

The Undue Burden of Architecture:

**Scapegoat Interview
with George
Johannes, Lori
Brown, and Eliza
McCullough**

Scapegoat: In June, 2016 the Supreme Court decided *Whole Women's Health v. Hellerstedt*, a landmark case that served as a referendum on the “undue burden” standard established in 1992 by *Planned Parenthood v. Casey*. In *Casey*, the court ruled that states could not place “obstacles” in the path of women seeking abortion that would place an undue burden on them, or in effect, that states cannot simply make it so hard to access abortion services that they cease to exist even though abortions are legal on paper. So this 2016 Supreme Court case reviewed a series of regulatory measures in Texas, known as House Bill 2, signed into law by Governor Rick Perry, which amended Texas’s abortion regulations in two primary ways: HB2 mandated that doctors who perform abortions have admitting privileges in a hospital within 30 miles of the facility where they provide care, and second, that the building codes for abortion clinics meet the regulatory standards of ambulatory surgical centres (ASCs). These standards are difficult to meet because ASC regulations are there to ensure a sterile environment for open surgery, and sterile environments are not easy or cheap to build. As abortions are medically non-sterile operations, they don’t require these kinds of spaces (See Figures 2 and 3 for a comparison of ASC regulations and a pre-HB2 abortion clinic). I think we can agree that this was a cunning legislative strategy, in that it successfully closed over half of all abortion clinics in Texas not because abortion is immoral, or because it violates religious beliefs, or misunderstands the nature of Life in some

way, but rather in the name of protecting women’s health. After the decision, Ted Cruz wrote that “Texas enacted HB2’s commonsense health standards to ensure that women receive safe care. ... Unfortunately, the Supreme Court sided with abortion extremists who care more about providing abortion-on-demand than they do protecting women’s health.”¹ It was subterfuge. George, you were called on to give expert testimony as an architect to the court in Texas reviewing HB2. What were these discussions like, and how did you find yourself drawn into this debate?

George Johannes: My involvement in the field of abortion care started when I got a commission from a woman who asked me to design her new abortion clinic, and I said yes. It was Hope Clinic for Women in Granite City, Illinois, just on the border with Saint Louis, Missouri. The project went incredibly well ... so well that we decided we should get married. [laughter]

Sally Burgess was the Executive Director of Hope Clinic, and served on the Board of Directors of the National Abortion Federation (NAF), being elected Chair in 2008. So I would go to their annual national meetings

¹ Lauren Gambino, “Clinton hails Texas Abortion Decision as ‘Victory for Women,’ Trump Stays Silent,” *The Guardian*, 28 June 2016, <https://www.theguardian.com/law/2016/jun/27/us-supreme-court-abortion-clinton-trump-sanders-november-election>.

and got to know a lot of folks working in this field. I also presented a number of times at NAF meetings on subjects like clinic security and design. Many of the clinic people were not aware of things like the NFPA 101 (National Fire Protection Association code). Are you familiar with that document? It's a code book that's specific to buildings like schools and hospitals and ambulatory surgical centres and it sets out what the requirements are. Many people at these conferences weren't familiar with these regulations, or the regulations in the International Building Code (IBC), so they were seeking assistance in interpreting the new regulations being enacted by state legislatures that were targeting abortion clinics. As for operational and procedural requirements that were part of the legislation, the clinic operators knew this realm well and typically met these requirements long before the new state regulations were enacted. If the regulations said you



photo: Marc Godefroy for www.womenonwaves.org

had to scrub a certain way before a procedure, that was easy, but if they said you needed so many air changes in an operating room, they weren't familiar with that. So when TRAP laws (Targeted Regulation of Abortion Providers) were passed by the Virginia legislature and signed by then Governor Robert McDonnell, eight abortion providers there sought assistance in interpreting the impact these new laws would have on their practices. So Charlotte Taft, who was Director of Abortion Care Network and knew my work in this field, recommended me to some clinics in Virginia, and I went to assess the eight clinics there. We didn't go to court over that, and I think the Governor may have gone to jail over a Rolex watch or something,² but only a few of the clinics in Virginia had to close. Most of them were able

to negotiate improvements, but these laws were tough in Virginia,³ similar to HB2 in Texas. Basically what the clinics hired me to do was to figure out how they could meet the new requirements in Virginia, how much it was going to cost, and how long it would take to do. A couple of years later I was hired to do pretty much the same work in Michigan. Michigan had a more enlightened health department. Actually, Virginia's health department was good but they were just totally under the thumb of the Governor, and in fact I believe the director of Virginia's health department quit over these laws, but in Michigan most of the clinics were able to negotiate improvements based on my report. For instance, they would say "these parts of the regulations we can't meet, but this, this, and this, we can do," and they were able to stay open. In fact, I think all of them were able to stay open. I also worked on George Tiller's clinic in Kansas.⁴ After Tiller was assassinated, the woman who picked up the clinic wanted to reopen it, but she was anticipating a regulatory crackdown so she asked me to come take a look to find out how far off they were from meeting the requirements in Kansas. Of course, George Tiller, being the man that he was, had already totally complied. He was totally prepared for this type of thing, and there was no problem with the facility.

It met the physical architectural requirements for Kansas. Of course, the clinic was still vulnerable to other kinds of attacks. Then when HB2 came along in Texas, Amy Hagstrom Miller asked me to testify through the CRR (Center for Reproductive

² As a State Representative, Bob McDonnell was a sponsor or co-sponsor of 35 anti-abortion bills. One of these bills required women seeking an abortion to undergo a medically unnecessary transvaginal ultrasound, whether these women wanted this procedure or not. In this procedure, an ultrasound device is inserted into the vagina. Then, after McDonnell was elected Governor of Virginia, Republicans in the legislature passed his ultrasound bill, bringing the legislation to McDonnell's desk to be signed into law. Huge protests over this possibility then erupted in Virginia, along with a national outcry, and in response McDonnell tried to distance himself from the bill that he had been fighting for since his time in the legislature. "Governor Ultrasound" was a name given to McDonnell during these protests in order to counter his attempts to distance himself from his own legislation. Initially, Governor McDonnell requested that the mandatory transvaginal ultrasound be stripped from the bill. House Delegates then passed a revised version in which women could "reject" a transvaginal ultrasound, in which case they would still be required by the state to have an abdominal ultrasound.

McDonnell signed the bill in 2012, making Virginia the seventh state to require women to have an ultrasound procedure before they can legally have an abortion. In 2014 McDonnell was found guilty of accepting thousands of dollars in cash and bribes. In 2016, however, the Supreme Court vacated his conviction.

³ In 2013, the Virginia legislature passed law regulations requiring clinics that perform five or more first-trimester abortions per month conform to the same architectural requirements as hospitals. The Virginia Board of Health repealed the law in 2016 following the *Whole Woman's Health v. Hellerstedt* decision. Gail Deady, "Virginia Board of Health Sees TRAP Laws for What They Are," ACLU, 26 October 2016, <https://www.aclu.org/blog/reproductive-freedom/abortion/virginia-board-health-sees-trap-laws-what-they-are-poorly>.

⁴ In 2009 George Tiller was shot in the head and killed in Wichita, Kansas by an anti-abortion extremist. He was one of the few doctors in the US who performed late-term abortions. Joe Stumpe and Monica Davey, "Abortion Doctor Shot to Death in Kansas Church," *New York Times*, 31 May 2009, <http://www.nytimes.com/2009/06/01/us/01tiller.html>.

Rights) in New York. So that's how I got involved in the HB2 case in Texas. It's been fascinating, totally fascinating, to see how many smart and dedicated people worked on this. The attorneys of CRR are really smart, and I doubt that they make a lot of money doing this important work.

SG: So do I have this right that you went around and surveyed all the remaining clinics that were still open in Texas?

GJ: Not all. Only those who joined the lawsuit. In Texas I visited the seven clinics that were part of the lawsuit against HB2. These were clinics that were suddenly being asked by the State of Texas to comply with ASC regulations, after they had been built to meet an entirely different building code. The lawsuit was an attempt by these clinics to convince the Texas courts that this was an unfair request that the legislature was making of them. My job was to look at all the NFPA codes and all the HB2 regulations, anything that Texas could use to make a judgement as to whether these clinics should be licensed or not, and survey each clinic. I looked at what they had, and what was required. Requirements were noted as either "met" or "not met," and that became the basis of the report. Then the remainder of the report was my assessment of what it would cost to take the clinic from where it was to where it needed to be. What I found was that realistically none of the clinics would have been able to meet the new Texas requirements. In a number of cases, the building site was too small to add what would have been needed, or the building itself was not capable of such an addition. In most cases the sensible thing to do would have been to simply start from scratch. The average remodeling cost for the clinics was between \$1,700,000 and \$2,400,000, and the ground-up cost for a new facility was approximately \$3,400,000.

Lori Brown: Those costs also assume that the clinic would be able to find and hire the building trades necessary for those construction projects, correct?

GJ: Yes, in the analysis and report for each facility, we assume the best in that regard. That part of the argument would be very speculative. I'll give you an example. At Hope Clinic the building is made out of a very nice finished concrete block, called "ground face block." It almost looks like terrazzo, but it's actually a concrete block with some nice aggregate in it. The people we would have normally bought it from refused to sell it to an abortion clinic, so we had to get it from another source, and that was more expensive. Ethically, and this is something I talk about in my teaching, when you run into that situation you don't really know if the people who sell the concrete block are highly principled or whether they are simply concerned their work with the archdiocese, or some other customer, might go away if word got out that they were selling block to an abortion clinic. So Lori, you're absolutely right, our numbers assumed that we could find people to do the work. Our general contractor for Hope Clinic is great, he's not the type of person to be pushed around by popular opinion, but we did have some issues with subcontractors on the project. On Hope Clinic we

were kind of surprised. There was some graffiti put up by one of the subcontractors, but it had nothing to do with abortion—it was anti-Semitic graffiti that targeted the general contractor because he was Jewish.

SG: I also assume that in Texas costs vary widely depending on what part of the state you're in?

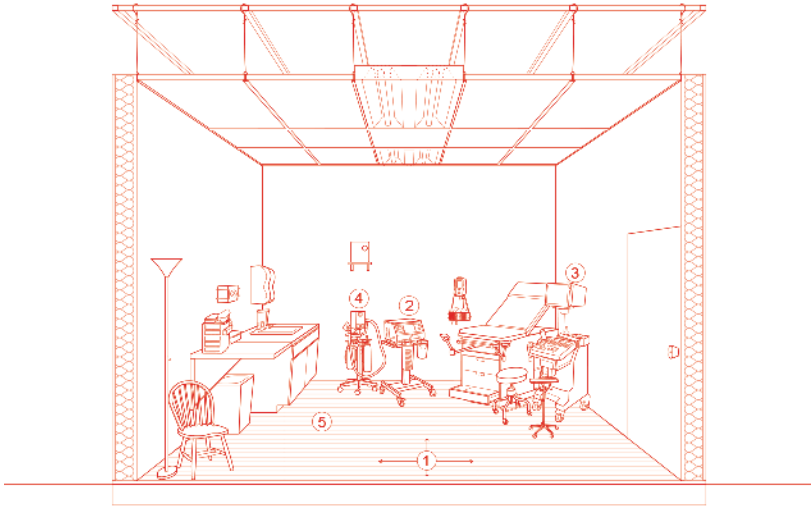
GJ: Yes, the distances in Texas are large, and this came up in the trial. In Texas the farthest drive, and by far the poorest area was McAllen, which is down in the Rio Grande Valley, and it was one of the clinics that the state was going to close. The closest clinic to McAllen is in San Antonio, a four-hour drive away. So if you factor in the 72-hour waiting period, a woman in McAllen would have to take off three or four days off work, explain to her employer why she's disappearing, maybe arrange child care, and since many of the women in that area don't drive or have cars they would need to arrange transportation to San Antonio. El Paso is even more remote, although during the trial in Texas someone from the Attorney General's office suggested that if the state closed the clinic in El Paso, that wouldn't pose any undue burden on women because they could still just go across the border to New Mexico. It was a shocking argument to hear, I mean, if they have an issue with this, maybe a moral issue, sending someone

across state lines doesn't solve the problem, does it? It was really disingenuous.

LB: Yes, this is interesting in relation to the *Casey* decision regarding undue burden. There are now seven states with only one abortion clinic, so at what point does that become an undue burden? Can the state argue that women should simply cross state lines? The issue of undue burden becomes quite murky when we're talking about interstate travel to seek medical care. It seems to me that having to cross state lines simply to access basic reproductive health care that a woman needs is absolutely an undue burden, but that line of reasoning hasn't been considered by the courts.

SG: So what was the state's position in this case?

GJ: The state's position wasn't evidence-based at all. As you probably know, one of the safest medical procedures in terms of complications is abortion. They happen, but having an abortion is, in fact, vastly safer than childbirth and most other medical procedures. So the state was arguing that they needed to protect women's health, but they didn't have any evidence to say that women's health was in danger. They were simply trying to eliminate women's access to abortion. As you said Seth, it was a very cunning strategy. After they tried waiting periods, and parental consent, they just decided to subject clinics to building codes they couldn't meet. At the core of the state's argument was this very dangerous idea that if a certain amount of safety in a facility is good, wouldn't ten times that safety



NON-ASC CLINIC PROCEDURE ROOM

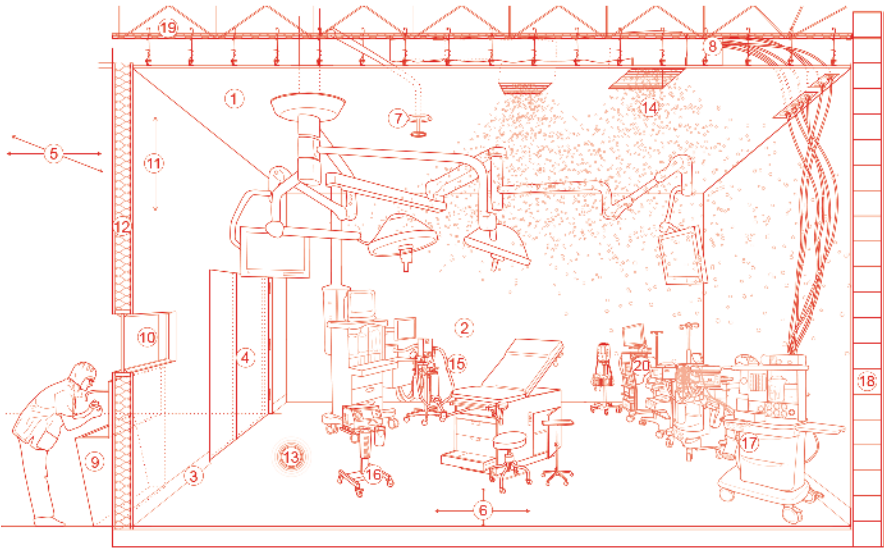
1. Procedure room is apx. 120 sq feet or 10' x 12.'
2. Aspirator is used as suction during the abortion procedure.
3. Ultrasound machine
4. Room must have oxygen (can be on a cart)
5. Floor 1' x 1' vinyl tile

be better? It sounds good, right? I mean sure, ten times that safety would be better. Everyone knows that more is better than less. This is what Ted Cruz means when he calls the legislation “common sense.” But then when you think about what are the evidence-based results of that, you realize that for all that expense you get back virtually nothing in safety. It’s just a lot of unnecessary expense, and it’s not improving the level of healthcare or the safety of women. It’s simply denying them access to healthcare, which is making them far less safe. It’s “big government” at its worst.

Eliza McCullough: Do we know how often a woman would actually have to go to a hospital as a result of complications during an abortion? I’m thinking of the regulation requiring a physician to have admitting privileges to a hospital within 30 miles of the clinic. What was the state’s justification for this?

GJ: Complications do happen, but they are incredibly rare, and when they do happen you don’t worry about doctors with admitting privileges, you just go straight to the nearest emergency room. In that situation, the emergency room would never, and can never, ask about admitting privileges. They just get to work.

LB: Yes, and actually there is always an admitting agreement between the clinic and the nearest hospital. The 30-mile requirement is completely redundant because hospitals are required to receive anyone arriving in an



AMBULATORY SURGICAL CENTRE (ASC) OPERATING ROOM

1. Ceilings must be monolithic (seamless), typically gypsum board, painted. If the ceiling has any penetrations, those must be sealed in order to prevent any transfer of airborne contaminants.

2. Walls have to be smooth, impervious, and able to be wet-cleaned.

3. Floors must be seamless with integral base at walls. Typically vinyl with heat sealed joints.

4. Door must be 3'8" wide to accommodate a gurney.

5. Door must open onto an 8' wide sterile corridor, which is the shared access to all the operating rooms if there is more than one. This corridor must lead to the physicians' gowning area and patient entry from opposite directions. The gowning area entrance must come from a non-sterile area. The corridor will also lead to a separate pre-operating area and post-op (recovery area) with a minimum of one bed per OR plus one for post-op, and one bed per OR for pre-op. Each bed requires 3' on either side, 4'6" between beds or lounges, and 6' at the foot of the bed. All patient corridors in an Ambulatory Surgical Centre must be a minimum of 5' wide, rather than the standard 3'6" in a commercial building.

6. Minimum square footage in the operating room is 240 square feet. The shortest dimension in the room shall be no less than 14' clear (length or width), exclusive of cabinetry.

7. Facility must have sprinklers if the building has more than one storey.

8. Facility must have emergency power.

9. There shall be no scrub area in the operating room. The scrub area will be located in a sterile corridor within 5' of the door to the operating room.

10. Scrub area must have a window with line of sight into the operating room.

11. Ceilings have to be a minimum of 9' if there is ceiling-hung equipment and 8'6" high if not.

12. Walls and ceiling must be sound-insulated with two layers of drywall or special insulation.

13. Temperature at 3' off the floor must be between 70-78 degrees

14. There must be 20 air changes per hour. This means that all the air in the operating room is replaced every three minutes. Additionally, 20% of this air needs to be from outdoors, rather than recirculated air from inside the facility. All air must be filtered. The operating room must also be pressurized to have a positive air pressure balance. This means that more air is pumped into the room than is taken out, so that when the door to the sterile operating room opens air flows out rather than in.

15. Room must have oxygen (can be on a cart).

16. Aspirator is used as suction during the abortion procedure.

17. Sterile cart (stainless cabinetry or cart).

18. Firewall to separate the facility into two fire-and-smoke-separated compartments (two-hour fire wall required for compartmentalization). Wall has to go to the roof with no penetrations and sealed tight to deck. Shown here as an 8" concrete block.

19. Above ceiling: 20" deep bar joist with steel pan roof deck.

20. Ultrasound machine

ambulance. A hospital cannot deny a woman treatment for this reason. This law is simply trying to over-legislate agreements that already exist, and are already working. The first waves of shutdowns in Texas, when they went from 41 clinics to 19, were shutdowns that were all the result of the 30-mile limitation rather than the ASC regulations. It was strategic. Areas outside of metropolitan zones were the most affected.

SG: Part of what is so strange about all this to me is that these same bizarre arguments, which can't stand up to scrutiny, which clearly have ulterior motives, keep showing up in identical legislation in different states all over the country. How does that happen?

GJ: It's not coincidental.

LB: No, it's not.

GJ: There are organizations like American Legislative Exchange Council (ALEC).

EM: Yes they do very scary work, also on prisons.

GJ: This is how it works: an organization like ALEC drafts a piece of legislation like the 30-mile rule, and then if you are a representative in a state legislature you literally may get handed the finished bill. You don't have to do any research, you don't have to do any work—all of that has already been done, and all you have to do is introduce it to a vote. They say, we just got this passed in Indiana, try it out in Kansas and see if it flies.

SG: And what happens after that?

GJ: Almost all of these health-code regulations start as legislation. Once they're passed they go down to the Health Department in the state. Most of the time the health department takes a look at it and says "this doesn't make any sense," and they figure out a way to issue waivers, or allow grandfathering. This is what happened in Michigan, but in Virginia there was a lot of pressure put on the health department by the governor and there was nothing they could do. The people who actually know about this stuff, the people who oversee hospitals and ambulatory surgical centres, they have a good sense of what's really needed and what's not, but their hands were tied.

SG: Thinking about how this legislation moves from state to state, Lori, I know you have done a lot of comparative work on TRAP laws, looking at how they are being deployed across the country. Back in 2011 you published some of your research on this in our second issue of *Scapegoat*.⁵ Would you consider HB2 a TRAP law?

LB: Yes, there are several embedded TRAPS within the law. TRAP stands for "Targeted Regulation of Abortion Providers," and describes a range of strategies that try to systematically reduce access to abortion. Waiting periods, parental consent, ultrasound laws, and building regulations could all be considered TRAP laws here. There is also the Hyde amendment, which was passed in 1977 and stipulated that government funding cannot be used to pay for abortion. This is an annual rider that must be passed every year.

Although considered every year, it depends on which party is in the White House as to whether it is passed. Recently anti-choice advocates have started to argue for a concept of “fetal pain” that would challenge the third trimester standard set by *Roe v. Wade*.

SG: What is fetal pain?

LB: Anti-choice advocates are attempting to use the argument that the fetus can feel the abortion procedure, and that it is painful, and therefore the time-limit on abortions should be further reduced, from the third trimester to sometime during the second trimester—the moment the fetus becomes capable of feeling pain. The third trimester, which is around 28 weeks, is currently considered the point at which the fetus is considered viable and therefore the moment that the state has a vested interest in the fetus as distinct from the mother. Currently, it has not been demonstrated that the fetus can feel pain through the second trimester.

GJ: TRAP law regulations are also distinct for not being applied equally to other procedures. That’s what the “targeted” part is all about. So, for instance, if there’s an ambulatory surgical centre that’s operating successfully right now, they can continue to operate no matter what new building regulations are passed by the legislature. This is called “grandfathering.” With HB2, while existing general procedure ASCs were allowed to be exempted from applying

new requirements, abortion facilities were specifically denied this common right. There was no grandfathering allowed, and that was targeted against abortion clinics. If they didn’t meet the new standard, they had to close.

SG: Do you know of any other examples of a regulation that didn’t allow grandfathering for existing buildings?

GJ: Generally, no. While there are some things out there that, unlike abortion clinics, are actually pretty hazardous, we would live in a totally chaotic world without grandfathering. Building codes are reviewed and rewritten every three to four years. If every building had to be brought up to current code every three years, it would be great for architects and contractors, but nobody would ever go into business. You just wouldn’t invest in something that you knew in three years would be out of code. The future would be too uncertain. I explained this logic and process to the court in my testimony.

SG: We often think about grandfathering as a kind of exception to the rule, but what you’re describing is the way in which the exception is the only

⁵ Lori Brown, “Abortion: Spaces of Contestation,” *SCAPEGOAT: Architecture | Landscape | Political Economy* 01 (2011): 26.

⁶ *Roe v. Wade* first set legal precedent for the idea of fetal viability. The court ruled that the interests of the fetus cannot be put before those of the mother until the fetus is viable. Conven-

tional medical wisdom at the time claimed fetal viability begins somewhere during the third trimester. Because the measurement is not exact, the court ruled that doctors must determine fetal viability on a case-by-case basis. See: Guttmacher Institution, “Later Abortion;” <https://www.guttmacher.org/evidence-you-can-use/later-abortion>.

thing that makes the rule possible, and in this case, it's because of the way laws get made into buildings. In a building, the law moves from being a series of aphorisms to being a physical object, made of materials, that have a mass. When we suddenly decide to change the law, what confronts us is this physical object, and there are costs, limitations, and investments. What I find so interesting about your description of why grandfathering is a precondition of, well, civil society, is that it's a matter of speed. Laws can change quickly, but the physical objects that materialize those laws are slower. The law slows down in buildings. In some ways the violence of HB2 was an attempt to subject buildings to the speed of the law, in order to attack those buildings, because of the laws they materialized.

GJ: Grandfathering is a cultural agreement. It's important to understand that in practice a lot of this agreement is unspoken, and can be implemented in different ways. There are trigger points. For instance, maintenance on a building doesn't trigger the need to update the whole building to the new code. It's the same building. If you decide to paint the building, it's still grandfathered in on the old regulations. However, if you start changing things that would affect exiting routes, now you've got to bring all the exits up to code. If you do a few other things, you have to do more, and at a certain point you trigger an entire upgrade of the building to the new code. It's a different building. There's a hotel that I've stayed at in DC that has really terrible staircases. They could fix the staircases, but if they touch them it would trigger a whole raft of things they would have to do that would put them out of business. So the staircases stay as they are.

LB: George, there's something I want to ask you about. There's only one architect I know that has publicly worked with abortion clinics. Anne Fougeron has designed beautiful clinics for Planned Parenthood in California. Have you come across any other architects publicly working with reproductive healthcare providers?

GJ: Not many. The only one I know of is HOK, who did the new Planned Parenthood centre here in St. Louis. It's difficult, and you have to know where you stand. I was doing a daycare centre for the archdiocese while I was building the abortion clinic. Now, they didn't know that at the time, but if they did they probably would have fired me over it.

LB: Besides Anne Fougeron, you're the only one I know that openly builds clinics.

GJ: That's not surprising. The day that Sally hired me to do the clinic, she said that there were a few things she needed to warn me about. The first few things were about the people who might not want to work with us anymore, but the other thing she mentioned, and unfortunately this is an ongoing issue, is physical risk. She said you have to be very careful when you open your mail. Offices have been targeted, and she said that I might wind up with protesters outside of my office. I think it's something that architects take into consideration. Is it worth it? For me, the response has been 99% positive, but I think a lot of architects think hard about what they're clients might think.

LB: I have to acknowledge that as an academic, I'm not reliant on clients or design jobs as my income, but I think there's a complicity within architecture to look the other way, to not take political stands, because of the capitalist system that we operate in. But I also think that if we want to impact the world around us, we have to take these stands, and there is an economic fallout. Whether I'll ever be able to get another academic position, I don't know, because of the work I've done, and that's a choice I've made. But I think it's something that architecture as a discipline has to become more invested in. What role do we play politically in the built environment? Space is not neutral. And to think otherwise is to be naïve and not engage with reality. It really enrages me when architecture tries to appear so neutral and not participate politically, when we are absolutely a part of the political system on one side or the other. I think we really need to be more outspoken.

SG: Yes, this is such a rare treat to be talking to two architects who think so deeply about the relation between politics and professional practice. Can we say more about the relation between built spaces and politics? I mean, personally, I was amazed how much more I needed to know about HVAC systems to understand core issues of reproductive choice as I was reading your testimony, George. Can we say more about the relation

between buildings and politics?

GJ: Well, there's definitely a relationship. I think that, Lori, you and I feel a little bit differently about it though. The state of Texas created the intersection between architecture and healthcare and women's well-being by what they decided to do. To me the issue wasn't inherently there, it was created for purely political reasons. On a political level, you know Michael Brown is from here. After he was killed by a Police Officer in Ferguson we had a faculty meeting to talk about it. It was a great meeting, people really bared their souls there. One of our faculty got very emotional and said that the solutions to these problems are architectural, and that we have to step in and fix them. Personally, I can't get there. As much as we like to think that the things we do are incredibly important, these situations are very complex. They are political, they are economic, they operate on so many levels that architecture just can't fix. I tend to be a little bit more cautious in terms of how I think of what I can actually touch, what I can actually fix. Architecture can and should be incredibly powerful, but I don't believe it's always political.

LB: In the way I think about this issue, it's not only the object or the thing that gets created, but also how architects participate more broadly in the conversations, and the legislating,

and the coding of what gets produced. So when your colleague says “we need to fix this,” like you I don’t necessarily agree that we can fix it, but we need to be at the table and participating in the conversation as part of a larger group of individuals who are thinking about ways to improve the built environment. I don’t think everything we do has to result in buildings, but I think our expertise can intersect with a range of disciplines that are responsible for various aspects of our built world. In that sense, architects have continued to pull back from that role in society. It’s our own fault. I’m hoping that this last generation, and the upcoming generation, are far more interested in engaging the discipline at this level. For me in my teaching, it’s about designing opportunities, be those design studios, seminars or symposia, for students to intersect with these issues, and think about their role as not only a citizen but as a citizen architect.

GJ: I do agree with that. By necessity, architects find themselves at the table with lawyers, at the table with doctors, at the table with the people who haul the trash. You’re right that we’ve kind of shrunken back, and given up some of that voice that comes from always working between diverse parts of society, and giving that up is political.

EM: Something interesting that’s come up here is the way that codes may not be there for the right reasons, and that codes can be there for political reasons. How do we know when to challenge those codes?

GJ: You’ve just hit a hot issue with me. I’m a big believer in sensible regulation, and sensible codes. If you’re going to have a healthy free-market system, you’ve got to know where the foul lines are. I mean, I don’t know whether a fire stair should be two hours or an hour and fifty minutes in terms of fire resistivity, but somebody does, and they’ve written a code around that. If they say my building is over two storeys, and my stairs are going to have to be two-hour protected, I’m going to take their word for that. These codes are the result of looking at thousands of disasters, thousands of incidents, where doing things in a different way would have solved a problem, and now I’ve got a book with a blue cover on it that hands me that wisdom. If I build to those specifications, I know I’m being responsible. Also, if I have a client that doesn’t want to spend money on a second fire stair, I don’t want to have to have an argument with them where I say “well, really, it’s safer to have two,” I don’t want to have that discussion. I just want to hold up the code book and say, sorry, you have to have two stairs, end of conversation. So Eliza, when you ask when do you defy or when do you challenge the codes, it’s a great question, and this is what burns me about what the state of Texas did. Codes should not be political. They should be evidence-based, reliable, tried and true. So when Texas turns the code book into a totally political document, it not only hurts women, but it casts doubt on the sincerity and validity of the whole system. If the whole thing is just some politicians in an office somewhere, then why would I provide two stairs if one is cheaper? How do I know that some politician’s brother isn’t in the stair business?

SG: In 2016 the Supreme Court invalidated HB2, so where are we now? Are we out of the woods? Does the Supreme Court's ruling immediately invalidate all these laws, across every state?

GJ: Well, it varies state by state. In some states, you would have to file a lawsuit to prove that what the state is doing is unconstitutional on the basis of the recent Supreme Court decision. In other states where there is a little more goodwill around the issue, the legislature might step up and rescind the law, but they could also just put another law into place. You might recall Trump's immigration ban, where he just tweaked the law a little bit after the court decision. Basically, it's not an automatic thing. There are 17 states that have these kinds of laws on the books. In Missouri, Planned Parenthood is taking the lead on making sure that the state complies with the new ruling. But this isn't over. In Missouri we now have a proposed requirement that women must provide a formal burial for the fetus. That might cost \$500, and is purely an effort to make women's lives miserable and complicated and expensive.

SG: How do you bury a fetus in Missouri?

GJ: I don't know if anyone's figured that out yet. It was just some bright idea that some politician came up with.

LB: I think they're trying to do that in Texas as well.

GJ: That doesn't surprise me. It's probably where Missouri got the idea.

SG: This is really putting the 2016 *Whole Women's Health* decision into perspective for me, because on the one hand we can think about this decision as a great victory, and we saw Hillary Clinton and Barack Obama come out and praise the ruling as a huge step forward for women, but if we're keeping score, over half of the abortion clinics in Texas closed down. For them to reopen would require a massive investment, and this is just one of many waves of attacks that the clinics will continue to be subject to if they reopen. So if you zoom out, doesn't the picture of this great victory look different? The anti-choice movement lost the *Whole Women's Health* decision, but big picture, aren't they winning even when they lose?

LB: Yes, many of those clinics will not reopen, and in that sense they have succeeded in reducing access. The closures also disproportionately affect poor women of colour, because the clinics that manage to stay open are usually in cities rather than rural areas like the Rio Grande Valley.

EM: Nationwide, we currently have the fewest abortion clinics since *Roe v. Wade*. If you look at the numbers it's been a steady decline since the 1990s, even though nearly one in five women will have an abortion in her reproductive lifetime.⁷ In that sense this isn't as politicized an issue as it appears in the national conversation.

LB: It's also interesting to understand the spatial history of

these abortion clinics. Really, abortion services should be included in an OB-GYN's office, it should be included in hospital care, and the only reason these clinics were created in the first place was because hospitals were having such an onslaught of protestors that they moved the services into these clinics, thinking that the clinics would be safer and less conspicuous. Lori Freedman's research has traced the change in hospital ownership in the US, and the rise of religiously affiliated hospitals. In the US today, one-sixth of all hospital beds are managed by Catholic-owned health systems, and these hospitals do not offer the full range of reproductive healthcare because of the Catholic Church's anti-abortion position.⁸ They are also tax exempt because of their religious affiliation, so not only are they benefiting from federal subsidies but providing the full range of care that women are seeking. If women could actually receive care in hospitals, access would dramatically increase. Instead, we get these clinics that have been expelled from the system, in part because of how the medical establishment has decided to treat reproductive health as an outlier rather than a part of mainstream medical practice. The founding of the American Medical Association (AMA) is in large part the beginning of the difficulties for women seeking care. As doctors were beginning to professionalize in the mid-to-late-1800s, they sought to expand their domain that until then, had been the purview of midwives and abortion practitioners. Today many medical students are still not educated about women's reproductive healthcare. It is not a given that in-depth reproductive healthcare education will be provided within medical curricula across the country. There are a lot of intersections that we should be aware of that are instrumental in making it difficult to access care in this country.

GJ: You may have heard about this: studies have noticed a considerable drop in the number of abortions being sought in the US. There's been all sorts of speculation as to why that's happened. One of the possible theories is that women are self-aborting, and it turns out there was just a report a few days ago from National Public Radio that Misoprostol is being flown in from Mexico by drones.⁹

SG: Yes, this is also happening in Poland, where abortion is also severely restricted. The organization Women on the Waves flew drones over Poland carrying packages of World Health Organisation-approved abortion pills. Lori, you've written about Women on the Waves, and there's a documentary about them that just came out called *Vessel*. They seem to be incredibly talented at understanding how to circumvent regulatory spaces using purely architectural solutions. They first built an abortion clinic in a shipping container, and now they are flying drones across international borders. If part of what we have been discussing is how the war on reproductive choice is deeply spatial, as clinics were first expelled from hospitals, then attacked through building codes and assassinations, do Women on the Waves offer a spatial solution to a spatial problem?

LB: Absolutely. What I find so inspiring by the Dutch organization Women

on Waves is that they offer a way to imagine access that transcends most obstacles that they have encountered thus far, both spatial and legal. If it is illegal to access an abortion in a country, then boat the women 12 miles out into international waters where Dutch law prevails and because abortion is legal in the Netherlands, it is legal on their boat. This was a brilliant strategy that upended several countries. When this tactic becomes too cumbersome and difficult, mail the abortion pill to women who are unable to buy it locally, circumventing the need for medical space altogether. The drone is another tactic, flying through uncontrolled airspace, delivering packages of abortion pills that will be dispensed by local organizations. In addition to providing access, another critical aspect of Women on Waves is raising international awareness about the extreme difficulties women encounter in seeking abortion access in countries where it remains illegal. The clever interpretation of nation-state boundaries and borders, their porosity and ability to be transgressed is, for me, what locates Women on Waves at the forefront of these debates.

⁷ In 2008, the Guttmacher Institute reported that one in three women will have an abortion in her reproductive lifetime; however, the Guttmacher released another report based on 2014 data which found abortion rates have declined by 14%, reaching the lowest rate ever observed in the US. Today about 17% of women, or around one in five women, will have an abortion in her reproductive lifetime. For reference, see Rachel Jones and Megan Kavanaugh, "Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion," *Obstetrics & Gynecology* 117, no. 6 (2011): http://journals.lww.com/greenjournal/Fulltext/2011/06000/Changes_in_Abortion_Rates_Between_2000_and_2008.14.aspx; and Guttmacher Institute, "Induced Abortion in the United States," <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>.

⁸ Lori Freedman, *Willing and Unable*

Doctor's Constraints in Abortion Care (Nashville: Vanderbilt University Press, 2010). More recent statistics confirm these numbers as well. See Nina Martin, "The Growth of Catholic Hospitals, by the Numbers," *ProPublica*, 18 December 2013, <https://www.propublica.org/article/the-growth-of-catholic-hospitals-by-the-numbers>; ACLU, "Women Who Have Been Denied Medically Necessary Health Care at Catholic Hospitals Speak Out," 5 May 2016, <https://www.aclu.org/news/new-report-reveals-1-6-us-hospital-beds-are-catholic-facilities-prohibit-essential-health-care>.

⁹ Misoprostol can be used to end pregnancies and is especially effective when used with mifepristone. It must be prescribed by a medical professional in the US, but is available over-the-counter at pharmacies in Mexico and Latin America. See "Misoprostol," WebMD, <http://www.webmd.com/drugs/2/drug-6111/misoprostol-oral/details>.