The Role of the Coronavirus Pandemic in State-Level Abortion Restrictions

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Abstract. In response to COVID-19, many state governments chose to halt elective or nonessential procedures to free up personal protective equipment (PPE) for frontline medical workers. To help guide and inform state health policies, an emerging body of literature developed which contextualized the role of abortions as time-sensitive, essential medical procedures. Despite this, Texas, Indiana, and Iowa issued executive orders restricting elective or nonessential procedures and included abortions among the medical services being banned. This content analysis analyzed executive orders and subsequent communications from officials in all three states to identify rhetorical patterns and the language that was used to connect the coronavirus pandemic to abortion care. The major themes that emerged were the expansion of gubernatorial powers due to the declaration of an emergency, connecting abortion services to PPE shortages, classifying abortions as “elective” procedures, differentiating medical and surgical abortions, and purposeful avoidance of the actual term “abortion.” The findings indicate that governors in each of these three states used COVID-19 to further restrict abortion access, and they were able to use rhetoric to create a distinct narrative and justify their policies.

Keywords: abortion access, coronavirus, reproductive healthcare, state government

I. Introduction

In the wake of the COVID-19 pandemic, efforts to restrict abortion access on the state-level have been amplified. For many years, American discourse surrounding the topic of abortion has sparked some of the nation’s fiercest and most polarizing debates. Since the United States Supreme Court ruling in Roe v. Wade in 1973, which affirmed women’s constitutional right to abortion, there have been numerous policies and court cases which have emerged at the state-level restricting abortion. The emergence of “fetal heartbeat” bills and statewide bans on abortion, like Alabama’s H.B. 314, demonstrate how state governments aim to circumvent Roe v. Wade. These policy decisions reveal the growing power of state officials to write and pass abortion legislation. As the coronavirus pandemic swept the nation, many state governments used the public health emergency as a pathway to increase abortion regulations.

In March 2020, the United States, alongside much of the world, began to experience the fast and deadly spread of the coronavirus. However, as the disease spread across the nation, the United States continued to lack federal mandates or orders, leaving many critical decisions about how to slow the spread of the virus up to state governors. As a result, many governors used executive orders to implement policies quickly. Coronavirus patients overwhelmed hospitals, and many governors and state officials subsequently chose to issue orders that temporarily stopped all elective or nonessential surgeries to divert resources and preserve personal protective equipment (PPE).

In Texas, Indiana, and Iowa, governors used executive orders and subsequent communications to halt elective or nonessential procedures and included abortion services in their restrictions. These actions brought forth some of the most substantial barriers to abortion access since the ruling in Roe v. Wade.
v. Wade. Particularly, multiple forms of abortions were banned with minimal specification and providers received little to no notice. The severity of these state-level abortion restrictions, as well as their contextualization within the broader lens of the coronavirus, makes it imperative that these policies be analyzed. Specifically, the intersection of COVID-19 and abortion policy created significant rhetorical patterns at the state-level and revealed the ways in which language has been used to connect COVID-19 to abortion access. This research seeks to understand the ways in which state governments used the COVID-19 pandemic and gubernatorial executive orders to restrict access to abortion care in the United States.

II. Literature Review

A. Abortion Access Prior to COVID-19

The history of abortion in the United States reveals a centuries-long struggle surrounding access and widespread debate about women’s rights to reproductive healthcare (Reagan, 1997). Looking specifically at the intricacies of abortion access following Roe v. Wade, individual states have taken steps to either further advance or counteract the ruling. While 13 states and the District of Columbia have passed legislation protecting a woman’s right to abortion, nine other states have passed legislation that directly contradicts Roe v. Wade and either limits or entirely bans abortion access (“Abortion Policy in the Absence of Roe,” 2020). Many such anti-abortion policies were designed to go to the Supreme Court in the hopes of overturning the ruling in Roe v. Wade and either limits or entirely bans abortion access (“Abortion Policy in the Absence of Roe,” 2020). Many such anti-abortion policies were designed to go to the Supreme Court in the hopes of overturning the ruling in Roe v. Wade and represented notable threats to abortion access in the United States. Between 2008 and 2014 alone, researchers found that nearly 300 restrictive abortion laws were passed in 33 states (Bentele, 2018). The significant rise in state-level abortion restrictions has also been accompanied by a staggering decrease in recent decades in the number of abortion providers. The number of abortion providers in the United States peaked in 1982, with approximately 2,900 facilities; by 2017, this number had dropped to 1,587 (Jones et al., 2008; Jones et al., 2019). Overall, abortion access in the United States is becoming increasingly regulated and decreasingly available.

B. Role of Rhetoric in Abortion Policy

The direction of the abortion debate in American politics over the last few decades has undoubtedly been influenced by key rhetorical choices. This was made apparent in the passage of the Partial-Birth Abortion Ban Act of 2003 in the United States Congress – where the term “partial-birth abortion” was a politically constructed tool used to justify abortion restrictions (Armitage, 2010). In practice, partial-birth abortions is a vague term which encompasses multiple forms of abortion that are typically provided during the second trimester of pregnancy (McCarthy, 2003). The American College of Obstetricians and Gynecologists (ACOG) directly rebuked the term as having no medical foundation, and the legislation itself was harshly criticized in a public statement by ACOG that deemed the act “inappropriate, ill advised, and dangerous” (“ACOG’s stance on partial-birth abortion hasn’t changed,” 2002, p. 20). Despite this, the legislation banning partial-birth abortions passed and was upheld by the United States Supreme Court in the case Gonzales v. Carhart (Gee, 2007). Ultimately, the term partial-birth abortions infiltrated the political and public discourse and infused pro-life rhetoric into United States law (Armitage, 2010).

Another more recent example of the manipulation of rhetoric in the abortion debate stems from the passage of fetal heartbeat bills. A study by Evans and Narasimhan (2019) analyzed the rhetoric used in Georgia’s fetal heartbeat bill, HB 481. The authors found that the use of terms like “heartbeat” and “unborn child” allowed legislators to develop “an indication of life, creating a new protected class of persons with subsequent legal protections, and the expansion of states’ rights to guarantee legal protections to fetuses above and beyond those afforded by federal law” (Evans & Narasimhan, 2019, p. 7). The word choice of the Georgia state legislators reveals a well-planned, coordinated effort to use specific language and deliberately build pro-life sentiment into public discussion, as well as legal code. Similar bills were passed in a number of states, and subsequent research found that the term heartbeat continued to be used to indicate personhood and attribute rights to the “unborn” (Narasimhan et al., 2020).
Widespread use of terms like heartbeat and unborn child would fundamentally alter the landscape of the abortion debate in the United States and would likely undercut rhetoric promoted by pro-choice organizations.

C. The Role of State Governments in the COVID-19 Response

In response to COVID-19, one of the most commonly used tools to create public health guidelines has been gubernatorial executive orders (GEOs). Although the scope and frequency of GEOs vary from state to state, prior to the pandemic they were commonly used to make appointments, offer disaster relief, and direct or reorganize state agencies (Ferguson, 2008). Researchers had previously suggested that GEOs could advance public health programs since they “blur some of the traditional lines created through the separation-of-powers framework” (Gakh et al., 2013, p.127). Essentially, GEOs provide governors with a pathway to circumvent the state legislature and enact policies that may be controversial or time sensitive (Gakh et al., 2013, p. 127).

The use of GEOs can be highly impactful, which is why it has previously been suggested that GEOs could broaden public health policies at the state-level (Gakh et al., 2013). GEOs allow governors to avoid legislative stalemates and efficiently create new regulations. Particularly within the context of COVID-19, GEOs have been identified as an important tool to quickly and effectively create public health policies in the face of an emergency (Corder et al., 2020). Despite their usefulness, numerous concerns still surround GEOs, particularly in regard to their limitations and dangers (Ferguson, 2008). Firstly, GEOs are greatly limited by whether or not an infrastructure exists for them to be implemented within. For example, a GEO passed regarding new public health regulations will only be as effective as the existing public health system allows it to be. Ultimately, since GEOs cannot be used to fundamentally alter social and political structures, their power is limited to the capacity of existing systems. Furthermore, the rise in the use of GEOs during COVID-19 has raised concerns about the misuse of GEOs and the lack of accountability associated with them. Without much recent history of misuse of GEOs prior to the pandemic, very little evidence exists about how GEOs can be abused or overextended (Ferguson, 2008).

When the coronavirus pandemic swept the United States in March 2020, governors across the country turned to GEOs to make many of their most critical decisions (Corder et al., 2020). Within a few weeks, 42 governors had issued Shelter-In-Place Orders (SIPOs), almost all of which took “the form of gubernatorial executive orders” (Corder et al., 2020, p. 335). A number of governors also issued GEOs that temporarily stopped all elective or nonessential surgeries to preserve PPE and minimize the risk of spreading the virus (Meredith et al., 2020). In certain states, this step highlighted the discord between politicians and health officials, as some of the rhetoric used in executive orders and subsequent communications sat in direct contradiction to scientific literature (Bayefsky et al., 2020).

D. Abortion Access During COVID-19

On March 18, 2020, ACOG issued a joint statement with a number of other prominent medical and public health organizations stating that they unequivocally “do not support COVID-19 responses that cancel or delay abortion procedures” (Bayefsky et al., 2020, p. 47-1). This sentiment was echoed in a statement issued on March 30, 2020 by the president of the American Medical Association (AMA), which deemed abortion essential and urged politicians to allow physicians to determine which procedures should be delayed in the interest of the pandemic (Bayefsky et al., 2020). However, in the weeks and months surrounding the issue of these unanimous statements from the medical community, a number of states proceeded to categorize abortions as nonessential or elective, and temporarily banned the procedure (Ruggiero, 2020). While many politicians claimed this was being done in an effort to preserve PPE, an article published in The New England Journal of Medicine directly addressed this argument as illogical and ultimately exposed it as a thinly veiled political guise to exploit the power granted to state governments amidst the coronavirus pandemic (Sackeim, 2020; Bayefsky et al., 2020). Additional researchers addressed the political classification of abortion as an elective or
nonessential procedure by certain governors. They found that by giving “time-sensitive reproductive health procedures” like abortion this categorization, states were not only defying widespread scientific recommendations, but they were also choosing to limit women’s access to reproductive healthcare (Robinson et al., 2020, p. 219). As a result of direct contradictions between some states’ policies and medical recommendations surrounding abortions, researchers issued guidelines for providers on how to best continue ensuring access to abortion care (Cohen et al., 2020). These provisions included an increase in telehealth screenings prior to abortions and an expansion of medication abortion protocols – both of which were changes which would improve access for women in areas with restrictive policies in place.

E. Abortion Policies in Texas, Indiana, and Iowa

During the pandemic, individual states largely built off of their past abortion policy landscape, subsequently amplifying existing issues. Though abortion access was an issue in several states amidst the pandemic, I chose Texas, Indiana, and Iowa because each of these states had specific abortion legislation and partisan leanings which influenced their COVID-19 related policies. Texas, in particular, has experienced some of the sharpest declines in the number of abortion clinics in the country in recent years (Jones et al., 2019). This is largely the result of a 2013 bill that was passed in the Texas legislature and imposed a new set of strict guidelines on abortion clinics (H.B. 2, 2013). The bill included requirements for clinics to be within a certain distance of and have admitting privileges at a nearby hospital, as well as for clinics to meet the safety and structural requirements that are necessary for ambulatory surgical centers (Reingold & Gostin, 2016). These restrictions faced legal challenges and were eventually blocked by the United States Supreme Court; however, many clinics had already terminated providing abortion services and were unable to resume after the court ruling was finalized (Whole Woman’s Health v. Hellerstedt, 2016; Jones et al., 2019).

In Indiana, several legal battles have ensued recently in response to restrictive abortion policies being passed at the state and local levels. In particular, state-level legislation has been passed which bans dilation and evacuation, a specific type of second trimester abortion, as well as others which require doctors to perform ultrasounds preceding abortions and obtain parental consent for minors seeking an abortion (H.B. 1211, 2019; Magdaleno, 2020). It is important to note that in both Indiana and Texas, abortions done through prescription medication are prohibited from being prescribed through telehealth appointments (“State Facts About Abortion: Indiana,” 2020; “State Facts About Abortion: Texas,” 2020).

Finally, in Iowa, the state legislature and governor have passed significant abortion restrictions since 2017. The state passed a ban on abortions past 20 weeks, as well as a fetal heartbeat bill, which was later struck down in the courts (S.F. 471, 2017; Leys, 2019). However, unlike Texas and Indiana, Iowa allows physicians to administer prescription medication for abortions “remotely through video teleconferencing” (Yang & Kozhimannil, 2016, p. 313). This provision is the result of a unanimous ruling from the Iowa Supreme Court in 2015 which protected the right of abortion providers to practice and prescribe via telemedicine (Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine, 2015).

When looking at abortion policies passed in recent years, all three states show a clear preference towards anti-abortion legislation. This is further reflected in the political makeup of these states’ governments. Although this was not always the case, political leanings have become increasingly tied to specific viewpoints in the abortion debate (Layman, 2001). Research has found that over the course of the past 30 years, media has played an integral role in linking the Republican and Democratic parties to pro-life and pro-choice sentiments, respectively (Carmines et al., 2010). Texas, Indiana, and Iowa all have Republican governors and Republican majority legislatures, indicating that the overwhelming share of the states’ politicians subscribe to pro-life ideology.

While there were a number of states in which COVID-19 was used as a vehicle to limit abortions, these three states were of particular interest because of their approaches. In all three states, the governors used executive orders and subsequent
communications from their offices to pause elective or nonessential surgeries, and in doing so also temporarily banned abortions. All three states used GEOs to create their policies, however they varied in how they applied their executive orders to abortions. In Texas, the state’s attorney general issued a statement clarifying that the governor’s executive order applied to abortions. In Indiana, the state’s governor explicitly cited abortion clinics in his executive order among the healthcare providers who should halt all elective procedures. In subsequent communications, the governor further clarified why abortion services were included in the policy. In Iowa, a two-sentence statement from the governor’s office was the only notification given to women and providers that abortions would be among the procedures that were temporarily banned. In all three states, executive orders restricting nonessential and elective procedures, including abortions, went into effect immediately or within days after they were signed. Any subsequent communication from each governors’ offices about the impact of their orders on abortion access was released within one day. This context is critical when evaluating the states’ policies surrounding abortion access and the rhetoric that state officials used to connect COVID-19 to abortions. While research exists about state regulation of abortion, there is an emerging gap in the literature surrounding the relationship between state-level political rhetoric and the coronavirus pandemic. This research aims to fill this break in knowledge by studying specific policies which were implemented to restrict abortion during COVID-19.

III. Methods

In order to analyze the relationship between the coronavirus pandemic and increased restrictions to abortion access by governors, this research analyzed executive orders and subsequent communication from state officials regarding nonessential or elective procedures and abortion access in Texas, Indiana, and Iowa. All three states released executive orders which were openly available on the state governments’ websites. The subsequent communication consisted of public follow-up statements made by state officials related to the original executive orders. A qualitative approach was most suitable for studying this data because of its entrenchment in partisan platforms and past policies, as well as its implications for state-level power and rhetorical connotations.

I conducted a content analysis on each of the states’ executive orders and follow-up communications. This research method allowed me to glean rhetorical patterns and generalizable themes from each of the state’s policies. Once the raw data was compiled, I coded the documents manually and utilized a grounded theory approach. As such, the codes I used were developed from the documents themselves rather than being established beforehand. After producing an initial list of codes and a word frequency map for all of the documents, the codes were consolidated based on how key words and phrases were used throughout the documents. The streamlined codes were then used to do a second round of analysis on the documents and ultimately develop themes. Based on the literature review, it was clear that certain patterns may emerge, including the characterization of abortion as “elective,” the allocation of PPE, and the explicit distinction of different types of abortion procedures (Bayefsky, 2020). However, by utilizing grounded theory, I was able to assess the documents with more detailed codes than if I had exclusively developed codes based on past literature. Therefore, the resulting themes were specific to abortion access amidst the coronavirus pandemic. After coding each document and establishing themes, the documents were thoroughly analyzed and compared with one another. This process revealed rhetorical similarities and differences between each state’s approach and gave way to an analysis of the implications of the language being used in the policies.

IV. Results and Discussion

All three states’ executive orders and subsequent communications had a number of commonalities. The newly imposed restrictions all applied to a broad range of procedures, including dental services, dermatological care, and various outpatient surgeries. Additionally, each state used this executive order, or one closely related, to
reduce restrictions to telehealth and better equip doctors to diagnose, treat, and prescribe virtually. However, when it came specifically to abortion access, the executive orders exhibited distinct rhetorical patterns that highlighted their similarities and differences.

The states shared three patterns. First, all three states cited the expanded powers of governors in response to a public health “disaster” or “emergency” to justify their use of executive orders. Second, each state used preservation of PPE as a key reason for their executive orders. As it related to abortion, state officials either said or implied that the continuation of abortion services would deplete the supply of PPE unnecessarily. Third, all three states characterized abortion services as “medically unnecessary” or “elective.” However, states did take different approaches in their use of discourse around surgical and medical abortions and the use of the term “abortion.”

A. Theme 1: Gubernatorial powers during a public health “disaster” or “emergency.”

All three executive orders cited the expansion of gubernatorial powers in response to a public health “disaster” or “emergency.” GEOs are not used frequently by governors, however the declaration of a public health emergency paved the way for their use during COVID-19 (Corder et al., 2020). For example, in Indiana’s executive order, Governor Eric Holcomb stated that under Indiana law, he had “broad authority to take actions, necessary to prepare for and respond to the prompt and efficient rescue, care and treatment of persons victimized or threatened by a disaster, which include an epidemic, public health emergency and any other public calamity requiring emergency action” (Exec. Order No. 20-13, 2020). Similar provisions exist and were enacted in Texas and Iowa, highlighting how the official declaration of an emergency allowed the governors to take far-reaching, unprecedented actions in an attempt to handle the pandemic quickly and effectively.

The declaration of a state of emergency in response to COVID-19 not only allowed governors to exert increased power over their constituency, but it also permitted them to utilize GEOs and circumvent legislative approval. Although this approach allowed policies to be implemented quickly, it also eliminated the checks and balances which typically regulate policy as it moves through the legislative process. Particularly as it relates to abortion policy, this allowed governors in all three states to implement abortion restrictions without any forum for disagreement, either from other politicians or public health professionals. As a result, these executive orders went into effect without any debate, and their abortion restrictions stood in direct contradiction with policy guidelines from the medical community.

Numerous medical experts, including ACOG, issued statements prior to the signing and implementation of all three executive orders saying that abortions are essential medical procedures (Sackeim, 2020). Despite this, these executive orders were signed into effect and applied to abortion services without any significant difficulties. This is indicative of the expanded authority given to governors during disasters. Under normal circumstances, abortion restrictions as severe as those included in the executive orders would receive widespread public and political backlash. However, with the traditional forums for policy development cast aside to prioritize efficiency, the only way to challenge these executive orders was through legal avenues after the policies had already been put into effect. By allowing such severe abortion restriction to be passed before they were able to be contested, new strategies were exposed in how reproductive freedoms can be undercut and overturned on the state-level.

B. Theme 2: Preservation of PPE and abortion access.

In the early months of the pandemic, massive shortages in PPE left healthcare workers unprotected as they fought COVID-19. While many of these shortages were a result of supply chain issues and the lack of a federal response, many governors felt that suspending nonessential medical services would help save PPE and free up other healthcare resources (Ranney et al., 2020). While this strategy was used by numerous states, in Texas, Indiana, and Iowa, the restriction of nonessential medical services to preserve PPE was extended to include abortions. In each of the three states, the governors...
used language which implied that nonessential procedures take PPE away from frontline workers in a large enough capacity that the issue must be regulated. In Texas, Governor Greg Abbott stated in his executive order that “hospital capacity and personal protective equipment are being depleted by surgeries and procedures that are not medically necessary to correct a serious medical condition or to preserve the life of a patient” (Exec. Order No. GA-09, 2020). A subsequent statement from the Texas Attorney General, Ken Paxton, clarified that “no one is exempt from the governor’s executive order on medically unnecessary surgeries and procedures, including abortion providers” (Attorney General of Texas, 2020). Taken together, the statements create a clear narrative that at the state-level, abortion providers are actively contributing to the depletion of PPE in a way that is directly harmful to frontline workers. Figure 1, below, shows examples of the language used by Indiana and Iowa’s state officials to describe how their executive orders would increase the availability of PPE.

Though each governor seemed motivated by PPE shortages to reduce nonessential procedures, they also all stated or implied that abortion services in particular affected the supply of PPE. While in Indiana, Governor Holcomb made more outright connections between abortion services and PPE, in Texas the explicit connection of abortion access to PPE shortages was made in subsequent communication from the state’s attorney general. In Iowa, the connection was less clear than in Indiana and Texas, however it was still evident. Iowa’s executive order was founded on the notion that non-urgent procedures must come to a halt to preserve PPE, and abortion services were explicitly identified as nonessential procedures.

The narrative emerged in each state that abortion care specifically contributed to taking PPE away from other healthcare workers who were battling COVID-19. This pattern is noteworthy because it creates the sense that when PPE is distributed, abortion providers directly take PPE away from frontline medical workers. Not only is this a misrepresentation of how PPE is distributed, but doctors have pointed out that “continuing pregnancy and delivery will almost certainly require more PPE than an abortion

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<tr>
<th>State</th>
<th>Example</th>
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<td>Indiana</td>
<td>“To preserve PPE for health care providers who are battling the COVID-19 pandemic, beginning April 1, 2020, all health care providers, whether medical, dental or other, and health care facilities, whether hospitals, ambulatory surgical centers, dental facilities, plastic surgery centers, dermatology offices and abortion clinics, are directed to cancel or postpone elective and non-urgent surgical or invasive procedures.” Source: Indiana Executive Order 20-13</td>
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<td>Iowa</td>
<td>“The COVID-19 pandemic has increased demands for hospital beds and has created a shortage of personal protective equipment needed to protect health care professionals and stop transmission of the virus. Postponing surgeries and procedures that are not immediately medically necessary will ensure that hospital beds are available for those suffering from COVID-19 and that PPEs are available for health care professionals.” Source: Iowa Executive Order on March 26, 2020</td>
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Figure 1: Examples of state specific rhetoric regarding the preservation of PPE.
obtained early in pregnancy” (Sackeim, 2020, p. 1457). While the proper allocation of PPE was certainly a consequential issue at the start of the pandemic, the misrepresentation by governors and their offices that abortion services would unduly steal PPE from other healthcare workers is a gross mischaracterization.

C. Theme 3: Classifying abortions as “elective” or “medically unnecessary.”

In either the executive orders or subsequent communications from each states’ officials, abortion was categorized as either “elective” or “medically unnecessary.” In Texas, the restrictions applied to “any type of abortion that is not medically necessary to preserve the life or health of the mother,” thereby classifying all abortions which are not driven by health risks as medically unnecessary (Attorney General of Texas, 2020). In Indiana, the executive order classified care given at abortion clinics as “elective and non-urgent surgical or invasive procedures.” This establishes that a broad range of reproductive healthcare services which are provided at abortion clinics are “elective.” However, similar to Texas, Governor Holcomb clarified that the executive order would not apply in situations where the doctor felt the patient’s health was at risk. In Iowa, Governor Kim Reynolds’ office communicated that surgical abortions fall within the realm of “nonessential or elective surgeries and procedures.” Therefore, they are included in the restrictions set forth by her executive order.

In both Texas and Indiana’s COVID-19 related restrictions, clear guidance is given which allows abortions to occur when the mother’s life or health is at risk. In Iowa, although the executive order does not specifically relay this message in the context of abortion, it states that any surgery can be performed if the patient’s life is at risk without that procedure. This stipulation is significant because it indicates that in these specific instances, abortions are not elective and represent a critical medical procedure. This characterization of abortion services undercuts the role of abortions in women’s reproductive healthcare and further delegitimizes the procedure. The repeated use of terms like “elective,” “nonessential,” and “non-urgent” create a definitive picture of abortion as a choice rather than a fundamental right. Moreover, all three states have included provisions which allow abortions under certain circumstances. Therefore, the governors in each state had to undergo the process of determining which abortions are acceptable and which are not, a process which relies on personal prejudices regarding abortion rather than objective judgement (Janiak and Goldberg, 2016). Ultimately, the state governments’ depiction of abortion services as elective not only renegotiates the scientifically established role of the procedure, but it further infringes upon women’s right to abortion as it is established by Roe v. Wade. As the Supreme Court ruling explicitly outlines, state-level restrictions that limit the necessity of abortion to cases where the mother’s life is at risk are a violation of the Fourteenth Amendment and ultimately diminish “a woman’s qualified right to terminate her pregnancy” (Roe v. Wade, 1973). Beyond its unconstitutionality, the invented dichotomy between necessary and unnecessary abortions constructs a hierarchy of acceptability for the reasons behind a women’s abortion. While political rhetoric has deemed that physical health risks are an acceptable reason for an abortion, this rhetoric is also involved in stigmatizing any other reason for getting an abortion (Cockrill, 2013). The social and political ramifications of this understanding of abortion are vast because they contribute to the narrative that abortions are only permissible, and “necessary,” in cases where the mother’s health is at stake. Furthermore, maternal health is often oversimplified in these cases to only include physical health when legal precedent, per the 1973 Supreme Court case Doe v. Bolton, established that health encompasses “all factors physical, emotional, psychological, familial, and the woman’s age” (Doe v. Bolton, 1973). Therefore, these state level policies not only undermine legal precedent, but they further delegitimize the various reasons that women choose to seek abortions.

D. Theme 4: Distinguishing medical and surgical abortions.

Medical abortions, or medication abortions, are noninvasive abortions that are typically administered through a prescription medication within the first nine weeks of pregnancy (Weitz et al., 2004). Surgical abortions refer to a range of
different methods which all require a physician to perform a procedure that results in the termination of pregnancy (Weitz et al., 2004). While Texas and Indiana did not specify the type of abortion being restricted by their executive orders, Iowa specifically banned surgical abortions. In Texas and Indiana, state officials most heavily referred to “abortion providers” and “abortion clinics” in their policies. This language allowed officials in these states to cast a wider net and restrict a greater number of abortions. In Iowa, Governor Reynolds only specifically applied her executive order to “surgical abortions.” So, unlike the other states, Iowa’s executive order had no impact on medical abortions.

Although the three states differed on their identification of different types of abortions, both choices represent meaningful rhetorical decisions in the broader context of abortion policy in the United States. Beginning with Texas and Indiana’s choice not to distinguish between the types of abortions, this represents a commonly observed pattern in recent anti-abortion legislation to create one singular narrative for all abortions. This phenomenon is best observed in fetal heartbeat bills which have recently been passed in a number of states (Evans & Narasimhan, 2019). These bills lump together all abortions performed after the detection of a fetal heartbeat, and do not create detailed policies to differentiate medical abortions from surgical abortions. By avoiding high-levels of detail, pro-life legislators are able to construct one dominant narrative of abortion services in the United States. This rhetorical choice is ultimately most beneficial for anti-abortion policies because it overshadows the discussion of medical abortions, which are a non-invasive form of abortion. Medical abortions, which made up approximately 39 percent of all abortions in the United States in 2018, only occur in the first nine weeks of pregnancy and do not require any type of procedure (Kortsmit et al., 2020). However, discussing medical abortions at length would likely detract from pro-life rhetoric, which often relies on politically charged terms and highlights more invasive forms of abortion (Weitz et al., 2004).

While the tactic seen in Texas and Indiana deliberately avoids specifying amongst the types of abortion procedures, the rhetorical implications of Iowa’s policies are also powerful. By singling out surgical abortions in the coronavirus-related restrictions, Governor Reynolds was able to specifically target abortions which occur further along in pregnancy. Surgical abortions are not only the most prevalent form of abortion, but there are also various types of surgical abortions which are performed up to 13 weeks of pregnancy and beyond (Kortsmit et al., 2020). As seen in past abortion policies passed in Iowa, it has been the goal of pro-life politicians to regulate and diminish abortions services that occur later in pregnancy, whether it be after 20 weeks of gestation or after the detection of a fetal heartbeat. By implementing a ban on surgical abortions, Iowa was able to continue the same efforts it has pursued in past legislation and limit abortions as the weeks of gestation increase.

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<tr>
<th>State</th>
<th>Executive Order</th>
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<td>Texas</td>
<td>No</td>
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<td>Iowa</td>
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Figure 2: Use of the term “abortion” in state-level policy and communications.
E. Theme 5: Use of the term “abortion.”

In two out of the three states analyzed, Texas and Iowa, the governors did not use the term abortion anywhere in their executive orders. Rather, it was only in subsequent communications that state officials clarified that their executive orders would also apply to abortions. Indiana was the only state whose executive order explicitly used the word “abortion.” However, even in this scenario, the term “abortion” was only used once in the executive order and further clarification was not given until a subsequent press conference. In Figure 2, a clear breakdown is shown when each particular state used the term “abortion.”

The deliberate avoidance of the term “abortion” in Texas and Iowa’s executive orders represents a critical rhetorical decision on the part of the states’ governors. The term abortion has become a politically charged word in the United States and its mention has the power to transform a bipartisan issue into a fiercely divisive debate (Armitage, 2010). The choice not to include the term abortion in the initial policy indicates that state officials not only wanted to minimize political uproar, but that the inclusion of abortions in the overall restrictions was purposefully covert. By utilizing subsequent communication to apply and clarify how the orders included abortions, governors were able to dodge more widespread backlash to the executive orders as a whole. The rhetorical choice seen here, to omit a word rather than use it, is just as important because it is indicative of increasingly surreptitious tactics being used to pass and enforce abortion restrictions.

VI. Conclusion

Overall, in all three states, governors and state officials made purposeful rhetorical decisions to connect COVID-19 to abortion restrictions. By expanding their powers through emergency declarations and the use of GEOs, governors were able to pass broad and controversial abortion bans with minimal backlash. The signing and implementation of these abortion restrictions were further bolstered by rhetoric which argued abortion services took PPE away from frontline medical workers, and that the procedure itself was medically unnecessary. Additional rhetorical choices, including the differentiation between medical and surgical abortions, and the selective use of the term abortion, represented calculated judgement calls. Each of these themes helped create one overall narrative that persisted between states about why abortion access needed to be restricted due to COVID-19. Without these distinct language choices, the states’ governors would not have been able to present as persuasive or impactful of an argument. Although each of these executive orders faced legal backlash, their ability to be created and signed represents the increasing fragility of abortion protections on the state-level.

The future implications of this research are vast, and represent the evolving nature of state power and partisan rhetoric. Certain language used by states to restrict abortion either directly contradicted existing legal precedent or undermined medical judgement regarding the issue. As state government officials become increasingly emboldened, new questions emerge about the power of political representatives in public health, as well as the legitimacy of executive orders when they undercut United States Supreme Court rulings. Overall, the power exerted by governors and state governments during the pandemic has been unprecedented, and it is essential that work be done to study how this influences state-level policy in the years following the pandemic. Additionally, the abortion policies implemented during the pandemic, while they may
appear highly specialized for crisis conditions, may create rhetorical models which can be used in the future to characterize abortions on a state-level and further advance anti-abortion policies. Ultimately, the rhetoric used on the state-level to define and describe the relationship between COVID-19 and abortion access will not only have widespread implications for how abortion was accessed during the pandemic, but it will have a lasting impact on how the procedure is viewed in terms of its necessity and permanence.

VII. Acknowledgements

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