section I reflect on how the concept of "solidarity" has been abused in the COVID-19 abortion bans in the United States in a way that increases the vulnerability and social marginalization of women/people with gestational capacity. In light of this, I argue that the 2008 Baylis et al. framework, which calls for attentiveness to the vulnerabilities of marginalized groups, should be updated such that it acknowledges this real possibility for abuse, and provides conceptual resources for responding to it.

4. Pandemic abortion care and relational solidarity

I previously explored how certain appeals to solidarity and "the common good" have, in fact, been harmful to women/people with gestational capacity in the United States during COVID-19. Recall that Texas Governor Greg Abbott defended the Texas COVID-19 abortion ban on that grounds that abortion care diverted resources from COVID-19-related medical care. Other lawmakers have followed suit in deeming abortions "nonessential" medicine. Here, appeal to the "common good" and to shared public health goods—core components of the conception of pandemic solidarity that Baylis et al. theorize—are being used to justify limiting healthcare options for an oppressed social group. If our solidarity is based solely upon our shared needs for available ventilators, hospital bends, masks for E.R. doctors, and vaccines, abortion care needs may be deemed threatening to the common good and thus morally and politically problematic. In fact, appeals to solidarity could be employed not only to justify abortion bans but also to discourage those most affected by them from protesting the associated burdens (e.g., through conveying to pregnant people that their desired abortions fail to promote the common good).

To be clear, it does not follow from all this that solidarity is an *inappropriate* value to include in a system of pandemic ethics. After all, the U.S.-based political actors who have exploited the COVID-19 pandemic to promote their preexisting, anti-choice agendas were not truly acting on the principle of solidarity. Rather, they abused it for political gain and employed questionable references to the "common good." It does seem to be the case, however, that basing solidarity *exclusively* on shared health interests during pandemics (i.e., vaccines, treatment options, ventilators) can, albeit unintentionally, lend some support to this sort

of abuse. This doesn't mean that Baylis et al. are wrong to conceive of solidarity in terms of shared public health interests; rather, it only follows that we need to envision how solidarity can proceed in the event of real abuse. Finally, I submit that if aspects of our pandemic ethics, developed as they are under nonideal conditions, have been abused to further oppression during a pandemic, our ethics system should be updated to reflect this and provide for addressing the problem. My proposed amendment is, I believe, supported by Baylis et al.'s call for special attention to the vulnerabilities of marginalized subpopulations.

While it is beyond the scope of this paper to develop an alternative account of solidarity with which to supplement that of Baylis et al., I shall briefly sketch the beginnings of a proposal here, with a view toward encouraging further academic conversation on this topic. We might, I argue, supplement their account of solidarity with an alternative, relational account of the solidarity that often arises *after* injustice has occurred, and in the face of ongoing injustice. That is: if our standard principle of pandemic solidarity, which is based on our shared public health interests in things like ventilators, vaccines, and scientific research into treatments for disease, is being abused to further oppress vulnerable social groups like women/people with gestational capacity seeking abortions, we should promote, as part of our commitment to solidarity, group-specific efforts to contest that oppression.

Sally Scholtz's (2008) theory of solidarity is, I believe, a potentially helpful supplement to that of Baylis et al. Noting that solidarity is a relation that holds between persons, Scholtz argues for a conception of "political solidarity," which she defines as "a moral relation that marks a social movement wherein individuals have committed to positive duties in response to a perceived injustice" (3). Political solidarity, she explains, is both project related and oppositional. Scholtz (2007) argues that it involves different forms of opposition to norms and policies "inherent in another system" (39). The experience of political solidarity comes from shared commitment to a particular cause. However, Scholz maintains that one need not embody a particular social identity or experience a particular set of emotions in order to engage in solidarity.

Scholz's theory of political solidarity is a potentially helpful for our purposes for the following reasons. First, unlike Baylis et al.'s framework, Scholtz's theory highlights the solidarity that occurs in response to an injustice like the COVID-19 abortion bans. Thus, in incorporating her framework into our relational pandemic ethics, we can provide resources for responding to political abuse of our ethical values. Second, a theory of political solidarity enables us to recognize how pandemics themselves are political, and thus require political contestation at various levels, including those of non-state actors, like pro-choice activists and sympathetic physicians. COVID-19 has taught us that pandemics can be used to further oppression, so we need a theory of solidarity to govern actions of non-state actors who may be contesting that oppression. At the same time, states can actively adhere Scholtz's account of solidarity by supporting the efforts of those groups that are actively contesting the abuse of

pandemic mitigation efforts to further oppression. Third, given that Scholtz's framework allows for people with different social identities to stand in relations of solidarity to one another—as long as they share a commitment to a political project—it avoids the sort of "us versus them" thinking to which Baylis et al. rightfully object in their own account.

In proposing Schultz's view as a supplement to that of Baylis et al, I believe that my proposal is not vulnerable to the objections that Meena Krishnamurthy (2013) has made to Scholtz's article. In particular, Krishnamurthy has argued that Schultz's theory, as a *reactive* theory of political solidarity, fails to account for the kind solidarity that can exist among individuals in the absence of a perceived injustice. To be clear, I do not offer Scholtz's view as a standalone theory of solidarity for a system of pandemic ethics. Instead, I propose that it can help us to promote solidarity in specific instances of injustice emerging during pandemics. Given that the principle of solidarity has been abused by powerful political actors during COVID-19, pandemic ethics guidelines would benefit from the incorporation of a reactive, political theory of solidarity.

5. Conclusion

In this paper I have argued that the 2020, COVID-19 abortion bans in the United States demonstrate a need for a relational pandemic ethics that takes seriously considerations of structural injustice. I have explored Baylis et al.'s (2008) feminist, relational framework, and argued that it provides important resources for addressing some of the abortion-related injustices that have occurred over a decade later. However, I have also explored how this system of ethics—and particularly the principle of solidarity—has been abused by anti-choice political actors who have abused the notions of solidarity and the "common good" to limit, and even eliminate, abortion access during the 2020 pandemic. Because of this, I have argued that Baylis et al.'s framework should be updated to acknowledge this potential for abuse, and provide conceptual resources for responding it. I have proposed that Scholtz's reactive, political theory of solidarity could serve as a helpful supplement to that of Baylis et al. for this purpose, with a view toward encouraging further academic exchanges on this topic.

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NOTES

1. There are a number of ways in which to conceive of people with gestational capacity as an oppressed social group. For the purposes of this essay, I follow Ann Cudd's (2006) account of oppression. To conceive of this group on the grounds that they endure a greater number of unjust constraints on their actions due to the relationship between various sociopolitical factors and gestational capacity.
2. Of course, there is also need for a relational analysis of shelter-in-place orders, as such orders impact different groups in different ways.

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