

**Alito is Wrong:
We *Can* Assess the Impact of *Dobbs*, and It Is Bad for
Women’s Health**

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INTRODUCTION

It is not hyperbole to describe *Dobbs*¹ as one of the most significant legal opinions of our lifetime. Not only does the decision eliminate a constitutionally protected right to end a pregnancy until the point of viability, but it also undermines an established constitutional methodology with broad implications beyond the abortion context. The decision is likely to have reverberating effects across all of society for decades with respect to many deeply personal decisions that impact identity, formation of relationships, and autonomy. As the dissent notes, it could affect rights related to same-sex intimacy and marriage, contraception, sterilization, and other similar interests.² This Article, however, focuses specifically on the maternal health implications of the decision.³

In the majority opinion in *Dobbs*, Justice Alito wrote that one reason *stare decisis* did not preclude the Court from overturning the

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¹ *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

² *See id.* at 2319 (Breyer, J., dissenting).

³ Until recently, only women could become pregnant. Recent technological advances in medicine, however, have made it possible for some transgender men to become pregnant. *See* Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 *OBSTETRIC MED.* 4, 5 (2016). As a result, pregnancy no longer affects just women. Because the *Dobbs* opinion and dissent largely focus on women, and because women are still the largest group impacted by pregnancy regulations, this Article frequently interchanges the words “woman/women” and “pregnant person/people.” The focus on women and maternal health is not intended to ignore the significant interests that transgender men also have with respect to the impact of *Dobbs*.

nearly half-century of precedent set by *Roe v. Wade* (and reaffirmed by *Planned Parenthood v. Casey*⁴) was the alleged lack of a “concrete reliance interest.”⁵ Alito faulted *Casey* for upholding *Roe* by relying, in part, on a “novel and intangible form of reliance,” which focused on the “effect of the abortion right on society and in particular on the lives of women.”⁶ That assessment, he claimed, was an “empirical question that is hard for anyone”—especially a court—to make.⁷

But Alito is wrong. Well before *Dobbs* was decided, empirical data already revealed the harmful impact of not being able to access abortions on women’s well-being.⁸ And in the few short months since, we are beginning to witness many of the predicted harmful effects of denying the right to an abortion on the financial, social, psychological, and medical well-being of people who can become pregnant. In many ways, *Dobbs* exacerbates the societal impacts we already observed as abortion has become increasingly inaccessible to certain populations of pregnant people.

Dobbs, of course, allows states to prevent people from obtaining abortions, which as this Article will show can impact health in various ways. But *Dobbs* is not just about control over abortion. It also defines a locus of control over the pregnant (or even potentially pregnant) body that is at odds with common law and prior constitutional norms about bodily autonomy. That control has potential health ramifications beyond whether or not someone can end an unwanted pregnancy. In ignoring the bodily autonomy interests of the pregnant person and focusing largely on the “unborn child,” *Dobbs* allows states to regulate health care in ways that pit the physician against the state, the patient against the physician, and/or the patient against the physician and the state, all with serious harms to maternal health.

The maternal health implications of *Dobbs* are vast and far reaching. The financial impacts alone, particularly for the most vulnerable, will undoubtedly be detrimental to the health of populations that already face heightened health risks because of income insecurity. This Article, however, will focus more narrowly on how *Dobbs* affects the health care and clinical research contexts by altering the relationships between doctor and patient and between

⁴ 505 U.S. 833 (1992).

⁵ *Dobbs*, 142 S. Ct. at 2276.

⁶ *Id.*

⁷ *Id.*

⁸ See, e.g., DIANA GREENE FOSTER, THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING—OR BEING DENIED—AN ABORTION (2020).

researcher and research participant. It contends that these impacts are the logical conclusion of a jurisprudential trend within the Supreme Court that devalues medical expertise and the pregnant person's bodily autonomy interests and agency.

Part I begins with a survey of the evolution of constitutional doctrine regarding abortion from *Roe* to *Dobbs*. It shows how the Court, as its composition has changed, has increasingly exceptionalized abortion within health care and reduced the ability of health care providers to exercise their medical discretion and expertise in providing reproductive care. *Dobbs* takes us to new heights in this exceptionalization of abortion and in so doing, pits the state against physicians and potentially physicians against patients in the context of abortion and other health care.

Part II shows how *Dobbs* allows states to act in ways that harm the relationships between physicians and patients in the health care context and enhance gender inequities in the research context. It also discusses both the direct and indirect impacts of altering those relationships on maternal health. Part II begins by showing how *Dobbs* allows legislatures to disregard medical evidence or data about appropriate care for patients by granting them nearly unlimited power to dictate medical care in the reproductive context, even when the dictates are contrary to the medical standard of care. This imposes contradictory legal obligations on physicians, which creates deeply problematic conflicts of interest and undermines the ethical and legal fiduciary obligations of health care providers to patients. The resulting conflicts of interest can cause direct harm to patients, potentially even death, and it can cause indirect harms by undermining patient trust, which is so central to health care.

Part II also shows how *Dobbs* enhances the potential for medical disagreement between patient and doctor over the management of pregnancy and other related care. While these conflicts are not new, *Dobbs* increases the likelihood of such disagreements by disregarding the bodily autonomy interests of the pregnant (and perhaps even potentially pregnant) person and by privileging fetal interests. As a result, it gives courts ammunition to relegate medical decision-making with the provider, even when the patient does not consent to medically recommended treatment. In this context, therefore, it empowers (and even potentially incentivizes) physicians to focus primarily on fetal interests regardless of maternal wishes, at least in certain states. Such conflicts further undermine the doctor-patient relationships and health care generally.

Building on this third point, Part II demonstrates how *Dobbs* allows states to pit the state and physician against the patient in criminalizing behavior during (and before) pregnancy, whether or not the behavior is otherwise illegal. The harms are significant in further undermining trust, but there are also direct harms from the punishment itself. Again, this is not a new problem; *Dobbs*, however, heightens the risks in privileging fetal well-being over maternal well-being and interests. Finally, in an area much less discussed, *Dobbs* potentially intensifies the long-standing problem of the underrepresentation of women in research, which compromises our ability to understand disease courses in women, to develop appropriate pharmaceutical and other treatments, and to diagnose conditions accurately and in a timely manner.

Part III offers some thoughts about what is needed to move forward, including litigation to challenge abortion laws at the state and federal levels, including challenges about the lack of important exceptions. The goal is to identify rights within state constitutions that protect access to abortion and to build a body of law at the federal level for a future Supreme Court to restore the right to abortion. Professional organizations and medical boards must also speak out and lobby against abortion laws as a medical issue and advocate for the ability of providers to practice medicine according to the standard of care⁹ so they can protect their patients' well-being. Providers also require institutional support to encourage and enable them to practice to the limits of the law and to push for protections of pregnant people. Now more than ever, the country needs partnerships between doctors and lawyers to bring together their respective expertise in underscoring the serious health impacts of the various abortion restrictions and to push for laws that allow for proper medical care. Finally, patients and providers must share their stories with the public about the harms of a world where women do not have access to abortion. Given that the fate of abortion rights now rests with the electorate, voters must understand in clear and visceral terms that women's lives and health lie in the balance.

⁹ The standard of care is a term used in tort law that establishes the kind of behavior needed to avoid being found negligent. Generally, it is based on what a reasonably prudent person would do. In the context of medical malpractice, the standard of care is established by the custom within the profession. *See Robbins v. Footer*, 553 F.2d 123 (D.C. Cir. 1977).

I. HOW THE EXCEPTIONALIZATION OF ABORTION WITHIN HEALTH CARE LED US TO *DOBBS*

Deciding whether to have an abortion is both a personal and medical decision. But the Supreme Court has often treated it differently from other medical decisions. While *Roe* describes abortion in medical terms, perhaps more than any other Supreme Court case addressing abortion, the general trend in the cases since then (with some exceptions along the way) has been to exceptionalize abortion within health care. This Part will describe that trend and how it led us to *Dobbs*, which completely disregards the medical and health aspects related to abortion care.

In *Roe*, the Court recognized a fundamental constitutional privacy right to abortion.¹⁰ While *Roe*, in ordinary parlance, is synonymous with the pregnant person’s “right to choose,” the opinion reads much more like a decision that protects medical professional autonomy than anything else. Justice Blackmun’s majority opinion described “the abortion decision in all its aspects” as “inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician,” at least until the point where the state has a compelling interest.¹¹ Even his articulation of the state’s authority to regulate abortion was framed in medical terms: under *Roe*, the Constitution prohibited the state from regulating abortion in the first trimester; permitted it to regulate abortion to protect maternal health in the second trimester; and only allowed the state to ban abortion in the third trimester, except when the health or life of the mother was at stake.¹²

Roe can be (and has been) critiqued for its paternalism in describing the doctor’s judgment as central to the decision, with the pregnant woman seemingly a minor player.¹³ Nevertheless, from the

¹⁰ *Roe v. Wade*, 410 U.S. 113, 153–54 (1973), *overruled by Dobbs*, 142 S. Ct. 2228 (2022).

¹¹ *Id.* at 166; *see also id.* at 164 (“For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician.”); *id.* at 165–66 (“The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention.”).

¹² *Id.* at 164–65.

¹³ *See, e.g.*, Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician’s Role in “Private” Reproductive Decisions*, 63 WASH. U. L.Q. 183, 187 (1985).

perspective of maternal health concerns, *Roe* was important, not only in granting women the right to abortion, but also in underscoring the important fact that abortion is an essential part of medical care.

When *Planned Parenthood v. Casey* reaffirmed the basic holding of *Roe* nearly two decades later, the Court's framing of the abortion decision focused far less on the physician. Instead, it brought the pregnant woman from the metaphorical wings of *Roe* to center stage, downplaying the centrality of the physician to the abortion decision. It emphasized, for example, that

the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.¹⁴

Ironically, and in spite of the grand rhetoric about the intimate and personal nature of abortion and the woman's interest in shaping "her own conception of her spiritual imperatives and her place in society," *Casey* actually weakened the constitutional right to abortion in several ways. It rejected the trimester framework, which it found to be a "rigid prohibition" against the state's interest from the outset of pregnancy in protecting "the life of the unborn."¹⁵ It also redefined the right as a liberty interest instead of a fundamental privacy right, downgrading the standard of review from strict scrutiny to the more solicitous and ambiguous undue burden test.¹⁶ By allowing the state to regulate abortion as long as the purpose or effect did not pose a substantial obstacle to the woman's right to choose an abortion,¹⁷ the *Casey* plurality upheld four state provisions: mandated disclosure of

¹⁴ *Casey*, 505 U.S. at 852; see also *id.* at 884 ("Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position.").

¹⁵ *Id.* at 873, 869.

¹⁶ *Id.* at 874.

¹⁷ *Id.* at 877.

specific information,¹⁸ a twenty-four-hour waiting period between disclosure of the information and the procedure,¹⁹ a parental notification requirement,²⁰ and emergency reporting.²¹

Casey also exceptionalized abortion within health care in its treatment of informed consent. The common law obligates physicians to disclose information either based on what a reasonable physician would disclose or what is material to a reasonable patient,²² and it tends to require that the mandated disclosure is centered on therapeutic purposes.²³ *Casey*, however, upheld a state law that mandated a much broader scope of disclosure, including information well beyond medical concerns, such as descriptions of the fetus and information about adoption and child support.²⁴

Moreover, *Casey* explicitly recognized the right of the state to shape informed consent requirements around the state's interest in promoting life, which is a moral or religious—but not medical—interest. The Court allowed the state to put its thumb on the scale to “further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.”²⁵ This holding overturned prior decisions that had invalidated informed consent mandates as “an outright attempt to wedge the Commonwealth’s message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician.”²⁶ The *Casey* Court, however, was not troubled by the fact that the mandatory disclosure had “no direct relation to [the

¹⁸ *Id.* at 881–85.

¹⁹ *Id.* at 885–87.

²⁰ *Casey*, 505 U.S. at 899–900.

²¹ *Id.* at 900–01. *Casey* did, however, overturn the spousal notification provision. *Id.* at 893–94.

²² See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 786–87 (D.C. Cir. 1972); *Natanson v. Kline*, 350 P.2d 1093, 1106, *decision clarified on denial of reh'g*, 354 P.2d 670, 672 (Kan. 1960).

²³ See *Arato v. Avedon*, 858 P.2d 598, 599–600 (Cal. 1993).

²⁴ *Casey*, 505 U.S. at 881. See Sonia M. Suter, *The Politics of Information: Informed Consent in Abortion and End-of-Life Decision Making*, 39 AM. J.L. & MED. 7, 25, 48 (2013).

²⁵ *Casey*, 505 U.S. at 883.

²⁶ *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 762 (1986).

woman's] health," as long as it was "truthful and not misleading."²⁷ As the Court noted, although the woman has a right "to make the ultimate decision," she has no "right to be insulated from all others in doing so," including from state efforts to persuade her not to.²⁸ Although *Casey* claimed that the mandated disclosures were "no different from a requirement that a doctor give certain specific information about any medical procedure,"²⁹ scholars have noted how the informed consent mandates it upheld deviated from traditional informed consent in medicine.³⁰

*Gonzales v. Carhart*³¹ further exceptionalized abortion within health care. At issue in that opinion was the constitutionality of a congressional ban of a particular late-term procedure (with the decidedly non-medical moniker: "partial-birth abortion").³² Finding that the procedure was "never medically necessary," Congress banned it but only retained a life—and not a health—exception.³³ In upholding the ban against a facial challenge, the Court failed to credit testimony in the lower courts from "numerous 'extraordinarily accomplished' and 'very experienced' medical experts" who explained that the banned procedure was sometimes safer than the alternative procedure and even sometimes necessary.³⁴ Instead, the Court thought it was a "contested factual question" whether the ban created "significant health risks for women."³⁵

Demonstrating disregard for the professional opinions of experts in the field of abortion care, the Court decided it would be too

²⁷ *Casey*, 505 U.S. at 882–83 (noting that it would be constitutional to require physicians to disclose to kidney transplant recipients' information about the risks to the donor).

²⁸ *Id.* at 877.

²⁹ *Id.* at 884.

³⁰ See, e.g., Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1608–09 (2008).

³¹ 550 U.S. 124 (2007).

³² This term, however, is not a medical term. Julie Rovner, *'Partial-Birth Abortion': Separating Fact From Spin*, NPR (Feb. 21, 2006, 9:44 PM), <https://www.npr.org/2006/02/21/5168163/partial-birth-abortion-separating-fact-from-spin>.

³³ Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (Supp. IV 2000).

³⁴ *Gonzales*, 550 U.S. at 177 (Ginsburg, J., dissenting). The *Gonzales* majority notes the proper means to consider exceptions is through an as-applied challenge, but the dissent was not persuaded that an as-applied challenge would be sufficient given the Court's lack of clarity on what this lawsuit would entail. *Id.* at 167; *id.* at 189 (Ginsburg, J., dissenting).

³⁵ *Id.* at 161.

exacting to overturn the ban simply because *some* medical professionals “were *disinclined* to follow the proscription.”³⁶ As Justice Ginsburg noted, the majority dismissed “the reasoned medical judgments of highly trained doctors . . . as ‘preferences’ motivated by ‘mere convenience.’”³⁷ The Court also disregarded the fact that a major professional organization like the American College of Obstetricians and Gynecologists (ACOG) found it “necessary and proper” in some cases to use the banned procedure.³⁸ And while the *Gonzales* majority claimed not to place “dispositive weight on Congress’s findings,”³⁹ its holding ultimately deferred considerably to them. Those findings, however, relied on testimony from individuals who lacked expertise to assess the necessity of the banned procedure because they “had no training for, or personal experience with, the intact [dilation and evacuation] procedure, and many performed abortions only on rare occasions.”⁴⁰

Ultimately, because the Court concluded that the necessity of the banned procedure was a matter of “medical and scientific uncertainty,” it held that the legislature should be granted “wide discretion to pass [such] legislation.”⁴¹ As it reasoned, “[c]onsiderations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends.”⁴² The result of the holding was to water down the health exception of *Roe* and *Casey*, which had previously been understood to prohibit state regulations from “subjecting women to health risks not only where pregnancy itself creates a danger, but also where state regulation forces women to resort to less safe methods of abortion.”⁴³

Throughout, the *Gonzales* expressed disdain for health care providers who perform abortions and dismissed their expertise. As Justice Ginsburg noted in her dissent, Justice Kennedy’s majority opinion repeatedly “refers to obstetrician-gynecologists and surgeons who perform abortions not by the titles of their medical specialties, but

³⁶ *Id.* at 166 (emphasis added).

³⁷ *Id.* at 187 (Ginsburg, J., dissenting) (citing *id.* at 134, 166).

³⁸ *Id.* at 170–71 (Ginsburg, J., dissenting).

³⁹ *Id.* at 165.

⁴⁰ *Gonzales*, 550 U.S. at 180 (Ginsburg, J., dissenting).

⁴¹ *Id.* at 163.

⁴² *Id.* at 166.

⁴³ *Id.* at 172 (Ginsburg, J. dissenting).

by the pejorative label ‘abortion doctor.’⁴⁴ He also “writes with unmasked contempt”⁴⁵ for providers he describes as seeking “unfettered choice in the course of their medical practice”⁴⁶ and performing the banned procedure “for mere convenience.”⁴⁷ While physicians returned to the center of the abortion stage in *Gonzales*, they were recast quite differently from ordinary health care providers.

Further exceptionalizing abortion within health care, the majority justified the ban with its lack of a health exception on the basis of new and vague state interests about social coarsening—interests that have nothing to do with fetal or maternal health.⁴⁸ As Justice Ginsburg noted, the ban “saves not a single fetus” because late-term abortions will still occur.⁴⁹ Nevertheless, the Court allowed Congress to impose health risks on women for whom the banned procedure would be safer compared to other late-term abortions⁵⁰ simply to promote its vague moral concerns.

Finally, the Court’s approach to informed consent departed even more substantially from standard informed consent doctrine than *Casey* had, allegedly in the name of protecting maternal health. Whereas *Casey* allowed the government to put its thumb on the scale with informed consent mandates, *Gonzalez* relied on concerns about uninformed decisions and maternal regret to justify eliminating the option to use a procedure that professional medical organizations believe is sometimes medically necessary. The Court first asserted that “some women come to regret their choice” to terminate a pregnancy, even while acknowledging the lack of “reliable data to measure the phenomenon.”⁵¹ It then claimed that doctors might prefer not “to disclose precise details” about the banned abortion procedure, which the Court feared could lead pregnant people to make uninformed decisions to use the procedure and ultimately experience regret.⁵² In the Court’s view, therefore, the ban served as an important

⁴⁴ *Id.* at 186–87 (Ginsburg, J., dissenting-); see also Sonia M. Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1571–72 (2008).

⁴⁵ Suter, *supra* note 44, at 1571.

⁴⁶ *Gonzales*, 550 U.S. at 1636.

⁴⁷ *Id.* at 1638.

⁴⁸ See Suter, *supra* note 44, at 1580–81.

⁴⁹ *Gonzales*, 550 U.S. at 181 (Ginsburg, J. dissenting).

⁵⁰ See *id.* at 176–78 (Ginsburg, J. dissenting).

⁵¹ *Id.* at 159.

⁵² *Id.* at 159–60.

prophylactic against both uninformed decisions regarding a matter “so fraught with emotional consequences” and maternal regret.⁵³ As Justice Ginsburg noted, however, there is great irony in depriving “women of the right to make an autonomous choice, even at the expense of their safety” simply to prevent uninformed decisions.⁵⁴ The Court never explained how removing choice instead of requiring more expansive disclosures could possibly optimize informed decision-making.⁵⁵

If the woman had center stage in *Casey* as a robust figure, capable of shaping her destiny based on “her own conception of her spiritual imperatives and her place in society”⁵⁶ (albeit with more limited rights than in *Roe*), her presence on the *Gonzales* stage was reduced to a vulnerable creature in need of governmental protection against regret and poorly informed decisions. She may not have disappeared yet, but her presence was diminishing. And her rights were further reduced, including her right to make decisions regarding certain abortion procedures and her right to protection with a meaningful health exception.

It is worth noting that there were two major exceptions in the gradual diminishment of the protection of rights of pregnant people and the role of medical professionals since *Casey*. *Stenberg v. Carhart*, the decision that *Gonzales* essentially reversed, found unconstitutional Nebraska’s ban of the same late-term abortion procedure, also without a health exception.⁵⁷ But in that case, the Court credited the testimony of medical organizations like ACOG to conclude that the banned procedure was sometimes “necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”⁵⁸ The Court emphasized that necessity “cannot refer to an absolute necessity or to absolute proof,” but instead has to be assessed and contextualized “in light of estimated comparative health risks (and health benefits) in particular cases” and that it must “embody the judicial need to tolerate responsible differences of medical opinion.”⁵⁹

⁵³ *Id.*

⁵⁴ *Id.* at 184 (Ginsburg, J. dissenting); see also Dresser, *supra* note 30, at 1608–09; Suter, *supra* note 44, at 1576–79.

⁵⁵ Suter, *supra* note 44, at 1578–79.

⁵⁶ *Casey*, 505 U.S. at 852.

⁵⁷ 530 U.S. 914 (2000).

⁵⁸ *Id.* at 937 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992)).

⁵⁹ *Id.*

The robust understanding of the scope of the health exception thus preserved both autonomy for, and protected the well-being of, pregnant women.

Sixteen years later, in *Whole Woman's Health v. Hellerstedt*, the Court overturned a Texas statute requiring physicians who provide abortions to have admitting privileges within thirty miles of the facility where the abortion was performed and requiring abortion facilities to meet minimum standards for ambulatory surgical centers.⁶⁰ Relying on evidence from the record below, including expert evidence, the Court found that the laws provided no benefits to pregnant women and were an undue burden and therefore unconstitutional.⁶¹ Like *Stenberg*, this decision took evidence from medical experts seriously. In addition, by invalidating a law that unduly burdened pregnant people seeking abortions, it protected their bodily autonomy. But the composition of the Court would continue to change, weakening even this holding in another case, *June Medical Services v. Russo*.⁶² In that opinion, Chief Justice Roberts wrote a concurrence to emphasize that the understanding of the undue burden test in *Whole Woman's Health* was not adequately lenient in reviewing abortion regulations.⁶³

As the Court gradually chipped away at the right to abortion in the years following *Roe* and especially *Casey*, legislatures in conservative states increasingly flexed their political muscles to further exceptionalize abortion within health care. They doubled down on informed consent mandates, some of which included unbalanced or blatantly inaccurate statements that doctors were required to disclose to patients.⁶⁴ States also passed burdensome requirements on providers and clinics that were not rooted in evidence-based medicine,

⁶⁰ *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 590–91 (2016).

⁶¹ *Id.* at 582.

⁶² 140 S. Ct. 2103 (2020).

⁶³ *Id.* at 2138–39 (Roberts, C.J., concurring). See also Sonia M. Suter, *June Medical Services v. Russo: A Temporary Victory for Reproductive Rights*, GEO. WASH. L. REV.: ON THE DOCKET (July 5, 2020), <https://www.gwlr.org/june-medical-services-v-russo-a-temporary-victory-for-reproductive-rights>.

⁶⁴ Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER INST. (Nov. 8, 2007), <https://www.guttmacher.org/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent> (describing state abortion laws after *Gonzales* that required physician disclosure of “at least some information not in keeping with the fundamental tenets of informed consent”).

often called targeted restrictions against providers (TRAP laws).⁶⁵ While allegedly rooted in health concerns, such laws are clear efforts to hijack medical decision-making authority from health care providers who perform abortions.

In addition, during the early days of the COVID-19 pandemic, when states issued directives to limit “non-essential adult elective surgery and medical and surgical procedures”⁶⁶ to ease the burdens of the overtaxed health care system, some state officials interpreted the orders as prohibiting abortions, sometimes explicitly directing clinics to stop procedures.⁶⁷ Several professional organizations specializing in

⁶⁵ *Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INST. (Jan. 22, 2020), <https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws>.

⁶⁶ CTRES. FOR MEDICARE & MEDICAID SERVS., NON-EMERGENT, ELECTIVE MEDICAL SERVICES, AND TREATMENT RECOMMENDATIONS (2020), <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>.

⁶⁷ Oklahoma’s Governor stated in a press release that the order applied to “any type of abortion services . . . [that] are not a medical emergency or necessary to prevent serious health risks to the mother.” Press Release, Okla. Governor J. Kevin Stitt, Governor Stitt Clarifies Elective Surgeries and Procedures Suspended Under Executive Order (Mar. 27, 2020). In Texas, the Attorney General published a press release entitled, “Health Care Professionals and facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve resources to Fight COVID-19 Pandemic.” Press Release, Ken Paxton Att’y Gen. of Tex., Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic (Mar. 23, 2020), <https://www.texasattorneygeneral.gov/news/releases/health-care-professionals-and-facilities-including-abortion-providers-must-immediately-stop-all>. The West Virginia Attorney General concluded that most, if not all, abortion services are impermissible under this executive order. Brad McElhinny, *Morrisey Says Order Halting Elective Medical Procedures Applies to Abortion Facilities*, METRONews (Apr. 1, 2020), <https://wvmetronews.com/2020/04/01/morrisey-says-order-halting-elective-medical-procedures-applies-to-abortion-facilities>. In Ohio, the Attorney General sent letters to abortion providers stating there were complaints that they were performing “surgical abortions,” and ordering them “to immediately stop performing non-essential and elective surgical abortions.” Sabrina Tavernise, *Texas and Ohio Include Abortion as Medical Procedures That Must Be Delayed*, N.Y. TIMES (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/us/coronavirus-texas-ohio-abortion.html>. And in Louisiana, the Attorney General sent representatives to abortion clinics and threatened to shut them down claiming they violated the state directive. See Sam Karlin, *Louisiana Officials Investigating Abortion Clinics During Coronavirus Stay-At-Home Order*, NOLA.COM (Apr. 9, 2020), https://www.nola.com/news/coronavirus/louisiana-officials-investigating-abortion-clinics-during-coronavirus-stay-at-home-order/article_db45b2d8-7a92-11ea-9a6c-17ab001f5b4b.html. These stringent interpretations conflicted with CMS’s admonition that health decisions “remain the responsibility of local healthcare delivery systems, including state and local health

reproductive care, including ACOG, urged that abortions should not be canceled because abortion is “an essential component of comprehensive medical care” and “a time-sensitive service.”⁶⁸ It emphasized that delays of weeks or sometimes days could increase health risks or make abortions entirely inaccessible in states with bans later in pregnancy.⁶⁹ Nevertheless, some courts upheld the abortion restrictions,⁷⁰ resulting in a temporary ban of many preivable surgical abortions.⁷¹

officials, and those surgeons who have direct responsibility to their patients,” and are contextual based on the clinician’s evaluation of “the clinical situation” and “resource conservation.” *CMS Adult Elective Surgery and Procedures Recommendations: Limit All Non-Essential Planned Surgeries and Procedures, Including Dental, Until Further Notice*, CMS: CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 7, 2020), <https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf>. Karlin, *supra*.

⁶⁸ *Joint Statement on Abortion Access During the COVID-19 Outbreak*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Mar. 18, 2020), [acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak](https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak).

⁶⁹ *Id.*

⁷⁰ The Eighth Circuit reversed an injunction granted by the federal district courts in Arkansas. *Little Rock Family Planning Servs. v. Rutledge*, 454 F. Supp. 3d 821 (E.D. Ark. 2020); *In re Rutledge*, 956 F.3d 1018 (8th Cir. 2020). In Texas, the Fifth Circuit reversed injunctions granted by the district court on two instances. *Planned Parenthood Ctr. for Choice v. Abbott*, 450 F. Supp. 3d 753 (W.D. Tex. 2020); *mandamus granted*, 954 F.3d 772 (5th Cir. 2020); *Planned Parenthood Ctr. for Choice v. Abbott*, No. 20-cv-00323, 2020 WL 1815587 (W.D. Tex. Apr. 9, 2020), *stay granted in part*, 800 F. App’x 293 (5th Cir. 2020), *emergency application filed*, *Planned Parenthood Ctr. for Choice v. Abbott*, No. 19A1019 (U.S. Apr. 11, 2020); *stay granted in part and denied in part*, *In re Abbott*, 809 F. App’x 200 (5th Cir. 2020); *mandamus granted and order vacated in part*, 956 F.3d 696 (5th Cir. 2020); *petition for cert. docketed*, *Planned Parenthood Ctr. for Choice v. Abbott*, No. 20305 (Sept. 3, 2020). Federal district courts enjoined the orders as applied to abortion in Alabama, Ohio, and Tennessee, and the Eleventh and Sixth Circuits affirmed. *Adams & Boyle, P.C. v. Slatery*, 455 F. Supp. 3d 619 (M.D. Tenn. 2020), *aff’d*, 956 F.3d 913 (6th Cir. 2020), *reh’g en banc denied* (6th Cir. May 14, 2020), *petition for cert. docketed*, No. 20482 (U.S. Oct. 14, 2020); *Robinson v. Marshall*, 454 F. Supp. 3d 1188 (M.D. Ala. 2020), *application for stay denied by Robinson v. Att’y. Gen.*, 957 F.3d 1171 (11th Cir. 2020). In Oklahoma, the district court’s preliminary injunction allowed medication abortions. *South Wind Women’s Ctr. LLC v. Stitt*, No. 5:20-cv-00277, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020), *appeal from TRO denied*, No. 206045, 808 F. App’x 677 (10th Cir. Apr. 13, 2020), *appeal dismissed as moot*, No. 206055, 823 F. App’x 677 (10th Cir. Aug. 18, 2020).

⁷¹ In Texas, there was a protracted legal battle that was in and out of the Fifth Circuit several times. Ultimately, the Circuit allowed the ban of all abortions (including medication abortions) except those near the legal limit. *In re Abbott*, 956 F.3d 696, 724 (5th Cir. 2020).

And finally, many states enacted trigger laws to ban abortions should *Roe* be overturned.⁷² Some states were even bolder in passing blatantly unconstitutional bans well before viability, daring opponents to bring legal challenges that could send the question of *Roe*'s and *Casey*'s constitutionality squarely before the Court.⁷³ As the Court's composition became increasingly conservative, the hopes of ultimately reversing *Roe* seemed ever-more achievable.

Dobbs represents the logical endpoint of this trajectory, which has exceptionalized abortion within health care by imposing requirements that do not exist for other procedures, interfering with the professional judgment and discretion of the providers, ignoring medical consensus regarding medical risks and benefits, undermining the pregnant patient's decision-making authority and bodily autonomy, and treating abortion as if it is not an essential part of health care. It does so most obviously by overruling *Roe* and *Casey* and rejecting the existence of a constitutional right to abortion. Because neither abortion nor privacy are mentioned in the Constitution, *Dobbs* insists there can be no constitutional abortion right unless it is "deeply rooted in this Nation's history and tradition."⁷⁴ Relying on what the dissent calls a "pinched view of how to read our Constitution"⁷⁵ and the fact that most states criminalized abortion in 1868 when the Fourteenth Amendment was ratified (by men, not women, as the dissent emphasized),⁷⁶ the majority concludes that abortion was simply not a part of our history and tradition. Thus, "the Constitution does not confer a right to abortion."⁷⁷

As a result, *Dobbs* holds that abortion regulations are now subject to rational basis review. That is, they can stand if they "serve legitimate state interests," including "respect for and preservation of prenatal life

⁷² Elizabeth Nash & Isabel Guarnieri, *13 States Have Abortion Trigger Bans—Here's What Happens When Roe Is Overturned*, GUTTMACHER INST. (June 6, 2022), <https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned>.

⁷³ See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 171.201 (West 2021); Gestational Age Act, MISS. CODE. ANN. § 41-41-191 (West 2018).

⁷⁴ *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2242 (2022). The Court quoted *Glucksberg v. Washington*, 521 U.S. 702, 721 (1997) for that proposition, even though *Glucksberg* had not been used in any other substantive-due-process case. *Dobbs*, 142 S. Ct. at 2242.

⁷⁵ *Id.* at 2325 (Breyer, J., dissenting).

⁷⁶ *Id.* at 2323–24 (Breyer, J., dissenting).

⁷⁷ *Id.* at 2279.

at *all stages* of development” and numerous other interests.⁷⁸ Notably, the Court says nothing about requiring any exceptions with abortion bans. In fact, it upholds Mississippi’s 15-week ban, despite its lack of exceptions for rape or incest. And it quite conspicuously fails to address whether abortion bans must include exceptions to preserve maternal life or health.⁷⁹

Chiding the dissent for “the absence of any serious discussion of the legitimacy of the States’ interest in protecting fetal life,”⁸⁰ the *Dobbs* majority brings to center stage the state interests in fetal life, while relegating the interests (and existence) of both pregnant people and the medical profession to the wings. Beginning with the latter, *Dobbs* allows the state to remove all medical authority from physicians as to when abortions can be performed, allowing states to ban and even criminalize abortion, seemingly with few exceptions. In other words, it opens the door for states to ignore the fact that abortion is an essential part of health care.⁸¹ Physicians’ medical concerns that might warrant or even demand an abortion can now apparently be considered irrelevant. Instead, nearly all deference is left to legislatures, regardless of their lack of expertise or experience regarding abortion and its role in health care.⁸² Thus, *Dobbs* downgrades the status of physicians who provide abortion from the protected role of *Roe* and even from the denigrated status as

⁷⁸ *Id.* at 2283–84 (emphasis added). It also listed the interest in protecting maternal health, preventing “gruesome and barbaric procedures,” protecting the integrity of the medical profession, and preventing discrimination based on race, sex, or disability (a not-so-veiled reference to reason-based abortion bans). *Id.*

⁷⁹ *See id.* at 2283–84; *see also id.* at 2329 (“The majority does not say—which is itself ominous—whether a State may prevent a woman from obtaining an abortion when she and her doctor have determined it is a needed medical treatment.”).

⁸⁰ *Dobbs*, 142 S. Ct. at 2261.

⁸¹ In states where the courts construe their constitution as more protective of reproductive rights than the Supreme Court has construed the federal Constitution, that may not be true. *See* Planned Parenthood S. Atl. v. State, No. 2022-001062, 2023 WL 107972 (S.C. Jan. 5, 2023).

⁸² Even if a handful of legislatures have medical training, most have not provided reproductive health care. In July 2022, there were seventeen federal-physician-legislators (3.1 percent) and eighty-six state-physician-legislators (1.1 percent). Tanvee Varma & Matthew Goldenberg, *Physician-Legislators in Federal and State Government in 2022*, 328 JAMA 2450, 2450 (2022). Of the seventeen physicians in the 117th Congress, only two practiced as OBGYNs. Claire Wallace, *The 17 Physicians in the 117th US Congress*, BECKER’S ASC REV. (Aug. 17, 2022), <https://www.beckersasc.com/asc-news/the-17-physicians-in-the-117th-us-congress.html>.

“abortionists” to potential criminal actors at virtually any stage of gestation.

Pregnant people and women also disappear from the stage almost entirely. They make a brief appearance when the Court describes the concerns of the opponents and defenders of *Roe*. But even there, the Court describes their interests thinly and agnostically. It notes that some believe the *Dobbs* holding will affect women’s “freedom to choose the types of relationships they desire” and limit their ability “to compete with men in the workplace and in other endeavors.”⁸³ In contrast, it points out that others believe there has been great progress in eradicating stigma against unmarried women, protecting women from pregnancy discrimination, guaranteeing family leave, increased private and public coverage for pregnancy-related medical care, and the growth of “safe haven” laws that allow women to place their unwanted child for adoption.⁸⁴

Nowhere in the opinion does the majority discuss or even acknowledge the physical, psychological, and medical burdens of forced pregnancy or the fact that abortion is a medical decision. In fact, the phrases “bodily autonomy” or “bodily integrity” never appear in the majority opinion. The word “bodily” only shows up in the majority’s lengthy appendix listing state laws that banned abortion in the mid-nineteenth century.⁸⁵ And the term “body” refers to the “legislative body” or case law more often than the body of the pregnant person.⁸⁶ In contrast, the majority repeatedly references the “potential life” and the “unborn human being.”⁸⁷

The limited focus on the pregnant person can be explained in part by Alito’s unsupported assertion that it is difficult to calculate the societal impact of rejecting a constitutional right to abortion. As noted earlier, the majority claims that determining the “novel and intangible form[s] of reliance endorsed by the *Casey* plurality . . . depends on an empirical question that is hard for anyone—and in particular, for a

⁸³ *Dobbs v. Jackson Whole Women’s Health Org.*, 142 S. Ct. 2228, 2258 (2022).

⁸⁴ *Id.* at 2258–59.

⁸⁵ *Id.* at 2298, 2300.

⁸⁶ *Id.* at 2256, 2268 (referring to legislative bodies); *id.* at 2271 (referring to a “body of cases”). The Court only uses “body” to refer to the body of the pregnant person twice: once in the first few sentences of the opinion and once in a quote from a seventeenth-century treatise. *Id.* at 2240, 2249.

⁸⁷ *Id.* at 2241, 2243–44, 2257–58, 2260–61, 2268, 2277, 2280, 2284.

court—to assess, namely, the effect of the abortion right on society and in particular on the lives of women.”⁸⁸

The dissent, in contrast, has no difficulty recognizing the “[e]normous physical, social, and economic consequences” of a decision that allows states to impose forced pregnancy. It notes that

[e]ven an uncomplicated pregnancy imposes significant strain on the body, unavoidably involving significant physiological change and excruciating pain. For some women, pregnancy and childbirth can mean life-altering physical ailments or even death. Today, . . . the risks of carrying a pregnancy to term dwarf those of having an abortion. Experts estimate that a ban on abortions increases maternal mortality by 21 percent, with white women facing a 13 percent increase in maternal mortality while black women face a 33 percent increase.⁸⁹

The dissent also points to the fact that despite the rosy picture painted by abortion opponents, many women still lack adequate pregnancy-related health care, still face pregnancy discrimination, and still cannot access paid family leave. And finally, it shows that even with safe haven laws, “few women denied an abortion will choose adoption.” In short, the dissent does not find it difficult to predict that, “[w]hether or not they choose to parent,” the *Dobbs* decision will cause pregnant people to “experience the profound loss of autonomy and dignity that coerced pregnancy and birth always impose.”⁹⁰

The dissent also centers the lost abortion right as a natural extension of a line of interwoven precedents that are “all part of the fabric of our constitutional life” and all about “bodily autonomy, sexual and family relations, and procreation.”⁹¹ Abortion rights, the dissent points out, are entirely consistent with the many cases protecting “bodily integrity” and recognizing the “sacred” and “‘carefully guarded’ ‘right of every individual to the possession and control of his own person.’”⁹² Pointing to Supreme Court cases that curtailed the government’s ability to interfere with medical decisions or compel treatments, it emphasizes that “[t]here are few greater incursions on a

⁸⁸ *Id.* at 2276–77.

⁸⁹ *Dobbs*, 142 S. Ct. at 2339.

⁹⁰ *Id.* at 2338–39.

⁹¹ *Id.* at 2327.

⁹² *Id.* at 2328 (quoting *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

body than forcing a woman to complete a pregnancy and give birth.”⁹³ Forced pregnancy, the dissent underscores, involves “all manner of physical changes, medical treatments (including the possibility of a cesarean section), and medical risk.”⁹⁴ As it makes clear, and as the majority ignores, banning abortion has psychological, physical, and medical consequences. As the next Part shows, in just the short time since *Dobbs* was decided, that reality has become heartbreakingly and crystal clear.

II. HARM TO MATERNAL HEALTH

In one sense, *Dobbs* has returned us to a world much like the mid-1900s when states had the authority to treat abortion care as criminal activity as opposed to essential health care. But in another way, things are quite different. For early-stage abortions, medication provides a safe and effective way to try to circumvent state bans that did not exist in the pre-*Roe* days.⁹⁵ Whereas the criminalization of abortion 150 years ago was driven by physicians’ attempts to gain power over the reproductive care of women by replacing midwives and other paraprofessionals,⁹⁶ today, the Court elides physicians’ power in providing abortion care, allowing the decision to be left largely in the hands of legislatures.

This undermining of medical authority in the abortion context has both a direct and indirect impact on maternal health, intensifying the health risks that pregnant people faced even before *Dobbs*. The implications of this new reality are vast for maternal care, leading to potential death or serious injury at the extreme, but also greater health threats and limited ability to make medical decisions during pregnancy by pitting health care providers against patient, and even potentially impacting research. Section A examines the maternal health effects when abortion bans impose conflicting legal obligations on providers. Section B then explores the ways that abortion bans allowed under *Dobbs* increasingly pit provider directly against the patient with respect

⁹³ *Id.* at 2328 (citing to *Winston v. Lee*, 470 U.S. 753, 766–67 (1985)) (regarding forced surgery); *Rochin v. California*, 342 U.S. 165, 166, 173–74 (1952) (regarding forced stomach pumping); *Washington v. Harper*, 494 U.S. 210, 229, 236 (1990) (regarding forced administration of antipsychotic drugs)).

⁹⁴ *Dobbs*, 142 S. Ct. at 2328 (noting that “an American woman is 14 times more likely to die by carrying a pregnancy to term than by having an abortion”).

⁹⁵ *Medication Abortion*, GUTTMACHER INST. (Feb. 6, 2023), <https://www.guttmacher.org/state-policy/explore/medication-abortion>.

⁹⁶ LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME 10–11 (2022).

to medical decisions and how that intensifies a problem that has already existed with respect to compelled medical treatment of pregnant people. Concerns about “improper” maternal care may lead to more than compelled treatment, however. It can, as Section C discusses, also result in the criminalization of women for pregnancy-related behavior, which is also directly and indirectly harmful to maternal health. And, finally, Section D explores how *Dobbs* exacerbates a long-standing problem of the underrepresentation of women in research and its public health impact.

A. *The Conflicting Legal Obligations Created by Abortions Bans*

As we have seen, *Dobbs* represents the pinnacle of the trajectory in which health care providers and medical experts can be denied professional autonomy and agency to practice medicine, at least in contexts associated with abortion. This is because *Dobbs* grants states the authority to regulate aspects of reproductive care presumably without much limitation. As noted above, the opinion clearly condones abortion bans with no rape or incest exception. Nor does it require an exception for fetal anomalies. In fact, the Court’s statement that concerns about discrimination are legitimate state interests seems to support both abortion bans based on fetal anomalies and bans without exceptions for fetal anomalies. Finally, it neither expressly nor impliedly requires a life or health exception.

Several states were quick to accept *Dobbs*’s invitation to pass or reinstate draconian abortion bans. Many of the bans were imposed from the start of pregnancy⁹⁷ and often without exceptions for health and fetal anomalies. This section examines the maternal health risks that can arise when abortion bans exclude these exceptions.⁹⁸ The lack of exceptions also forces providers to choose between conflicting legal obligations and creates legal confusion, which is itself a health risk.

1. Confusion and Conflicts Between Abortion Bans and the Standard of Care

Physicians have ethical and legal obligations to care for patients according to the medical standard of care. If the failure to follow the

⁹⁷ *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST. (Feb. 1, 2023), <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions>.

⁹⁸ *Id.* Many states have also passed laws without rape or incest exceptions, which also impose threats of trauma and psychological harm, as well as possibly physical harm, if a young child is forced to carry a pregnancy to term. A discussion of the harms from the lack of those exceptions is beyond the scope of this Article.

standard of care causes physical injury or death, it can result in liability under tort law for medical malpractice.⁹⁹ But abortion laws in several states are inconsistent with the medical standard of care, while also imposing significant criminal and/or civil penalties for violating them and threatening removal of medical licenses.¹⁰⁰ Many bans have maximum criminal penalties of ten years in prison and a \$10,000 fine.¹⁰¹ In some states, maximum prison sentences are life or 100 years¹⁰² and maximum criminal fines are \$100,000.¹⁰³ Civil liability is also a risk in some states with damages of at least \$10,000 in Oklahoma¹⁰⁴ or \$100,000 in Texas.¹⁰⁵ As a result, physicians may confront the prospect of civil liability for malpractice if they comply with their states' abortion bans and significant criminal and/or civil liability if they adhere to the standard of care. They are left, in other words, between the proverbial rock and a hard place.

In addition, providers can be confused about the reach of the laws themselves, especially when states have multiple laws with inconsistent

⁹⁹ B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS & RELATED RSCH. 339, 340 (2009).

¹⁰⁰ See, e.g., ARK. CODE ANN. § 20-16-1909 (West Ann. 2018) (A physician . . . who performs an abortion in violation of this subchapter shall be considered to have engaged in unprofessional conduct for which his or her license to provide healthcare services in this state shall be suspended or revoked by the Arkansas State Medical Board.); OKLA. STAT. ANN. tit. 63, § 1-729.3 (West. 2012) (A physician who performed or induced an abortion . . . shall be considered to have engaged in unprofessional conduct for which his or her license to practice medicine in the State of Oklahoma may be suspended or revoked by the State Medical Board of Licensure and Supervision or the State Board of Osteopathic Examiners.).

¹⁰¹ For example, Arkansas's ban classifies abortion as a felony with a maximum fine of \$100,000 or maximum imprisonment of ten years (or both). ARK. CODE ANN. § 5-61-304 (West 2022). Tennessee's ban classifies abortion as a Class C felony, TENN. CODE ANN. § 39-15-213 (West 2019), which can result in a three- to fifteen-year prison sentence and a maximum fine of \$10,000, TENN. CODE ANN. § 40-35-111 (b) (3).

¹⁰² Texas imposes a life sentence (a felony in the first degree) if an abortion is performed and "an unborn child dies as a result of the offense." TEX. HEALTH & SAFETY CODE ANN. § 170A.004 (West 2022); TEX. PENAL CODE ANN. § 12.32 (West 2009).

¹⁰³ Oklahoma has a maximum criminal fine of \$100,000. OKLA. STAT. ANN. TIT. 63, § 1-745.39 (West 2022). Arkansas also has a maximum criminal fine of \$100,000. ARK. CODE ANN. § 5-61-304 (West 2022).

¹⁰⁴ Oklahoma allows for a minimum of \$10,000 in civil liability. OKLA. STAT. ANN. TIT. 63, § 1-745.55 (West 2022).

¹⁰⁵ TEX. HEALTH & SAFETY CODE ANN. § 170A.005 (West 2022) (imposing civil liability for those who "knowingly perform, induce, or attempt an abortion" in violation of the statute). Texas also allows for damages of at least \$10,000 in civil suits against anyone found liable for aiding or abetting an abortion. TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2021).

prohibitions. A recently published study highlighted this problem in Oklahoma where providers must adhere to three “overlapping” abortion bans or risk serious civil and criminal penalties.¹⁰⁶ The bans are inconsistent, particularly with respect to when abortions are legal in medical emergencies.¹⁰⁷ Using “‘simulated patient’ research methodology,” research assistants—posing as married women who were six-weeks pregnant with mild pre-existing conditions—called hospitals in the state to ask about their policies for managing obstetrical emergencies.¹⁰⁸ The study, aptly entitled “No One Could Say,” found that

not a single hospital appeared to be able to articulate clear, consistent policies for emergency obstetric care that supported their clinician’s ability to make decisions based solely on their clinical judgement and pregnant patients’ stated preferences and needs.¹⁰⁹

The majority (65 percent) of hospitals could not offer information about their policies,¹¹⁰ and many (41 percent) provided “unclear and /or incomplete answers about whether doctors require approval to perform a medically necessary abortion.”¹¹¹ Most (62 percent) hospitals provided “no information on how staff prioritized the fetus over saving the life of the pregnant person in medical emergencies.”¹¹² According to individuals who contributed to the report, the findings “illustrate the untenable situation health care institutions and clinicians face,” where “legislatures have transformed what should be evidence-based medical decisions into fraught legal dilemmas.”¹¹³

These dilemmas are especially likely in states with abortion bans that have no exception for the health of the mother. So far, almost all states with abortion bans have a life exception.¹¹⁴ A few have no true-

¹⁰⁶ PHYSICIANS FOR HUM. RTS. ET AL., NO ONE COULD SAY: ACCESSING EMERGENCY OBSTETRICS INFORMATION AS A PROSPECTIVE PRENATAL PATIENT IN POST-ROE OKLAHOMA 6 (2023), https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages-NEW-4-27-23.pdf.

¹⁰⁷ *Id.* at 6.

¹⁰⁸ *Id.* at 9-10.

¹⁰⁹ *Id.* at 12.

¹¹⁰ *Id.* at 1, 13.

¹¹¹ *Id.* at 1, 15.

¹¹² PHYSICIANS FOR HUM. RTS. ET AL., *supra* note 106, at 16.

¹¹³ Michelle Heisler et al., *US Abortion Bans Violate Patients’ Right to Information and to Health*, 401 LANCET 1480, 1481 (May 6, 2023), <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2823%29008>.

¹¹⁴ *State Bans on Abortion Throughout Pregnancy*, *supra* note 97.

life exception but allow doctors, if prosecuted, to bring an affirmative defense that the abortion was required to save the woman's life.¹¹⁵ This, however, switches the burden of proof to the provider.¹¹⁶ Several bans have no health exception.¹¹⁷ Bans with a life but no health exception can make it difficult for physicians to know when and whether adhering to the standard of care puts them in jeopardy of criminal or civil liability or whether the care would fall within the life exception. Sometimes the laws are particularly onerous, requiring two doctors to certify that the woman faces a life-threatening risk before an abortion can be performed.¹¹⁸

Bans without health exceptions seem to imagine a certainty in medicine that simply does not exist. If a patient is in an emergent condition for which an abortion is medically indicated, there is no medical Magic 8 Ball to inform a provider that the patient will die without an abortion as opposed to “merely” suffer serious physical harm, such as “serious risk of substantial physical impairment of a major bodily function.”¹¹⁹ In addition, it is not always possible to determine how likely death is because that assessment is fraught with uncertainty. And, even if it were not, the laws do not make clear how

¹¹⁵ Christine Vestal, *Some Abortion Bans Put Patients, Doctors at Risk in Emergencies*, PEW (Sept. 1, 2022), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/09/01/some-abortion-bans-put-patients-doctors-at-risk-in-emergencies> (describing state abortion bans that allow providers “to offer evidence that the procedure was necessary to save the patient’s life only after they’re charged”).

¹¹⁶ See, e.g., ID. CODE § 18-622(3) (2023); TENN. CODE ANN. § 39-15-213 (2021). See Amy S. Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*, N.Y. TIMES (Jan. 21, 2023), <https://www.nytimes.com/interactive/2023/01/21/us-abortion-ban-exceptions.html>.

¹¹⁷ *State Bans on Abortion Throughout Pregnancy*, *supra* note 97.

¹¹⁸ Kate Zernike, *Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, N.Y. TIMES (Sept. 10, 2022), <https://www.nytimes.com/2022/09/10/us-abortion-bans-medical-care-women.html>.

¹¹⁹ See ALA. CODE §§ 26-23H-3–4. Alabama defines a “serious health risk to the unborn child’s mother” as: “a condition that so complicates [the child’s mother’s] medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function.” *Id.* Kentucky allows abortion under a health exception “to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman.” KY. REV. STAT. ANN. § 311.772 (West 2019). Missouri includes a health exception in its definition of medical emergency as necessary when “a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman.” MO. ANN. STAT. § 188.015 (West 2019).

probable death must be before the life exception applies.¹²⁰ Must the chance of death be more likely than not, probable, clear and convincing, or beyond a reasonable doubt? And how imminent must death be: within minutes, hours, days, or months? As one physician wrote soon after *Dobbs*:

[I]t's unclear what, precisely, "lifesaving" means. What does the risk of death have to be, and how imminent must it be? Might abortion be permissible in a patient with pulmonary hypertension, for whom we cite a 30-to-50 [percent] chance of dying with ongoing pregnancy? Or must it be 100 [percent]? When we diagnose a new cancer during pregnancy, some patients decide to end their pregnancy to permit immediate surgery, radiation, or chemotherapy, treatments that can cause significant fetal injury. Will abortion be permissible in these cases, or will patients have to delay treatment until after delivery? These patients' increased risk of death may not manifest for years, when they have a recurrence that would have been averted by immediate cancer treatment.¹²¹

These uncertainties can make it treacherous for providers to rely on a life exception to defend against or avoid criminal prosecutions for violating an abortion ban. The risk of miscalculating whether an exception applies looms as a terrible and coercive threat, pushing providers (and the legal counsel who support them and their institution) to be conservative in estimating whether a patient's life is threatened and requires an abortion.¹²²

¹²⁰ Arkansas, for example, defines its life exception under medical emergency as "a condition in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." ARK. CODE ANN. § 5-61-303 (West 2022). Texas defines the life exception similarly as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced." TEX. HEALTH & SAFETY CODE ANN. § 170A.002 (West 2022). See also Aria Bendix, *How Life-Threatening Must a Pregnancy Be to End It Legally?*, NBC NEWS (June 30, 2022, 1:57 PM), <https://www.nbcnews.com/health/health-news/abortion-ban-exceptions-life-threatening-pregnancy-rcna36026>.

¹²¹ Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of Roe v. Wade*, 386 NEW ENG. J. MED. 2061, 2061–62 (June 2, 2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2206246#.Yn2CbLw4QWE.twitter>.

¹²² See Mark Joseph Stern, *The Fall of Roe v. Wade Is Already Damaging Basic Obstetric Care in Red States*, SLATE (Aug. 2, 2022, 3:42 PM), <https://slate.com/news-and-politics/2022/08/abortion-bans-hospitals-obstetric-care-red-states.html>; Emily

These dilemmas have resulted in delays when treating patients with a range of conditions, including incomplete miscarriages, ectopic pregnancies, or non-viable pregnancies.¹²³ Sometimes the delays or denials are the result of confusion over the legal landscape.¹²⁴ Often they occur because there is no health exception. In those cases, physicians are essentially telling patients, “I cannot guarantee this will not kill you yet, and thus, if I perform an abortion, I could face years in prison.” Such scenarios are not as rare as one might imagine. As one physician noted, “this is happening every day, all the time” in states with no health exception.¹²⁵

The media has reported several cases where the treatment of miscarriages, which can occur as frequently as 26 percent of the time in pregnancies under twenty weeks’ gestation,¹²⁶ have been delayed or denied, thereby seriously threatening the woman’s health. This happened to one of the First Lady’s guests at the recent State of the Union address, Amanda Zurawski, who had finally become pregnant after a year and a half of fertility treatment, but then tragically began to miscarry at eighteen weeks.¹²⁷ The pregnancy could not be saved, but neither could it be terminated under Texas’s abortion ban because there was still a faint fetal heartbeat.¹²⁸ Amanda was sent home to wait for the pregnancy to end, but a few days later she developed septic shock.¹²⁹ Only after she suffered a high fever and extremely low blood

Baumgaertner, *Doctors in Abortion-Ban States Fear Prosecution for Treating Patients With Life-Threatening Pregnancies*, L.A. TIMES (July 29, 2022, 2:00 AM), <https://www.latimes.com/world-nation/story/2022-07-29/fearful-of-prosecution-doctors-debate-how-to-treat-pregnant-patients>; Lauren Coleman-Lochner et al., *Doctors Fearing Legal Blowback Are Denying Life-Saving Abortions*, BLOOMBERG L. (July 12, 2022, 10:30 AM), <https://news.bloomberglaw.com/health-law-and-business/doctors-fearing-legal-blowback-are-denying-life-saving-abortions>.

¹²³ Zernike, *supra* note 118.

¹²⁴ *Id.* See also Frances Stead Sellers & Fenit Nirappil, *Confusion Post-Roe Spurs Delays, Denials for Some Lifesaving Pregnancy Care*, WASH. POST (July 16, 2022, 9:09 AM), <https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care>.

¹²⁵ Zernike, *supra* note 118.

¹²⁶ CARLA DUGAS & VALORI H. SLANE, MISCARRIAGE (2022), <https://www.ncbi.nlm.nih.gov/books/NBK532992>.

¹²⁷ Bridget Grumet, *Austinite Amanda Zurawski Among First Lady’s Guests at Biden’s State of the Union Address*, AUSTIN-AMERICAN STATESMAN (Feb. 7, 2023), <https://www.statesman.com/story/news/2023/02/07/amanda-zurawski-state-of-the-union-biden-speech-texas-abortion-law/69881615007>.

¹²⁸ *Id.*

¹²⁹ *Id.*

pressure did physicians finally believe they legally could end the pregnancy.¹³⁰ Amanda is not alone; many other patients have gone through unnecessary medical ordeals because abortion laws led to delayed treatment for miscarriages.¹³¹

Similar problems have arisen with ectopic pregnancies, when the embryo implants in a location where the pregnancy cannot develop—90 percent of the time in a fallopian tube.¹³² The unequivocal standard of care is to terminate an ectopic pregnancy.¹³³ If the embryo develops in the fallopian tube, cervix, abdomen, or anywhere other than the uterus, it is not only incompatible with fetal life, but it can also lead to significant life-threatening hemorrhaging.¹³⁴ Yet there are several accounts of physicians who have avoided or delayed treatment for fear of violating draconian abortion bans.¹³⁵

As one physician predicted, in states with limited exceptions for abortions, even when abortions are medically indicated, providers “will likely ‘wait to that very last minute when it’s clear that a patient will die to do the procedure, and that’s just not an ideal time to do any kind of intervention.’”¹³⁶ This is a clear and direct threat to maternal health, especially in light of the fact that 14 percent of pregnancies are thought to face “severe complications.”¹³⁷ Already, the estimate is that

¹³⁰ *Id.*

¹³¹ See Selena Simmons-Duffin, *Her Miscarriage Left Her Bleeding Profusely. An Ohio ER Sent Her Home to Wait*, NPR (Nov. 15, 2022, 12:01 PM), <https://www.npr.org/sections/health-shots/2022/11/15/1135882310/miscarriage-hemorrhage-abortion-law-ohio#:~:text=An%20Ohio%20ER%20sent%20her%20home%20to%20wait,-Listen%20C2%B7%208%3A00&text=Meredith%20Rizzo%20FNPR-Weeks%20after%20her%20miscarriage%20was%20confirmed%2C%20Christina%20Zielke%20started%20bleeding,discharged%20soon%20after%2C%20still%20bleeding>.

¹³² *Facts Are Important: Understanding Ectopic Pregnancy*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy> (last visited Mar. 12, 2023).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ See, e.g., Simmons-Duffin, *supra* note 131. After Texas passed Senate Bill 8 (SB8), see *infra* note 143 and accompanying text, an MFM specialist reported their hospital (unnamed) no longer provided treatment for ectopic pregnancies. Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, 387 NEW ENG. J. MED. 388, 389 (2022). Even in states with liberal abortion laws, treatment for ectopic pregnancies is complicated. See Michelle Andrews, *\$80,000 and 5 ER Visits: An Ectopic Pregnancy Takes a Toll Despite NY’s Liberal Abortion Law*, KAISER HEALTH NEWS (Oct. 5, 2022), <https://khn.org/news/article/ectopic-pregnancy-new-york-abortion-law>.

¹³⁶ Bendix, *supra* note 120 (quoting Dr. Lisa Harris).

¹³⁷ Walker, *supra* note 116.

three-in-five maternal deaths are probably preventable; draconian abortion laws could increase the rate of such deaths.¹³⁸

Abortions may also be medically indicated when treating patients for conditions unrelated to pregnancy, such as cancer, heart conditions, kidney disorders, and sickle cell anemia.¹³⁹ In some instances, pregnancy exacerbates the condition, posing significant health risks to the pregnant person.¹⁴⁰ In other instances, abortions are recommended so that treatments like chemotherapy, which can be highly teratogenic or lethal to a fetus, can be administered in a timely fashion to treat the underlying cancer. In states that are highly protective of fetal life and prohibit abortion with no health exception, physicians may feel legally bound to delay medically necessary treatments until the person delivers.¹⁴¹ Whether delaying such treatment is a threat to life or simply to health is unclear given, as mentioned earlier, the issues as to how certain and imminent death must be to fit within the life exception.¹⁴² Delaying treatment that would be the standard of care can allow the illness to progress to a stage that requires more intrusive treatment, or it may even be life-threatening if the condition becomes untreatable.

The harms that can arise with delays in providing abortion care because of concerns about criminal or civil liability are not hypothetical as the cases described above indicate. Research shows that patients whose conditions required abortions after Texas imposed Senate Bill 8 (SB8),¹⁴³ which effectively bans abortions at six weeks, had to wait, on average, nine days until their complications posed “an immediate threat to maternal health.”¹⁴⁴ The result was that many suffered hemorrhaging and sepsis.¹⁴⁵ The authors of the study calculated that for patients in Texas presenting at less than twenty-two weeks’ gestation with medical indications for delivery suffered higher

¹³⁸ Bendix, *supra* note 120.

¹³⁹ Zernike, *supra* note 118.

¹⁴⁰ *Id.*

¹⁴¹ These cases also potentially present conflicts between physicians and patients if the patient insists on treatment and the physician refuses. *See infra* Part II.B.

¹⁴² *See supra* text accompanying notes 119–121.

¹⁴³ *See* S.B. 8, 87th Leg., Reg. Sess. (Tex. 2021) (codified at TEX. HEALTH & SAFETY CODE § 171.201 *et seq.*). *See also infra* note 196 and accompanying text.

¹⁴⁴ *See* Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks’ Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 AM. J. OBSTETRICS & GYNECOLOGY 648 (2022), [https://www.ajog.org/article/S0002-9378\(22\)00536-1/fulltext](https://www.ajog.org/article/S0002-9378(22)00536-1/fulltext).

¹⁴⁵ *Id.* at 648–49.

rates of “serious maternal morbidity” (57 percent) compared to that of patients who terminated their pregnancies in states without abortion bans (33 percent).¹⁴⁶ Thus, even if patients do not ultimately die as a result of delayed care—although some surely will—they may still suffer serious health effects.

Dilemmas can also arise with respect to desired pregnancies when prenatal testing or other circumstances demonstrate that the fetus will suffer debilitating disabilities or die. Most states with abortion bans have no exceptions for fetal anomalies, and those that do limit the exception to *lethal* fetal anomalies,¹⁴⁷ which are described variously.¹⁴⁸ Recently, two women in Kentucky were denied abortions after their fetuses were identified as having serious abnormalities because Kentucky’s abortion ban has no exception for fetal anomalies of any kind; in one case, the fetus had anencephaly¹⁴⁹—meaning that a portion of its head had not developed—a condition incompatible with life beyond a few days at most.¹⁵⁰ At twenty weeks’ gestation, when the diagnosis was made, Amy English was visibly pregnant and had to endure people asking to touch her belly or how far along she was.¹⁵¹ As she put it, “No part of me wanted to be pregnant anymore Every flutter and kick he gave felt like a literal gut punch reminder that I would never get to take him home.”¹⁵²

In the other case, Leah Martin’s fetus had a “fatal and painful condition,” but there was still a heartbeat at nine weeks, so she could not terminate the pregnancy.¹⁵³ At her next ultrasound appointment, she found herself hoping there would be no heartbeat. She described

¹⁴⁶ *Id.* at 649.

¹⁴⁷ *State Bans on Abortion Throughout Pregnancy*, *supra* note 97.

¹⁴⁸ UTAH CODE ANN. § 76-7-302(3)(b)(ii)(A) (2022) (describing the exception as “uniformly lethal”); LA. STAT. ANN. § 40:1061.1.2 (2022) (describing the exception as “medically futile” pregnancy). See also *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST. (Feb. 1, 2023), <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly>.

¹⁴⁹ Alex Acquisto, *A ‘Twisted’ Experience: How KY’s Abortion Bans are Depriving Pregnant Patients of Health Care*, LEXINGTON HERALD LEADER (Feb. 22, 2023, 5:01 PM), <https://www.kentucky.com/news/politics-government/article271925592.html>.

¹⁵⁰ *Anencephaly*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/birthdefects/anencephaly.html#:~:text=Anencephaly%20is%20a%20serious%20birth,part%20of%20the%20neural%20tube> (last visited Mar. 5, 2023).

¹⁵¹ Acquisto, *supra* note 149.

¹⁵² *Id.*

¹⁵³ *Id.*

it as “such a twisted experience being pregnant with a baby I desperately wanted, lying there hoping its heart had stopped It was horrible to have to wish for that in order to receive care. It just felt so unsafe and cruel.”¹⁵⁴

These examples are not just emotionally and psychologically painful in leaving patients to wait prolonged periods “with a baby dying inside,”¹⁵⁵ but sometimes the delays can also threaten the physical well-being of the mother. Mylissa Farmer, for example, experienced preterm premature rupture of the membranes (PPROM) at nearly eighteen weeks’ gestation.¹⁵⁶ If she delivered right away, there was zero chance of a live birth. Even if physicians managed to delay delivery, the prognosis would have been very poor for the fetus because the loss of amniotic fluid would inhibit proper lung development and cause abnormalities.¹⁵⁷ The medical standard of care is to terminate right away, but Missouri state law prohibited that. Instead, the law required Mylissa to wait until the rupture resulted in harm serious enough to constitute a medical emergency or until fetal cardiac activity had stopped.¹⁵⁸ Although she was able to drive to another state to obtain the abortion, not all women will have the resources to do so.¹⁵⁹

The *Washington Post* wrote about similar denial of care in Florida for PPRM with the headline “Two Friends Were Denied Care after Florida Banned Abortion. One Almost Died.”¹⁶⁰ It describes the new reality in the eighteen states that ban abortion before fetal viability, where “many hospitals have been turning away PPRM patients as doctors and administrators fear the legal risk that could come with terminating even a pregnancy that could jeopardize the mother’s well-being.”¹⁶¹ These kinds of conflicts are likely to arise repeatedly in abortion-restrictive states. Just PPRM alone occurs in two-to-three

¹⁵⁴ *Id.*

¹⁵⁵ Susan Szuch, *After Missouri Banned Abortions, She Was Left ‘With a Baby Dying Inside.’ Doctors Said They Could Do Nothing*, SPRINGFIELD NEWS-LEADER (Oct. 19, 2022, 10:27 AM), <https://www.news-leader.com/story/news/local/ozarks/2022/10/19/missouri-laws-abortion-ban-left-her-with-a-baby-dying-inside-pprom/10366865002>.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *See id.*

¹⁶⁰ Caroline Kitchner, *Two Friends Were Denied Care After Florida Banned Abortion. One Almost Died*, WASH. POST. (Apr. 10, 2023), <https://www.washingtonpost.com/politics/2023/04/10/pprom-florida-abortion-ban>.

¹⁶¹ *Id.*

percent of pregnancies,¹⁶² resulting in preterm birth in 25 percent of those instances.¹⁶³

2. Conflicts Between Abortion Bans and EMTALA

Abortion bans do not only present providers with quandaries about whether to adhere to the medical standard of care or to comply with abortion bans—they also pose potential risks of violating federal law, particularly the federal Emergency Medical Treatment and Labor Act (EMTALA),¹⁶⁴ which requires stabilization of patients in emergent conditions.¹⁶⁵ Enacted to ensure public access to emergency services regardless of one’s ability to pay, the statute requires Medicare-participating hospitals that offer emergency services to stabilize health care for patients who appear in the emergency room.¹⁶⁶ EMTALA defines an emergency as a condition where a lack of care could reasonably be expected to place the person’s health in “serious jeopardy” or result in “serious impairment to bodily functions” or “serious dysfunction of any bodily organ or part.”¹⁶⁷ In states with abortion bans with no health exception, EMTALA might require care that violates these bans because it mandates stabilization of patients in emergencies, which may include scenarios where the patient is very ill, but her life is not at risk.

Concerned that such bans conflict with EMTALA, the Department of Health and Human Services (HHS) issued strong guidelines in July 2022 stating that when there is a direct conflict between EMTALA and state law, EMTALA preempts state law under the Supremacy Clause of the United States Constitution.¹⁶⁸ The state

¹⁶² *Prelabor Rupture of Membranes*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Mar. 2020), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes>.

¹⁶³ Szuch, *supra* note 155.

¹⁶⁴ 42 U.S.C. § 1395dd.

¹⁶⁵ *Id.* HHS—OIG may impose civil monetary penalties either on the hospital or physician pursuant to 42 C.F.R. § 1003.500 for refusing to provide such care as is necessary under EMTALA.

¹⁶⁶ See § 1395dd; Memorandum from the Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG) to State Survey Agency Directors 4 (Aug. 25, 2022) (on file with the Centers for Medicare & Medicaid Services), <https://www.cms.gov/files/document/qso-22-22-hospitals.pdf>.

¹⁶⁷ § 1395dd(e)(1)(A)(i)–(iii).

¹⁶⁸ Press Release, HHS, Following President Biden’s Executive Order to Protect Access to Reproductive Health Care, HHS Announces Guidance to Clarify that Emergency Medical Care Includes Abortion Services (July 11, 2022),

of Texas quickly challenged the HHS emergency guidance regarding EMTALA in *Texas v. Becerra*, claiming that it is an “unconstitutional exercise of authority” in the wake of *Dobbs*¹⁶⁹ and seeking a declaratory judgment that the new guidance is unenforceable as a matter of law.¹⁷⁰ The court held for Texas.¹⁷¹ It first argued that the guidance goes “well beyond EMTALA’s text, which protects both mothers and unborn children, is silent as to abortion, and preempts state law only when the two directly conflict.”¹⁷² The court went on to say that because “the statute is silent on the question, the [g]uidance cannot answer how doctors should weigh risks to both a mother and her unborn child.”¹⁷³ As a result, it issued a temporary injunction, preventing enforcement of the guidance within the borders of Texas and in relation to two other groups of plaintiffs.¹⁷⁴

That was not the final word on EMTALA in the abortion context, however. After the Idaho legislature passed a bill banning abortion from the start of pregnancy, with no health exception, the United States sought to have the ban enjoined before it was to go into effect on the grounds of EMTALA preemption.¹⁷⁵ Just a day after the federal district court ruled in Texas, the Idaho district court ruled quite differently.¹⁷⁶ The Idaho district court recognized a direct conflict and, therefore, temporarily enjoined enforcement of the abortion ban in

<https://www.hhs.gov/about/news/2022/07/11/following-president-bidens-executive-order-protect-access-reproductive-health-care-hhs-announces-guidance-clarify-that-emergency-medical-care-includes-abortion-services.html>; *see also* Memorandum from the Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG) to State Survey Agency Directors 4 (Aug. 25, 2022) (on file with the Centers for Medicare & Medicaid Services), <https://www.cms.gov/files/document/qso-22-22-hospitals.pdf>.

¹⁶⁹ Complaint, *Texas v. Becerra*, No. 5:22-CV-185, 2022 WL 2763763 (N.D. Tex. July 14, 2022).

¹⁷⁰ *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 WL 3639525, at *5 (N.D. Tex. Aug. 23, 2022). In January, the court issued a final amended judgment, *Texas v. Becerra*, No. 5:22-CV-185-H, 2023 WL 2467217 (N.D. Tex. Jan. 13, 2022), and the federal government has appealed to the Fifth Circuit, *Texas v. Becerra*, 5:22-cv-00185-H (5th Cir. Mar. 10, 2023).

¹⁷¹ *Becerra*, 2022 WL 3639525, at *5.

¹⁷² *Id.* at *1 (emphasis omitted).

¹⁷³ *Id.*

¹⁷⁴ *Id.* at *31.

¹⁷⁵ Complaint, *United States v. Idaho*, No. 1:22-CV-00329-BLW, 2022 WL 3137290 (D. Idaho Aug. 24, 2022).

¹⁷⁶ *United States v. Idaho*, No. 1:22-CV-00329-BLW, 2022 WL 3692618, at *15 (D. Idaho Aug. 24, 2022).

instances when patients face emergencies as defined by EMTALA.¹⁷⁷ In other words, it immunizes physicians from criminal liability if they provide abortions as part of emergency care. Even so, the ban on almost all other abortions still went into effect.¹⁷⁸ It is important to note that this ruling does not protect physicians from performing abortions to protect maternal health if the patient's condition does not reach the level of an emergency as defined by EMTALA or to try to prevent the patient's condition from becoming emergent in the first place. What the ruling does is prevent physicians from being forced to allow a woman to reach a point near death before they can act. Thus, even in jurisdictions where EMTALA is enforceable, it only goes so far in protecting maternal health.

Most recently, the Centers for Medicare and Medicaid Services (CMS) announced that it had investigated two hospitals, one in Kansas and another in Missouri, for violating EMTALA when they failed to stabilize Mylissa Farmer¹⁷⁹ by performing an abortion after she experienced preterm premature rupture of the membranes.¹⁸⁰ CMS emphasized that the lack of care was not due to "the clinical judgment of her providers, but because the hospital policies would not allow an abortion to be performed."¹⁸¹ Noting "the terrifying ordeal she experienced," it emphasized that CMS "will do everything we can to protect [patients'] lives and health, and to investigate and enforce the law to the fullest extent of our legal authority, in accordance with orders from the courts."¹⁸²

It is not clear yet whether the federal government will impose fines or penalties for these violations, although it did send the hospitals notices that they had violated EMTALA.¹⁸³ In addition, the Secretary of Health and Human Services issued a letter to all hospitals and provider associations reminding them that they are "obligated under

¹⁷⁷ *Id.* at *15.

¹⁷⁸ *See id.*

¹⁷⁹ Amanda Seitz, *Feds: Hospitals that Denied Emergency Abortion Broke the Law*, DAILY RECORD (May 2, 2023), <https://thedailyrecord.com/2023/05/02/feds-hospitals-that-denied-emergency-abortion-broke-the-law/#:~:text=WASHINGTON%20%E2%80%94%20Two%20hospitals%20that%20refused,the%20federal%20government%20has%20found>.

¹⁸⁰ *See supra* text accompanying note 155.

¹⁸¹ HHS Secretary Xavier Becerra Statement on EMTALA Enforcement (May 1, 2023), <https://www.hhs.gov/about/news/2023/05/01/hhs-secretary-xavier-becerra-statement-on-emtala-enforcement.html>.

¹⁸² *Id.*

¹⁸³ Seitz, *supra* note 179.

EMTALA to offer stabilizing care to patients who need emergency care,” and that CMS “will not hesitate to enforce your obligations under the law.”¹⁸⁴ The threat of fines or penalties for EMTALA violations, however, many not be sufficient to persuade providers to perform abortions in medical emergencies if they still risk criminal prosecution for violating a state’s abortion ban.

3. The Health Impact of Conflicts of Interest and Undermining Trust

The scenarios described above demonstrate how abortion bans can undermine or eliminate professional discretion in the reproductive space and beyond. Rather than focus on the health care needs of the patient and adhere to the medical standard of care, physicians must weigh the liability (criminal and/or civil) risks to themselves against the risks to the patient in delaying or denying abortion care. As Dr. Kristyn Brandi, an obstetrician, describes it,

[m]any providers right now are in this really difficult space of “Do I intervene? There’s an emergency, I know what to do. I have the clinical skills that I know I can use, but do I call my lawyer first? Do I make sure that it’s legally acceptable for me to provide the care that I know that is evidence-based, that is the right thing to do? Or do I protect myself?” Which is a very reasonable thing.¹⁸⁵

Dr. Brandi emphasizes that these laws present significant tensions not only for abortion providers, but also for “so many other providers: high-risk maternal-fetal medicine providers, people that are ER physicians, people that are engaging in this in so many different ways.”¹⁸⁶

These difficult, even impossible, assessments of how much personal risk physicians are willing to take for their patients’ well-being create a profound conflict of interest, which compromises the fiduciary role of providers so central to the doctor-patient relationship.¹⁸⁷ As Dr

¹⁸⁴ HHS Secretary Xavier Becerra Statement, *supra* note 181.

¹⁸⁵ Emily Hutto, *Physicians vs Patients: Providing Abortion Care Post-Roe*, MEDPAGE TODAY (Jan. 15, 2023), https://www.medpagetoday.com/opinion/faustfiles/102639?xid=nl_mpt_DHE_2023-01-15&eun=g1478357d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%202023-01-15&utm_term=NL_Daily_DHE_dual-gmail-definition.

¹⁸⁶ *Id.*

¹⁸⁷ See AMA PRINCIPLES OF MEDICAL ETHICS, <https://www.ama-assn.org/system/files/code-of-medical-ethics-chapter-1.pdf> (last visited Apr. 25, 2023) (discussing the trust-

Jamila Perritt, obstetrician and CEO & President for Physicians for Reproductive Health,¹⁸⁸ put it:

I think it's not just a difficult position that providers are being put in and patients are being put in, but what's actually happening is that patients and providers are being pitted against one another.

Because what's happening is that now I'm no longer making decisions about what I think is best medically for you or making recommendations about your health and wellbeing. I am prioritizing my safety, myself, before the recommendations that I'm providing you Because this risk of criminalization, this threat of arrest and imprisonment of doctors is not theoretical.

We have seen this play out in this country in the past[] . . . so it's not an academic exercise, it's something that we have to take seriously. It's something that a lot of the providers that we hear from on the ground are taking seriously. So, the example . . . of a patient showing up and you're making a decision about the care you provide, but are deciding whether you should call your lawyer first, is something that we know is happening today on the ground in states where abortion is banned.¹⁸⁹

The fact that providers feel they must seek legal counsel is itself problematic on two fronts. First, it can slow the delivery of care, which is risky when patients face severe, emergent medical conditions.¹⁹⁰ Second, it shifts the focus of the medical needs of the patient to provider and institutional concerns about liability.

Sometimes the conflicts described above arise because the provider's or institution's legal counsel is particularly risk averse. As the *New York Times* reported six months after *Dobbs* was decided, very few exceptions have been granted with respect to the new abortion bans, even if the situation could conceivably apply to one of the exceptions.¹⁹¹ One provider explained that even if you have exceptions

based "relationship between a patient and a physician . . . which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare," and describing throughout the implications of that fiduciary relationship).

¹⁸⁸ *Dr. Jamila Perritt, President & CEO*, PHYSICIANS FOR REPROD. HEALTH (Sept. 8, 2020), <https://prh.org/staff/dr-jamila-perritt-president-ceo>.

¹⁸⁹ Hutto, *supra* note 185.

¹⁹⁰ *See Walker, supra* note 116.

¹⁹¹ *Id.*

for maternal life, “[w]hen you get into the nitty-gritty details of it, you actually don’t.”¹⁹² The *Times* investigation found that “[d]octors and hospitals are turning away patients” who need abortion care, “saying that ambiguous law and the threat of criminal penalties make them unwilling to test the rules.”¹⁹³ In one case in Ohio, when the state’s abortion ban was still in effect, a physician feared that her patient and the triplets she was carrying would suffer serious health complications if she did not perform a selective reduction—i.e., termination of some but not all of the fetuses.¹⁹⁴ While the provider, Dr. Ragsdale, believed the scenario fell within the ban’s health exception, the hospital’s attorney thought the risks were “not immediate enough.”¹⁹⁵

In a chilling anecdote shared by a colleague, a health care provider was told by her institution’s legal department that the institution would be far more comfortable defending a malpractice case against the provider than defending a criminal prosecution for violating an abortion ban. As unnerving as this anecdote is, it is not hard to imagine institutions making such risk-benefit assessments. They may believe there is some wiggle room regarding the context-dependent standard of care, whereas there is great uncertainty as to how jurisdictions will interpret the reach of an abortion ban and the application of its exceptions. The lack of precedent in this area only reinforces a risk-benefit assessment that favors the liability risks for malpractice over those for violating an abortion ban.

While one can explain the decisions to prioritize a health care institution’s interests over the medical needs of its patients, that approach is completely counter to both ethical and legal norms. Moreover, such attitudes undermine the provider-patient relationship and patient trust in their providers and health care institutions.

Empirical research on the impact of abortion restrictions before *Dobbs* demonstrates how these laws negatively affected the provider-patient relationship and undermined trust in one another. One study explored the impact of Texas’s SB8, a law passed in 2021 that creates a risk of civil liability for providers and anyone who knowingly engages in or intends to “engage[] in conduct that aids or abets the performance or inducement of an abortion,”¹⁹⁶ on clinicians

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ S.B. 8, 87th Leg., 3rd Call Sess. (Tex. 2021). This unique “bounty-hunter” law was strategically enacted to circumvent federal litigation pre-*Dobbs*. *Texas Finds a Way*

practicing in Texas in general obstetrics and gynecology, maternal and fetal medicine, or genetic counseling. The study found that some believed “[o]n the basis of legal guidance,” that they could not “counsel patients regarding the availability of abortion in cases of increased maternal risks or poor fetal prognosis” even if they would have done so before the law was enacted.¹⁹⁷ Patients, in response, described a sense of betrayal, hurt, and confusion. One patient who received a prenatal diagnosis of spina bifida and trisomy 18, with a very low chance of survival beyond a year of life,¹⁹⁸ “was shocked that her physician would not even inform her about termination options.”¹⁹⁹ She described feeling abandoned: “When you . . . have received news like that and can barely function, the thought of then having to do your own investigating to determine where to get this medical care and to arrange going out of state feels additionally overwhelming.”²⁰⁰

In the prenatal genetic counseling context, another empirical study of the impact of SB8 and other abortion restrictive laws before *Dobbs* showed that these laws changed many aspects of genetic counseling.²⁰¹ Some counselors discussed abortion restrictions with patients even before doing any prenatal testing, let alone before receiving a prenatal diagnosis.²⁰² Others reported feeling pressured by the laws to discuss topics before clients were in the right “headspace.”²⁰³ Genetic counselors in Texas also described a great deal of confusion about what they could or could not say to avoid

to Block Most Abortions, for Now, COMMONWEALTH FUND (Sept. 8, 2021), <https://www.commonwealthfund.org/blog/2021/texas-finds-way-block-most-abortions-now#:~:text=The%20Texas%20Abortion%20Prohibition,four%20months%20before%20fetal%20viability>.

¹⁹⁷ Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, NEW ENG. J. MED. 387, 388 (2022), <https://doi.org/10.1056/NEJMp2207423>.

¹⁹⁸ With trisomy 18, there is “a high risk of stillbirths and fetal loss.” Abbas Alshami et al., *Unusual Longevity of Edwards Syndrome: A Case Report*, 11 GENES (BASEL) 1, 3 (Dec. 2020). In addition, “more than 50 [percent] of infants . . . live beyond 1 week of age; however, only 5–10 [percent] will survive beyond 1 year old. Rarely, patients can survive to adulthood with close monitoring and follow-up.” *Id.*

¹⁹⁹ Arey et al., *supra* note 197, at 389.

²⁰⁰ *Id.*

²⁰¹ Grace Getchell et al., *Prenatal Genetic Counseling in States Hostile to Abortion in the Final Days of Roe v. Wade: A Qualitative Study*, J. GENETIC COUNSELING, Dec. 14, 2022, at 12, <https://pubmed.ncbi.nlm.nih.gov/36518087>.

²⁰² *Id.* at 5.

²⁰³ *Id.*

liability for aiding and abetting.²⁰⁴ While some said SB8 only affected the coordination of abortion care, others described “the need for very deliberate word choices in order not to be seen as ‘aiding and abetting.’”²⁰⁵

There is also evidence that abortion restrictions lead to wariness and even lack of trust on the part of both counselors and patients, even in the initial stages of counseling, long before a fetal diagnosis has been made. Genetic counselors described patients’ reluctance to disclose their full reproductive history for fear that it could grab the attention of aggressive prosecutors.²⁰⁶ And some counselors feared they might be secretly recorded in phone conversations with patients or by interpretive services, making them vulnerable to legal action. One counselor was quite explicit about the way that SB8 harms the provider-patient relationship: it “really puts a divide between the providers and the patients, because even when they ask us, like, I’m kind of scared to give them information which is not great, because they’re in like a very stressful situation to begin with if they’re considering this.”²⁰⁷

Diminished trust and openness between patient and provider can have negative health care impacts because both are crucial to good medical care and to achieving the best health outcomes.²⁰⁸ Many legal protections have been instituted to protect the confidentiality and privacy of medical information, precisely to bolster and preserve the trust in providers.²⁰⁹ When trust breaks down in the doctor-patient relationships, patients may not seek care in the first place. Lack of trust also curtails free and open discussions necessary to provide and receive adequate health care. Health care providers depend on accurate medical histories from patients to make proper diagnoses and to determine the best treatment options. Patients likewise depend on health care providers to discuss the full range of medically indicated

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ Personal communication with Laura Hercher, January 26, 2023.

²⁰⁷ Getchell et al., *supra* note 201, at 6.

²⁰⁸ See Johanna Birkhäuser et al., *Trust in the Health Care Professional and Health Outcome: A Meta-Analysis*, 12 PLOS ONE 1, 4 (2017).

²⁰⁹ Mary Anderlik Majumder & Christi J. Guerrini, *Federal Privacy Protections: Ethical Foundations, Sources of Confusion in Clinical Medicine, and Controversies in Biomedical Research*, *AMA J. ETHICS* 288 (2016), <https://journalofethics.ama-assn.org/article/federal-privacy-protections-ethical-foundations-sources-confusion-clinical-medicine-and/2016-03>.

treatments.²¹⁰ Diminished trust may also affect patient compliance with medical recommendations.²¹¹ When both parties muzzle themselves and are hampered in their respective roles in the complex process of medical decision-making, not only will the ideal of shared decision-making become impossible, but bad health outcomes are also more likely. Abortion bans that disregard the standard of medical care and that criminalize the provision of an essential health service are therefore a threat to maternal health because of their damage to trust.

Finally, the legal conflicts that abortion bans create for providers and health care institutions do not just impact the well-being of individual patients, but also the needs of the larger patient community. Physicians must consider not only the risks to themselves if they are prosecuted, but also the risks to the community if the providers are prosecuted and lose their licenses. As Dr. Brandi notes, providers must try to

navigate how [to] provide care knowing that if [they] face the consequences, if [they] go to jail, if [they're] criminalized, that also means that the *community* may lose that provider, that that provider won't be able to provide the prenatal care that's needed, the gynecologic care that's needed in that space. That's a really challenging place to put providers in right now.²¹²

Draconian abortion laws may also reduce the number of providers in a community by driving away physicians who can no longer bear the significant toll of incompatible legal obligations. Dr. Kylie Cooper, a provider in Idaho, recently explained her decision to leave her medical practice in Idaho after its abortion ban was passed:

My life as a physician has been turned upside down. How do I keep my patients safe? How do I stay safe? The total abortion ban does not have exceptions, only affirmative defenses. An affirmative defense means that the burden of proof lies with physicians to prove their innocence. In court, the physician must prove that the procedure was necessary to avert death or was due to rape or incest. There is no defense to protect the health of the mother which is the most common scenario we face. I need to be able to protect my

²¹⁰ See *Effective Patient-Physician Communication*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Feb. 2021), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/effective-patient-physician-communication>.

²¹¹ See Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CALIF. L. REV. 781, 831 (2014).

²¹² Hutto, *supra* note 185 (emphasis added).

patients' lives, their health and future fertility without fear of becoming a felon. This fear is why I'm leaving Idaho.²¹³

Not only are abortion bans driving obstetricians and maternal-fetal specialists out of practice in certain states, but doctors in training may also decide not to pursue those fields in the first place in this difficult legal climate. Further complicating the access issue is the impact that abortion laws will have on efforts to provide standardized training for residents in obstetrics and gynecology. Almost half of residents in that field train in states "poised to ban abortions,"²¹⁴ which means that fewer doctors will have the skills to perform abortions.²¹⁵ This means that the lack of access for an essential part of obstetric care, which had already been an issue in many parts of America pre-*Dobbs*, will only intensify.

B. *Conflicts Between Health Care Providers and Patients*

So far, I have addressed challenges from the provider's or institution's perspective as to what care to provide when legal obligations pull them in mutually exclusive directions. In those cases, it is the draconian abortion laws that lead to conflicts of interest that would not otherwise exist between provider and patient. Sometimes, however, conflicts arise between providers and patients when patients do not want to follow the medical advice of a physician. These conflicts can arise with respect to any care, but they become more complex with respect to pregnancy because of the idea among obstetricians, beginning in the middle of the twentieth century, that the fetus is a "medically vulnerable second patient."²¹⁶ That perspective has led physicians to push or try to impose treatment in the interests of the fetus (and sometimes also the pregnant person), even if the patient does not consent. Michelle Oberman has noted that the obstetrical

²¹³ Kylie Cooper, *Idaho's Abortion Laws Put Mothers and Babies at Risk*, SPOKESMAN-REV. (Feb. 9, 2023), https://www.spokesman.com/stories/2023/feb/09/kylie-cooper-md-idahos-abortion-laws-put-mothers-a/?utm_source=substack&utm_medium=email.

²¹⁴ Samantha Liss, *Almost Half of Nation's OB-GYN Residents Train in States Poised to Ban Abortion*, HEALTHCARE DIVE (June 28, 2022), <https://www.healthcaredive.com/news/half-ob-gyn-residents-train-states-ban-abortion/626066>.

²¹⁵ Katia Riddle, *Changes to Abortion Laws Mean OB-GYNs Have Less Opportunities to Learn Procedure*, NPR (Oct. 6, 2022, 4:25 PM), <https://www.npr.org/2022/10/06/1127307423/changes-to-abortion-laws-mean-ob-gyns-have-less-opportunities-to-learn-procedure>.

²¹⁶ See Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451,473 (2000).

view that there are two patients imposes a double standard in medicine because it results in fewer rights for women.²¹⁷

There has, however, been a shift in this attitude among professional organizations like ACOG, which recently declared that “[p]regnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life.” Therefore, physicians should respect “a decisionally capable pregnant woman’s decision to refuse recommended medical or surgical interventions.”²¹⁸ After *Dobbs*, however, states may create policies that promote the view that pregnancy involves two patients of equal import—the pregnant person and the fetus—increasing the risk of conflicts between doctors and patients regarding maternal care.

Even when there was a constitutionally recognized right to an abortion, however, such conflicts still arose. And some ended up in court.²¹⁹ Many cases concerned the method of delivery, including physicians pushing for the invasive surgical cesarean-section (C-section), while the pregnant person insisted on vaginal delivery.²²⁰ In other instances, physicians insisted on blood transfusions for fetal (and sometimes also maternal) well-being, but the patient, for religious or other reasons, refused.²²¹ Such conflicts can also arise with respect to other medical treatments. For example, a patient may want to undergo chemotherapy for cancer treatment that would otherwise be medically indicated, while the physician may believe it is appropriate to delay care because of concerns about harms to the fetus.²²²

²¹⁷ See *id.* at 487–88.

²¹⁸ *Refusal of Medically Recommended Treatment During Pregnancy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (June 2016), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/06/refusal-of-medically-recommended-treatment-during-pregnancy>.

²¹⁹ See generally *In re AC*, 573 A.2d 1235 (D.C. App. 1990); *Raleigh Fitkin-Paul Morgan Mem’l Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964); *In re Matter of Jamaica Hosp.*, 491 N.Y.S.2d 898 (Sup. Ct. 1985); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

²²⁰ See, e.g., *In re AC*, 573 A.2d 1235; *In re Baby Boy Doe*, 632 N.E.2d 326.

²²¹ See, e.g., *Raleigh Fitkin-Paul Morgan Mem’l Hosp.*, 201 A.2d 537; *In re Matter of Jamaica Hosp.*, 491 N.Y.S.2d 900.

²²² See *supra* text accompanying notes 121, 139–141.

When these cases were litigated in the past, most courts balanced the interests of the state and the pregnant person.²²³ In other words, they weighed the state's interest in life, the fetal diagnosis and prognosis, and the maternal wishes and religious views, even though the constitutional right to abortion was still the law of the land. A small number, however, ruled that the pregnant person, like any other person engaged in making medical decisions, should decide.²²⁴ These courts saw the central issue as the pregnant person's bodily autonomy, and therefore they allowed the pregnant person's wishes to "control in virtually all cases."²²⁵ As one court observed, "the tenet common to all medical treatment cases" is "that any [competent] person has the right to make an informed choice . . . to accept or forgo medical treatment."²²⁶ Moreover, it pointed out, "courts do not compel one person to permit significant intrusion upon his or her bodily integrity for the benefit of another person's health."²²⁷

The *Dobbs* ruling, however, encourages or at least legitimizes courts in abortion-restrictive states to privilege fetal well-being even at the expense of the patients' bodily autonomy and even, potentially, health interests. As a result, one would expect even more courts not only to engage in balancing tests, but potentially to defer to fetal interests in resolving these conflicts.

The atmosphere in states that are highly protective of potential life encourages such conflicts even more. If states enact fetal personhood laws, as Georgia has done,²²⁸ and as scholars have described as the next step in the anti-choice movement,²²⁹ concerns

²²³ *Raleigh Fitkin-Paul Morgan Mem'l Hosp.*, 201 A.2d at 538; *In re Matter of Jamaica Hosp.*, 491 N.Y.S.2d at 899–900; *Jefferson*, 274 S.E.2d at 460.

²²⁴ See *In re AC*, 573 A.2d at 1252 (refusing to decide "whether, or in what circumstances, the state's interests can ever prevail over the interests of the pregnant patient" and noting that "some may doubt there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a cesarean section, against that person's will"); *In re Baby Boy Doe*, 632 N.E.2d at 330 (refusing to balance the interests of the fetus or the state's interest in fetal well-being against the competent pregnant person's decision, even if the physicians believe her decision could put the fetus at risk).

²²⁵ *In re AC*, 573 A.2d at 1252.

²²⁶ *Id.* at 1243.

²²⁷ *Id.* at 1243–44.

²²⁸ The LIFE Act, H.B. 481, 154th Leg. (Ga. 2019).

²²⁹ See, e.g., Mary Ziegler, *The Next Step in the Anti-Abortion Playbook Is Becoming Clear*, N.Y. TIMES (Aug. 31, 2002), <https://www.nytimes.com/2022/08/31/opinion/abortion-fetal-personhood.html>. Some have suggested that the political will for fetal personhood laws may be limited because of concerns about the impact of such laws on

about liability for harm to the fetus could push physicians to become even more aggressive in seeking court orders when patients refuse to follow the recommended course of prenatal care. If some physicians today feel duty bound to protect both fetus and patient, legal recognition of the fetus as a person will only intensify the two-patient perspective, and maybe even privilege fetal interests.

If these conflicts arise and lead to legal action, all the concerns described above regarding patients' diminished trust in their providers²³⁰ become an issue. In addition, worries about liability on behalf of the fetus or undue enthusiasm in pushing for fetal-protective procedures may impact the physician's judgment and assessment of the balance of risks. Evidence already suggests that there is a high rate of misdiagnosis in these cases, perhaps as much as 50 percent of the time.²³¹ Often the dire predictions that led to legal action did not manifest when the patient avoided or was not made to comply with physicians' recommendations. For example, in a case where the court allowed the pregnant person to refuse a C-section, the baby was born "normal and healthy" despite predictions that there was a zero-percent chance of the fetus surviving natural childbirth.²³² These conflicts also run the risk of leading to criminalizing certain prenatal behavior as the next section discusses.

C. Criminalization of Reproductive Behavior

Another threat to maternal health that has long existed, but which *Dobbs* intensifies, is the criminalization of reproductive behavior. Although there were no laws post-*Roe* that directly criminalized women's decisions to terminate a pregnancy, prosecutors nevertheless found ways to charge women for certain behaviors during pregnancy under various laws, such as child endangerment or child abuse.²³³ *Dobbs* has enhanced these threats for all pregnant people, although it

access to technologies like in vitro fertilization. I. Glenn Cohen, Judith Daar, & Eli Y. Adashi, *What Overturning Roe v Wade May Mean for Assisted Reproductive Technologies in the US*, 328 JAMA 15, 16 (2022), <https://doi.org/10.1001/jama.2022.10163>. Laws like Georgia's, however, make distinctions between personhood for conceptuses that are in utero and those that are in vitro, such as frozen embryos. See Ga. H.B. 481.

²³⁰ See *supra* text accompanying notes 208–211.

²³¹ J. Fletcher, *Drawing Moral Lines in Fetal Therapy*, 29 OBSTETRICS & GYNECOLOGY 595, 599 (1986).

²³² See *In re Baby Boy Doe*, 632 N.E.2d 326, 328–29 (Ill. App. 1994).

²³³ See Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299, 320–21 (2013).

remains true that the populations most at risk for prosecution are also the populations most vulnerable generally.

Dobbs also opens the door to state legislatures enacting laws that explicitly allow for prosecution of women who seek abortions. Although some legislatures have contemplated such laws,²³⁴ so far no state has included criminal penalties against the pregnant person in their abortion bans. But there is debate within the anti-choice movement about punishing pregnant people as a strategy to end abortions. While not all support this approach, a faction believes that abortion is murder and that pregnant people who terminate their pregnancies are accomplices to this crime.²³⁵

As abortion moves outside of clinics and as pregnant people increasingly self-manage abortions by obtaining medical abortion pills on their own,²³⁶ the pressures to prosecute women will mount because, without a physician to prosecute, it will otherwise be difficult to penalize the act. We have already begun to see evidence that this will become a strategy with the recent threat from a prosecutor in Alabama that he will prosecute women for undergoing medication abortions under Alabama's child endangerment law.²³⁷ Although he ultimately walked back the statement three days later,²³⁸ his original position fits right into the playbook of using non-abortion laws to penalize behavior during pregnancy. It is not hard to imagine others following suit with

²³⁴ Abolition of Abortion in Louisiana Act of 2022, H.B. 813 (La. 2022); Blake Ellis & Melanie Hicken, *These Male Politicians are Pushing for Women Who Receive Abortions to Be Punished with Prison Time*, CNN (Sept. 21, 2022, 12:33 AM), <https://www.cnn.com/2022/09/20/politics/abortion-bans-murder-charges-invs/index.html>.

²³⁵ See Oriana Gonzalez, *The Post-Roe Fight Dividing Anti-Abortion Activists*, AXIOS (Jan. 20, 2023), <https://www.axios.com/2023/01/20/anti-abortion-roe-anniversary-divide-prosecution> (“While mainstream anti-abortion messaging still revolves around sanctioning doctors or clinics, a small but growing group of self-described abortion abolitionists are taking steps to single out and punish those seeking to end a pregnancy.”).

²³⁶ See Roni Caryn Rabin, *Some Women ‘Self-Manage’ Abortions as Access Recedes*, N.Y. TIMES (Aug. 11, 2022), <https://www.nytimes.com/2022/08/07/health/abortion-self-managed-medication.html> (describing how women in states that have banned abortion are “‘self-managing’ their abortions, seeking out the necessary know-how online and obtaining the medications without the supervision of a clinic or a doctor”).

²³⁷ *Alabama Could Prosecute Patients for Taking Abortion Pills, Attorney General Says*, KAISER HEALTH NEWS (Jan. 12, 2023), <https://khn.org/morning-breakout/alabama-could-prosecute-patients-for-taking-abortion-pills-attorney-general-says>.

²³⁸ Lindsay Carr, *Alabama Attorney General Steps Back on Abortion Pill Prosecution Statement*, CONTEMPORARY OB/GYN (Jan. 16, 2023), <https://www.contemporaryobgyn.net/view/alabama-attorney-general-steps-back-on-abortion-pill-prosecution-statement>.

respect to his original sentiment. For all these reasons, one can expect a heightened risk of prosecuting pregnant people for abortions.

Even without laws that explicitly make pregnant people criminally liable for their abortions, plenty of laws can, and have, been applied to legal and illegal behavior during pregnancy, including illicit substance use and certain methods of delivery. Pregnant women have been charged with crimes for falling down the stairs, eating a poppy seed bagel, failing a drug test, or taking illegal drugs, even if the fetus did not die.²³⁹ Much of the efforts to criminalize pregnancy focused on the crack epidemic in the late 1980s and early 1990s, which helped to popularize the notion of fetal rights.²⁴⁰ By focusing on crack, a drug associated with low-income people of color, as opposed to other drugs or substances used widely by wealthier people, such as alcohol, it reinforced the racism surrounding these prosecutions.

Most infamously, a South Carolina hospital, working with law enforcement and social agencies, devised a plan intended to address drug use during pregnancy by threatening patients who tested positive for cocaine use with arrest if they did not enroll in a substance use treatment program.²⁴¹ The plan tested patients for cocaine—if they had received little or incomplete prenatal care—when they arrived to deliver their babies at the public hospital. Because the patients went to a public hospital, they tended to be low-income women and women of color.

After some of the women sued the hospital and others, in *Ferguson v. South Carolina*, the Supreme Court concluded that the entire process violated the Fourth Amendment as a warrantless search and seizure.²⁴² That decision, however, did not prevent other efforts to prosecute women for substance use during pregnancy on the grounds of fetal endangerment or harm to the fetus.²⁴³ While most state courts have rejected the use of child endangerment or abuse laws for such

²³⁹ *The Mothers Society Condemns*, N.Y. TIMES (Dec. 28, 2018), <https://www.nytimes.com/interactive/2018/12/28/opinion/abortion-law-poverty.html>.

²⁴⁰ *Id.*

²⁴¹ *Ferguson v. City of Charleston*, 532 U.S. 67, 70 (2001).

²⁴² *Id.* at 85–86.

²⁴³ *See, e.g.*, *State v. McKnight*, 575 S.E.2d 168, 174 (S.C. 2003) (upholding a homicide conviction for child abuse in using cocaine during pregnancy and suffering a still birth); *Ex Parte Ankrom*, 152 So. 3d 397, 421 (Ala. 2013) (upholding convictions for chemical endangerment of a child by ingesting illegal substances during pregnancy).

prosecutions,²⁴⁴ more than half of the states enacted statutes that directly prohibit feticide or harm to the fetus.²⁴⁵ Such laws have subjected women to arrest and prosecution, even with little or no evidence that their behavior caused fetal harm.²⁴⁶

A groundbreaking study of the arrests, detentions, and other related deprivations of pregnant women's physical liberty between 1973—when *Roe* was decided—and 2005 found 413 cases in forty-four states, the District of Columbia, and federal jurisdictions.²⁴⁷ In the estimation of the authors, Lynn Paltrow and Jeanne Flavin, 413 is likely a “substantial undercount.”²⁴⁸ Not surprisingly, the study also found that Black and poor women were “significantly more likely to be arrested, reported [to state authorities] by hospital staff, and subjected to felony charges.”²⁴⁹ More recently, a study of the criminalization of self-care between 2000 and 2020 found sixty-one cases of individuals in twenty-six states who were “criminally investigated or arrested for allegedly ending their own pregnancy or helping someone else do so.”²⁵⁰ Again, the most vulnerable were disproportionately affected relative to their representation in the larger population: forty-one percent were “minoritized racial and ethnic groups” and the majority (56 percent) of “adult cases that proceeded through court . . . involved people living in poverty.”²⁵¹ In Lynn Paltrow's words, “[w]e have taken what is fundamentally a health problem and made it into a criminal law problem. We've used the criminalization of certain drugs for . . . controlling certain groups of people, particularly [B]lack and brown people.”²⁵²

After *Dobbs*, one could imagine law enforcement pursuing criminal action even more broadly. First, the opinion dismisses the

²⁴⁴ See, e.g., *State v. Wade*, 232 S.W.3d 663, 666 (Mo. App. 2007); *State v. Martinez*, 137 P.3d 1195, 1198 (N.M. App. 2006); *State v. Aiwai*, 123 P.3d 1210, 1225 (Haw. 2005); *Reinesto v. Superior Ct.*, 894 P.2d 733, 734 (Ariz. App. 1995); *Johnson v. State*, 602 So. 2d 1288, 1296 (Fla. 1992).

²⁴⁵ See Paltrow & Flavin, *supra* note 233, at 322–23.

²⁴⁶ *Id.* at 318.

²⁴⁷ *Id.* at 309.

²⁴⁸ *Id.* at 304.

²⁴⁹ *Id.* at 333.

²⁵⁰ LAURA HUSS, FARAH DIAZ-TELLO & GOLEEN SAMARI, SELF-CARE, CRIMINALIZED: AUGUST 2022 PRELIMINARY FINDINGS, IF/WHEN/HOW: LAWYERING FOR REPRODUCTIVE JUSTICE 2 (2022), <https://www.ifwhenhow.org/resources/self-care-criminalized-preliminary-findings>.

²⁵¹ *Id.*

²⁵² *The Mothers Society Condemns*, *supra* note 239.

bodily autonomy concerns or agency of the pregnant person at any stage of pregnancy, even in the earliest stages when the odds of miscarriage are roughly 50 percent.²⁵³ State concern about fetal well-being throughout the pregnancy could therefore lead legislatures to enact additional laws that criminalize specific behaviors thought to endanger the fetus, even if not otherwise illegal. Hot tubs in the early stages of pregnancy increase the risk for certain birth defects.²⁵⁴ Certain foods, like sushi and feta cheese, are considered harmful to the fetus.²⁵⁵ Alcohol is a known teratogen, associated with fetal alcohol syndrome and impaired physical development.²⁵⁶ States might directly criminalize these activities and others, such as the failure to follow a doctor's recommendations for prenatal care, or prosecute such actions as forms of child endangerment or abuse. Again, the risks of such prosecutions increase if states enact fetal personhood laws because any harm to the fetus would be treated as harm to a person, potentially punishable as murder or manslaughter if the behavior is linked to fetal demise.

The risk of legal action in such scenarios, of course, is a serious intrusion on bodily autonomy. It also imposes profound dignitary harms by robbing a pregnant person of agency over her body and the ability to make deeply personal medical and lifestyle decisions. But the risks also have health implications for the individual pregnant person and for public health generally. First, these laws create the same kinds of conflicts of interest described earlier with respect to abortion bans.²⁵⁷ Second, as Michele Goodwin noted, criminalizing pregnancy behavior draws health care providers into the deeply problematic role of "primary detectives and enforcers of state fetal protection statutes, often with the support of police, prosecutors, and even judges," as occurred in *Ferguson v. City of Charleston*.²⁵⁸ As the study of

²⁵³ *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2284 (2022) ("These legitimate interests include respect for and preservation of prenatal life at all stages of development.").

²⁵⁴ AJ Agopian et al., *A Case-Control Study of Maternal Bathing Habits and Risk for Birth Defects in Offspring*, ENV'T HEALTH, 2013, at 1, 2.

²⁵⁵ *People at Risk: Pregnant Women*, FOODSAFETY.GOV (Sept. 25, 2020), <https://www.foodsafety.gov/people-at-risk/pregnant-women>.

²⁵⁶ Dae D. Chung et al., *Toxic and Teratogenic Effects of Prenatal Alcohol Exposure on Fetal Development, Adolescence, and Adulthood*, 22 INT'L J. MOLECULAR SCIS., Aug. 16, 2021, at 1, 1.

²⁵⁷ See *supra* Part II.A.

²⁵⁸ See Goodwin, *supra* note 211, at 812, 824–26; *Ferguson v. City of Charleston*, 532 U.S. 67, 70–71, 73 (2001).

criminalization of self-care found, most cases came to the attention of law enforcement through mandatory reporters: health care providers reported in 39 percent of the cases; social workers in 6 percent.²⁵⁹

These dual roles of providing care for patients and reporting them for criminal investigations can cause several problems. First, health care providers may misinterpret the laws leading to criminal investigations that are not warranted under the law. Second, providers may “subordinate medical judgment and diagnostic objectives to their criminal law enforcement responsibilities,” potentially making them “prioritize criminal punishment over fiduciary responsibilities to patients.”²⁶⁰ This can lead to incorrect diagnoses or assessments of risks. In fact, the Paltrow and Flavin study found that a major factor leading to arrests, detentions and interventions of pregnant people was “[m]edical misinformation and ignorance about science and evidence-based research, particularly regarding drug use and pregnant women.”²⁶¹

The intersection between health care and law enforcement has other health implications in its corruption of the doctor-patient relationship. Again, it erodes trust, which as noted earlier can impede and impoverish medical care.²⁶² In this context, especially, it may also prevent pregnant patients from seeking important prenatal care in the first place, with serious health risks for both the fetus and the mother²⁶³ Timely medical care is crucial in detecting, preventing, and ameliorating serious conditions that can arise during pregnancy such as preeclampsia, gestational diabetes, and infections.²⁶⁴ Moreover, criminalization is counterproductive. As numerous medical organizations pointed out with respect to substance abuse, long before

²⁵⁹ HUSS ET AL., *supra* note 250, at 3.

²⁶⁰ Goodwin, *supra* note 211, at 813.

²⁶¹ *Executive Summary: Arrests of and Forced Interventions on Pregnant Women in the United States (1973–2005): Implications for Women’s Legal Status and Public Health*, PREGNANCY JUST. (Jan. 25, 2013), https://www.pregnancyjusticeus.org/executive_summary_paltrow_flavin_jhpl_article.

²⁶² See *supra* text accompanying notes 208–211.

²⁶³ George Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213, 1214 (1987).

²⁶⁴ See, e.g., *During Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 20, 2022), <https://www.cdc.gov/pregnancy/during.html>; *Gestational Diabetes and Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 14, 2022), <https://www.cdc.gov/pregnancy/diabetes-gestational.html>.

Dobbs became the law of the land, criminalizing drug addiction is not effective because it is not a crime, but a disease.²⁶⁵

Further, when concerns about fetal well-being lead to criminal punishment, the punishment itself is a threat to maternal well-being. Prison conditions are highly stressful, violent and abusive, and prisons often provide substandard health care.²⁶⁶ Professor Goodwin describes disturbing cases of shackling pregnant patients, even when they receive medical checkups, which undermines their health, not to mention their mental well-being and dignity.²⁶⁷ When shackling occurs during delivery, the harms are even more dangerous, given the risk that impaired movement could cause injury and impede the ability to find optimal positions for delivery.²⁶⁸

Finally, public health harms arise when criminalizing behavior in pregnancy disproportionately impacts already vulnerable populations. As noted, racial and economic disparities marked the policing of pregnancy even before *Dobbs* allowed abortion to be criminalized.²⁶⁹ There is every reason to believe that such disparities will continue as states become more aggressive in policing pregnancy as *Dobbs* allows—or even encourages—them to do. As the authors of *Self-Care, Criminalized* suggested just months after the Court decided *Dobbs*, the deployment of “trigger bans” across the nation “portends an increase

²⁶⁵ NAT’L PERINATAL ASS’N, NPA POSITION STATEMENT 2017: PERINATAL SUBSTANCE USE 2 (2017), https://www.nationalperinatal.org/_files/ugd/209d80_6c125977cd764f67933962492fd13b97.pdf; see also COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OP. NO. 473: SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST 1 (*reaff’d*, 2014), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy.pdf> (encouraging ACOG members to work with legislators to repeal laws that target substance use during pregnancy).

²⁶⁶ See NICOLETTE WOLFREY, NAT’L P’SHP FOR WOMEN & FAMILIES, NAT’L BIRTH EQUITY COLLABORATIVE, MOMS & BABIES SERIES: INCARCERATION HARMS MOMS AND BABIES 1 (2021), <https://www.nationalpartnership.org/our-work/resources/health-care/incarceration-hurts-moms.pdf> (citing Soumyadeep Mukherjee et al., *Mental Health Issues Among Pregnant Women in Correctional Facilities: A Systematic Review*, 54 WOMEN & HEALTH 816 (2014)).

²⁶⁷ See Goodwin, *supra* note 211, at 835, 837.

²⁶⁸ AM. COLL. OF NURSE-MIDWIVES, POSITION STATEMENT: SHACKLING/RESTRAINT OF PREGNANT WOMEN WHO ARE INCARCERATED (2012), <http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000276/Anti-Shackling%20Position%20Statement%20June%202012.pdf>.

²⁶⁹ See *supra* text accompanying notes 249–252.

in criminalization driven more by stigma than the letter of the law.”²⁷⁰ When these populations already face higher rates of maternal morbidity and mortality, with Black women facing over three times the rates of maternal mortality than white women,²⁷¹ the effects of enhanced criminalization during pregnancy will only exacerbate these harms and disparities.

D. Dobbs and Disparities in Research on Women

We turn now to a context outside of the doctor-patient relationship—clinical research. In this realm, *Dobbs* may also have an indirect impact on maternal health by discouraging clinical and pharmaceutical research on women, at least in some jurisdictions. Historically, such research has been notoriously limited compared to that of men. As one commentator puts it, “[f]emales remain broadly under-represented in the medical literature, sex and gender are poorly reported and inadequately analyzed in research, and misogynistic perceptions continue to permeate the narrative.”²⁷² Classic examples of these disparities are seen in federally funded studies on the role of aspirin in preventing heart attacks and the role of cholesterol level in heart disease; none of the thousands of participants enrolled in those studies were women.²⁷³

Some commentators attribute the exclusion of women from research in part to the disproportionate number of male researchers, which has “led to a bias in the choice and definition of problems with which scientists have concerned themselves,” particularly in the health sciences.”²⁷⁴ Researchers justify these exclusions because of concerns

²⁷⁰ HUSS ET AL., *supra* note 250, at 4.

²⁷¹ Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KAISER FAM. FOUND. (Nov. 1, 2022), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them>.

²⁷² Lea Merone et al., *Sex Inequalities in Medical Research: A Systematic Scoping Review of the Literature*, 3 WOMEN’S HEALTH REPS. 49, 49 (2022), <https://www.liebertpub.com/doi/10.1089/whr.2021.0083>.

²⁷³ See Paul Cotton, *Examples Abound of Gaps in Medical Knowledge Because of Groups Excluded from Scientific Study*, 263 JAMA 1051, 1055 (1990).

²⁷⁴ Terri D. Keville, *The Invisible Woman: Gender Bias in Medical Research*, 15 WOMEN’S RTS. L. REP. 123, 125 (1994) (quoting Evelyn Fox Keller, *Feminism and Science*, in *SEX AND SCIENTIFIC INQUIRY* 234 (Sandra Harding & Jean F. O’Barr eds., 1987)). “Historically, male researchers have either ignored matters of women’s health, or they have directed their attentions to specific areas of women’s anatomy in order to perpetuate societal norms regarding women’s roles and functions.” *Id.* Keville points to some absurd examples of this bias, including a study that examined “the impact of

about the practicability of research or health risks. For example, they cite worries (largely unfounded) that fluctuations in female hormone levels related to their menstrual cycles can make research more complicated and costly.²⁷⁵ They also point to threats to fetal well-being and liability risks for researchers if women should become pregnant during a clinical trial.²⁷⁶

This latter concern was amplified by the tragic history of physicians prescribing drugs during pregnancy that were later found to be teratogenic. For example, thalidomide, an anti-nausea medicine, was found to cause limb birth defects,²⁷⁷ and diethylstilbestrol (“DES”), a drug intended to prevent miscarriages, was found to cause cancer in the daughters of women who took DES.²⁷⁸ As a result of the thalidomide tragedies, the FDA issued “General Considerations for the Clinical Evaluation of Drugs” in 1977,²⁷⁹ which determined when women of child-bearing potential could participate in the three phases of clinical trials: Phase I investigates “a new drug’s safety and dose range” in a relatively small number of research participants; Phase II investigates an experimental drug’s effectiveness in treating a particular condition in a larger group of volunteers; and finally Phase III investigates both the safety and effectiveness of the new drug on a

obesity on breast and uterine cancer” using only male research participants. *Id.* at 126–27.

²⁷⁵ *Id.* at 127; see Yasmin Anwar, *Lack of Females in Drug Dose Trials Leads to Overmedicated Women*, BERKELEY NEWS (Aug. 12, 2020), <https://news.berkeley.edu/2020/08/12/lack-of-females-in-drug-dose-trials-leads-to-overmedicated-women>.

²⁷⁶ Keville, *supra* note 274, at 127 (describing concerns about fetal well-being); Anna C. Mastroianni et al., *Research with Pregnant Women: New Insights on Legal Decision-Making*, 47 HASTINGS CTR. REP. 38, 38 (2017) (describing concerns about liability risks).

²⁷⁷ James H. Kim & Anthony R. Scialli, *Thalidomide: The Tragedy of Birth Defects and the Effective Treatment of Disease*, 122 TOXICOLOGICAL SCIS. 1, 1 (2011), <https://pubmed.ncbi.nlm.nih.gov/21507989/>; Marci D. Cottingham & Jill A. Fisher, *Gendered Logics of Biomedical Research: Women in U.S. Phase I Clinical Trials*, 69 SOC. PROBS. 492, 494 (2020) (citing Kim & Scialli, *supra*).

²⁷⁸ Casey E. Reed & Suzanne E. Fenton, *Exposure to Diethylstilbestrol During Sensitive Life Stages: A Legacy of Heritable Health Effects*, 99 BIRTH DEFECTS RSCH. PART C 134, 134 (2013), <https://onlinelibrary.wiley.com/doi/epdf/10.1002/bdrc.21035>.

²⁷⁹ Katherine A. Liu & Natalie A. DiPietro Mager, *Women’s Involvement in Clinical Trials: Historical Perspective and Future Implications*, PHARMACY PRAC., Feb. 16, 2016, at 3, <https://www.pharmacypractice.org/index.php/pp/article/view/708/424>; see also *id.* (“The term ‘child-bearing potential’ was defined widely as any woman capable of becoming pregnant, including premenopausal single abstinent women, women using contraceptives, or women with sterile partners.”).

much larger group of participants.²⁸⁰ The FDA considerations stated that women of child-bearing potential should be excluded from Phase I and early Phase II research unless the research was aimed at testing drugs for life-threatening illnesses.²⁸¹ Only after evidence that the benefits sufficiently outweighed the risks could women participate “in later Phase II and Phase III trials if animal teratogenicity and fertility studies were finished.”²⁸²

This set of concerns led to “a climate of paternalistic and protectionist agendas regarding women’s role in clinical trials.”²⁸³ Some have suggested that this climate reinforces stereotypes about women as “‘walking wombs’ who are incapable of making responsible decisions about their own bodies.”²⁸⁴ And it prioritizes fetal health over the need to understand women’s health. Of course, the rationale has no basis in certain studies when female patients are likely to be past their reproductive years, such as studies of heart disease in which most women are postmenopausal.²⁸⁵

Sex-based disparities in clinical research came to the attention of policy makers in the mid-1980s. In 1985, for example, the United States Public Health Service Task Force on Women’s Health Issues highlighted how women’s exclusion from research made it difficult to understand their health needs.²⁸⁶ The report led to the passage of the National Institutes of Health Revitalization Act of 1993, which directed the National Institutes of Health (NIH) to establish guidelines for the inclusion of women and minorities in clinical research.²⁸⁷ As a result, NIH developed a policy that encouraged, but did not require, NIH-funded research to include female research participants; but if studies

²⁸⁰ *Clinical Trials Phases Defined*, UNIV. OF CINCINNATI COLL. OF MED., <https://med.uc.edu/depart/psychiatry/research/clinical-research/crm/trial-phases-1-2-3-defined>; *Step 3: Clinical Research*, FDA (Jan. 4, 2018), <https://www.fda.gov/patients/drug-development-process/step-3-clinical-research>.

²⁸¹ Liu & Mager, *supra* note 279, at 3.

²⁸² *Id.*

²⁸³ Cottingham & Fisher, *supra* note 277, at 494 (citing Oonagh P. Corrigan, “*First in Man*”: *The Politics and Ethics of Women in Clinical Drug Trials*, 72 FEMINIST REV. 40 (2002)).

²⁸⁴ Keville, *supra* note 274, at 127 (footnote omitted).

²⁸⁵ *See id.*

²⁸⁶ *See id.* at 126.

²⁸⁷ Public Health Service Act, Pub. L. No. 103-43, §§ 1(a), 492B, 107 Stat. 122 (1993) (codified as amended at 42 U.S.C. § 289a-2), <https://www.congress.gov/bill/103rd-congress/senate-bill/1/text>.

excluded women, they were required to explain their exclusion.²⁸⁸ Unfortunately, various factors, including a four-year delay in publishing the implementation guidelines, meant that many researchers receiving NIH dollars did not understand, or were not even aware, of this policy and that the different institutes within the NIH interpreted the policy differently.²⁸⁹ In addition, the policy did not apply to intramural research, and the NIH merely recommended, but did not implement, the exhortation that “researchers analyze their data to determine gender differences.”²⁹⁰ Nor was there any mechanism developed to monitor the policy’s effect to assess its potential impact.²⁹¹

The federal government has recently made efforts to expand diversity in clinical trials with respect to both women and minorities.²⁹² Applications for NIH-funded clinical studies on or after January 25, 2019, for example, must include descriptions of “planned distribution of subjects by sex/gender, race, and ethnicity,” the “rationale for selection of sex/gender, racial, and ethnic group members in terms of the scientific objectives and proposed study design,” and “reason[s] for limiting inclusion of any group by sex/gender, race, and/or ethnicity.”²⁹³

These guidelines, however, place a greater emphasis on diversity in the later stages of clinical trials. Under NIH policy, only Phase III studies are required to include how sex, gender, race, and ethnicity “will be taken into consideration in the design and valid analysis of the trial.”²⁹⁴ Additionally, in the process of proposing a Phase III clinical

²⁸⁸ Keville, *supra* note 274, at 126.

²⁸⁹ *Id.* (“Some institutes considered inclusion or exclusion of female subjects to be one criterion in evaluating the scientific merit of grant proposals, while other NIH divisions instructed grant reviewers to regard the gender of research subjects as a separate factor unrelated to scientific merit.”).

²⁹⁰ *Id.*

²⁹¹ *Id.*

²⁹² See, e.g., H.R. Res. 7667, 117th Cong. § 501(a)(5)(A) (as received in Senate, June 9, 2022); U.S. DEP’T OF HEALTH & HUM. SERVS., GENERAL INSTRUCTIONS FOR NIH AND OTHER PHS AGENCIES: SF424 (R&R) APPLICATION PACKAGES G.-252 (2018), <https://grants.nih.gov/grants/how-to-apply-application-guide/forms-e/general-forms-e.pdf>; *NIH Guidelines: Inclusion of Women and Minorities*, ORWH, <https://orwh.od.nih.gov/toolkit/nih-policies-inclusion/guidelines> (last visited Apr. 23, 2023); Max Kozlov, *FDA to Require Diversity Plan for Clinical Trials*, NATURE (Feb. 16, 2023), <https://www.nature.com/articles/d41586-023-00469-4>.

²⁹³ U.S. DEP’T OF HEALTH & HUM. SERVS., *supra* note 292.

²⁹⁴ *Id.*

trial, investigators are required to anticipate “clinically relevant differences” in results based on sex, gender, race, or ethnicity.²⁹⁵

Like the NIH, the FDA treats Phase I/II and Phase III clinical trials differently with respect to diversity of research participants.²⁹⁶ In 1993, despite removing roadblocks to inclusion of women in early phases of clinical trials, the FDA stated that it “[did] not at [that] time perceive a regulatory basis for requiring routinely that women in general or women of childbearing potential be included in particular trials, such as phase I studies.”²⁹⁷ The result is that women’s inclusion in Phase I trials is largely left to the discretion of the pharmaceutical company conducting the research.²⁹⁸

More recently, the FDA appears to be considering even more expansion of diversity requirements for Phase III clinical trial participants,²⁹⁹ and proposed legislation to amend the Food, Drug, and Cosmetic Act would add a requirement for a diversity action plan.³⁰⁰ There is, however, a provision in the proposed law that would allow “the FDA to waive the need for a diversity-action plan in certain circumstances; for example, during public-health emergencies, or if a disease or condition is not considered prevalent in the general population.”³⁰¹ This would provide the FDA some wiggle room regarding how stringently pharmaceutical companies must follow this requirement.³⁰²

The Common Rule, which guides federally funded research, also emphasizes that the selection of subjects should be equitable, with attention to the “purposes of the research and the setting” in which it

²⁹⁵ *NIH Guidelines: Inclusion of Women and Minorities*, NAT’L INSTS. OF HEALTH: OFF. OF RSCH. ON WOMEN’S HEALTH, <https://orwh.od.nih.gov/toolkit/nih-policies-inclusion/guidelines> (last visited Apr. 29, 2023).

²⁹⁶ Guideline for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs, 58 Fed. Reg. 39,406, 39,408 (July 22, 1993).

²⁹⁷ FDA itself described the shift from excluding women in Phase I and Phase II as “consistent with congressional efforts to prevent *unwarranted discrimination* against such women.” *Id.* (emphasis added).

²⁹⁸ Cottingham & Fisher, *supra* note 277, at 494 (citing Oonagh P. Corrigan, *First in Man: The Politics and Ethics of Women in Clinical Drug Trials*, FEMINIST REV., 2002, at 40).

²⁹⁹ Kozlov, *supra* note 292; H.R. 7667, 117th Cong. § 501(a)(5)(A) (2022).

³⁰⁰ H.R. 7667, 117th Cong. § 501(a)(5)(A) (2022).

³⁰¹ Kozlov, *supra* note 292.

³⁰² *Id.*

will be conducted.³⁰³ This requirement also seems to push for greater inclusion of women in trials.

The Common Rule also urges institutional review boards, which approve human research protocols, to be “particularly cognizant of the special problems” of populations that are “vulnerable to coercion or undue influence.”³⁰⁴ Prior to its 2018 amendments, the list of such groups included pregnant women.³⁰⁵ In response to criticisms that including pregnant women among those considered vulnerable was degrading to women, the revised version of the Common Rule removed pregnant women from that category.³⁰⁶ But it still retains special protections for pregnant women.³⁰⁷

Finally, there have been recent efforts to include *pregnant* women in clinical trials. In 2018, the Food and Drug Administration (FDA) issued draft guidance that highlighted challenges in properly labeling drugs for pregnant women due to a lack of clinical data.³⁰⁸ The FDA observed that “frequent lack of information based on clinical data often leaves the health care provider (HCP) and the patient reluctant

³⁰³ 45 C.F.R. § 46.111(a)(3) (2018). The Department of Health and Human Services regulates “the protection of human subjects in research” through what is known as the Common Rule. 45 *CFR* 46, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html> (last visited May 15, 2023). The regulations draw heavily from the ethical principles that the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research outlined in the Belmont Report in 1979. “The Federal Policy for the Protection of Human Subjects (also known as the ‘Common Rule’ and codified for HHS at 45 C.F.R. pt. 46(A)) was originally promulgated in 1991 and amended in 2005.” *Excerpts from the January 19, 2017 Revised Common Rule Preamble*, U.S. DEP’T OF HEALTH & HUM. SERVS. <https://www.hhs.gov/ohrp/regulations-and-policy/regulations/2018-req-preamble/index.html> (last visited May 15, 2023). The Common Rule was revised in 2017 and amended twice, with the final version of the rule, the “2018 Requirements” published on June 19, 2018. *Id.*

³⁰⁴ Federal Policy for the Protection of Human Subjects, 82 Fed. Reg. 7149, 7264 (Jan. 19, 2017).

³⁰⁵ 45 C.F.R. § 46.111(a)(3) (2009); § 46.111(a)(3) (2018) (describing vulnerable groups as limited to “children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons”).

³⁰⁶ Federal Policy for the Protection of Human Subjects, 82 Fed. Reg. at 7203–04 (to be codified at 45 C.F.R. pt. 46) (agreeing with “[a] majority of the comments [which] stated that the inclusion of pregnant women as an example of a group that might be vulnerable to coercion or undue influence was inappropriate . . . [and even] insulting to those populations”); § 46.111(a)(3) (2018).

³⁰⁷ § 46.204.

³⁰⁸ *See generally*, U.S. FOOD & DRUG ADMIN., PREGNANT WOMEN: SCIENTIFIC AND ETHICAL CONSIDERATIONS FOR INCLUSION IN CLINICAL TRIALS GUIDANCE FOR INDUSTRY 2 (2018) (draft guidance).

to treat the underlying condition, which in some cases may result in more harm to the woman and the fetus than if she had been treated.”³⁰⁹ Under its draft guidance, concerns about including pregnant women, or any women, in clinical trials can be mitigated through unblinding the trial if a woman becomes pregnant, and by providing informed consent so that the pregnant woman can decide whether the benefits for herself, and potentially her fetus, “outweigh the risks.”³¹⁰

All of these policies and attention to sex disparities in research have led to greater inclusion of women as research participants since the 1990s.³¹¹ But even with those improvements, women and pregnant women remain underrepresented in clinical trials, which is harmful to women by leading to inadequate or even inappropriate health care. A 1993 article noted several areas where treatment for women was delayed or limited compared to men: delayed diagnosis of serious heart issues, less aggressive treatment for coronary heart disease and heart attacks, greater tendency to discount chest pains, lower likelihood of providing kidney transplants or dialysis treatment, and lower likelihood of ordering tests to detect lung cancer.³¹² The article also pointed to inadequate research on treatments for conditions like breast cancer and a tendency to rely on hysterectomies for reproductive issues because of limited exploration of alternatives to surgery.³¹³

Thirty years later, we see many of the same problems. For example, recent data show that women are still underrepresented in trials relative to the proportion of women affected by the disease studied, including cardiovascular disease (women are 49 percent of the disease population but only 42 percent of the human participants),

³⁰⁹ *Id.*

³¹⁰ *Id.* at 8. In fact, the FDA states that [i]f fetal exposure has already occurred, a woman who becomes pregnant while enrolled in a clinical trial should be allowed to continue on the investigational drug if the potential benefits of continued treatment for the woman outweigh the risks of ongoing fetal exposure to the investigational drug, of discontinuing maternal therapy, and/or of exposing the fetus to additional drugs if placed on an alternative therapy.

Id.

³¹¹ Elizabeth Pratt, *We Don't Have Enough Women in Clinical Trials—Why That's a Problem*, HEALTHLINE (Oct. 25, 2020), <http://www.healthline.com> (search by the title listed here in the search bar; then click on “Women Underrepresented in Clinical Trials: Why That's a Problem”).

³¹² Keville, *supra* note 274, at 128–29.

³¹³ *Id.* at 130–31.

cancer research (women are 51 percent of the patients but only 41 percent of human participants), and psychiatric conditions (women are 60 percent of patients, but only 42 percent of participants).³¹⁴ There is also a lower likelihood that women will be offered tests for chronic obstructive pulmonary disease compared to men, resulting in under- or later diagnosis and more limited treatment options or even misdiagnosis of the condition.³¹⁵ Similarly, women are under- or misdiagnosed for cardiovascular disease relative to men because of “the erroneous notion,” rooted in the underrepresentation of women in clinical trials, that women are not at the same risk for this condition as men.³¹⁶

A related problem is inadequate understanding of the impact of drugs on women, including appropriate dosage, benefits, and/or side effects.³¹⁷ For example, even though women may be well represented in Phase III studies of pharmaceutical products today, dosing regimens are based on trials in earlier phases where women remain underrepresented.³¹⁸ As noted, early phase trials help researchers understand how drugs work,³¹⁹ which is another reason to include women in research at those stages. Relying on data from research on clinical drug trials with men when making determinations about how to prescribe drugs for women is problematic because the data cannot necessarily be extrapolated to women. Important differences between men and women in many areas—hormone levels, weight, body fat,

³¹⁴ Alexandra Z. Sosinsky et al., *Enrollment of Female Participants in United States Drug and Device Phase 1–3 Clinical Trials Between 2016 and 2019*, 115 CONTEMP. CLINICAL TRIALS 1, 3–4 (2022), <https://www.sciencedirect.com/science/article/pii/S1551714422000441?via%3Dihub>; see also Amy Westervelt, *The Medical Research Gender Gap: How Excluding Women From Clinical Trials is Hurting Our Health*, GUARDIAN (Apr. 30, 2015), <https://www.theguardian.com/lifeandstyle/2015/apr/30/fda-clinical-trials-gender-gap-epa-nih-institute-of-medicine-cardiovascular-disease>.

³¹⁵ Jamie Garfield, *The Surprising Facts About Women and COPD*, TEMPLE HEALTH (Jan. 21, 2022), <https://www.templehealth.org/about/blog/surprising-facts-about-women-and-copd>; see also Kenneth R. Chapman et al., *Gender Bias in the Diagnosis of COPD*, 119 CHEST J. 1691, 1693 (2001), [https://journal.chestnet.org/article/S0012-3692\(15\)52314-3/fulltext](https://journal.chestnet.org/article/S0012-3692(15)52314-3/fulltext).

³¹⁶ Essraa Bayoumi & Pamela Karasik, *Cardiovascular Disease in Older Women*, 37 CLINICS GERIATRIC MED. 651, 651–52 (Nov. 2021), <https://www.sciencedirect.com/science/article/abs/pii/S0749069021000446>.

³¹⁷ Yasmin Anwar, *Lack of Females in Drug Dose Trials Leads to Overmedicated Women*, BERKELEY NEWS (Aug. 12, 2020), <https://news.berkeley.edu/2020/08/12/lack-of-females-in-drug-dose-trials-leads-to-overmedicated-women>.

³¹⁸ Pratt, *supra* note 311.

³¹⁹ *Id.*; see also *supra* text accompanying note 280.

muscle mass, metabolic enzymes, etc.—can affect pharmacokinetic and pharmacodynamic parameters of pharmaceutical products.³²⁰

Finally, including pregnant women in clinical trials is important for several public health reasons as the FDA noted. Their inclusion is valuable because women “need safe and effective treatment during pregnancy.”³²¹ In addition, a “[f]ailure to establish the dose/dosing regimen, safety, and efficacy of treatments during pregnancy may compromise the health of women and their fetuses.”³²² Finally, sometimes, enrolling “pregnant women in clinical trials may offer the possibility of direct benefit to the woman and/or fetus that is unavailable outside the research setting.”³²³

Even greater efforts to ensure adequate representation of women and pregnant women in trials are needed for all the reasons described above. But in the post-*Dobbs* world, that may be difficult in abortion-restrictive states. Although the federal government regulates federally funded human subjects research or research that leads to FDA approval of drugs, state laws can impose added restrictions or regulations. A state’s focus on fetal life, which the *Dobbs* decision encourages, may lead to restrictions against including pregnant women in clinical trials. States may regulate research beyond actual pregnancy to the *possibility* of pregnancy to protect fetal health. One way of doing that is to restrict all women’s ability to participate in clinical trials. For women of child-bearing years in particular, even careful efforts to avoid pregnancy can fail, and therefore any research on women could potentially result in research on pregnant women. States could reason that preventing harm to the potential fetus warrants women’s exclusion as participants even at the expense of ensuring better representation of women in clinical research to study disease and develop pharmaceutical treatments for women.³²⁴

Sociologist Miranda Waggoner has described the concept of “anticipatory motherhood,” which is “a framework that positions *all* women of childbearing age as ‘prepregnant’ and exhorts them to

³²⁰ Liu & Mager, *supra* note 279, at 2 (providing examples such as the risk of “potentially fatal arrhythmia, after taking drugs which prolong QT interval” and finding that the same dose of zolpidem led to two times the levels of the drug in women as compared to men).

³²¹ U.S. FOOD & DRUG ADMIN., *supra* note 308, at 3.

³²² *Id.*

³²³ *Id.*

³²⁴ *Cf.* Cottingham & Fisher, *supra* note 277, at 492–95 (2022).

minimize health risks to phantom fetuses and future pregnancies.”³²⁵ She points out that treating women as “prepregnant” “conflate[s] women’s health and maternal health” and “exalts women as mothers and not women qua women.”³²⁶ This is precisely what the *Dobbs* opinion does. It treats women as merely a vessel for the fetus, and it fails to acknowledge pregnant people’s agency over their bodies. The following quote was written with respect to biases in research, but it seems even more fitting in a post-*Dobbs* world: “In this climate, the potential benefits of sex-based scientific research for its subsequent higher validity to women as medical consumers can be overshadowed by looming concerns for future children.”³²⁷

Efforts to protect fetal well-being by restricting women from participating in research implicate bodily integrity concerns for women. In addition, they undermine our ability to understand disease and drug treatment in women generally, which is a public health harm. If some states enact laws prohibiting pregnant women or women of child-bearing years from joining clinical trials, those laws might allow NIH-funded research in those states to be exempt from the federal requirements to try to expand inclusion of women in trials. Such laws might, for example, qualify as explanations for exclusion of women under NIH policies or potentially qualify as an exception under the proposed FDA guidelines.³²⁸

Even without state laws banning women’s participation in clinical trials, draconian abortion laws themselves might deter women’s willingness to participate in clinical trials for drugs or other interventions. Women in states with abortion bans might worry about the inability to obtain an abortion should they become pregnant. If unintended pregnancies occur during a clinical drug trial, for example, participants may feel uneasy not knowing about the safety of a drug they have ingested and may therefore want to terminate a

³²⁵ *Id.* (quoting Miranda R. Waggoner, *Motherhood Preconceived: The Emergence of the Preconception Health and Health Care Initiative*, 38 J. HEALTH POLS., POL’Y & L. 345, 347 (2013)).

³²⁶ *Id.* Anticipatory motherhood also assumes that “women are mothers-in-waiting and that it is the job of public health and medicine to control women’s bodies for the sake of the greater good.” MIRANDA R. WAGGONER, *THE ZERO TRIMESTER: PRE-PREGNANCY CARE AND THE POLITICS OF REPRODUCTIVE RISK* 7 (2017).

³²⁷ Cottingham & Fisher, *supra* note 277, at 494.

³²⁸ See *supra* text accompanying note 288.

pregnancy.³²⁹ The risks associated with the loss of this option might dissuade many women who would otherwise choose to participate in clinical trials from deciding to do so.

Finally, potential female research participants may be leery of FDA requirements that investigators verify that women enrolled in studies are not pregnant when the trial starts and that they monitor for pregnancy throughout the trial.³³⁰ In some jurisdictions, participants may worry about research entities gathering information about their reproductive state to determine if they become pregnant at any point of the trial. Given the concerns about potential criminalization of pregnancy,³³¹ one can imagine how any kind of reproductive monitoring would be a further deterrent to participation in clinical trials for women in their reproductive years.

Wariness regarding research participation would likely be even greater for minority women given the problematic history of unethical medical experimentation and research abuse on people of color in the United States, including but not limited to the Tuskegee experiments.³³² That fact alone has discouraged minorities from participating in research.³³³ Given our history of criminalizing pregnancy, particularly for Black and brown women, we should expect such women to be even more reluctant to participate in research than we already see in minority communities. Just as underrepresentation of women in research harms their maternal health, so too does underrepresentation of minorities. In this context, the intersection of gender and race only compounds the threats to women of color, just as abortion restrictions have done before *Dobbs* and as they will continue to do even more forcefully after *Dobbs*.

³²⁹ Jennifer Lubell, *Abortion Debate May Affect the Way Pregnant Women and Their Physicians Approach Teratogenic Medications*, MEDSCAPE (May 26, 2022), https://www.medscape.com/viewarticle/974677#vp_3.

³³⁰ Liu & Mager, *supra* note 279, at 6.

³³¹ See *supra* Part II.C.

³³² Darcell P. Scharff et al., *More than Tuskegee: Understanding Mistrust about Research Participation*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 879, 885–86 (2010).

³³³ *Id.* at 883–85.

III. MOVING FORWARD

Given that Supreme Court jurisprudence regarding abortion is not likely to change in the near future, there are limits to how much some of the threats to maternal health after *Dobbs* can be ameliorated. Even so, some things can be done to address the concerns described above.

First, lawyers can challenge the laws in both state and federal courts. At the state level, this may have some real potential to improve the legal landscape because state constitutions may provide rights not found by the current Supreme Court under the federal Constitution.³³⁴

At the federal level, litigation should press more broadly for different theories on which to support the right to abortion under the U.S. Constitution. Recently, for example, a U.S. District Court Judge suggested that the *Dobbs* ruling only held that the Fourteenth Amendment provided no basis for a right to abortion.³³⁵ She reasoned that the opinion left open the possibility for other legal bases on which to find the right, including potentially the Thirteenth Amendment.³³⁶ Noting legal scholarship and a court case that made such an argument, she asked the parties in a criminal case against several anti-abortion activists to address “whether the scope of *Dobbs* is in fact confined to the Fourteenth Amendment and [] whether, if so, any other provision of the Constitution could confer a right to abortion as an original matter”³³⁷

Challenges at the federal level can also attack the lack of certain exceptions in state laws, arguing that even under *Dobbs* the Constitution requires such exceptions. Although the *Dobbs* Court

³³⁴ South Carolina is an example of a state where the State Supreme Court had found a constitutional right to privacy under its constitution and therefore overturned the state’s Fetal Heartbeat and Protection from Abortion Act, which prohibited abortions after six weeks gestation. *Planned Parenthood S. Atl. v. State*, 882 S.E.2d 770, 785–86 (S.C. 2023). It remains to be seen whether that ruling will stand. Recently, the sole woman on the court, who authored the opinion striking down the abortion law, was replaced by a male jurist whom the state’s majority-male legislature chose. Jennifer B. Hawes, *How South Carolina Ended Up with an All-male Court*, PROPUBLICA (Apr. 28, 2023), <https://www.propublica.org/article/how-south-carolina-ended-up-with-all-male-supreme-court>.

³³⁵ *United States v. Handy*, No. 22-096 (D. D.C. Feb. 6, 2023).

³³⁶ *Id.*

³³⁷ *Id.* (first citing Andrew Koppelman, *Forced Labor: A Thirteenth Amendment Defense of Abortion*, 84 Nw. U. L. REV. 480 (1990); and then citing *Jane L. v. Bangerter*, 61 F.3d 1505, 1514–15 (10th Cir. 1995)).

upheld a fifteen-week ban with no rape or incest provision,³³⁸ it never discussed whether an earlier ban without such exceptions is constitutionally problematic. Nor did it indicate whether a ban at any stage of pregnancy without a health or life exception (in states that only allow physicians to bring affirmative defenses that an abortion was necessary to save the life of the pregnant person) violates constitutional principles. Challenges to the laws, as some scholars have suggested, could also attack them as void for vagueness.³³⁹

Undoubtedly, many federal district and appellate courts would find that abortion bans that do not include those exceptions violate rational basis review. But it is likely that not all would. A circuit split would raise the risk that the issue reaches the Supreme Court, which might conclude that rational basis review allows states to exclude such exceptions in the name of protecting fetal life (and perhaps fetal “personhood”). But even this Court might be wary about explicitly stating that women can die or suffer serious illness to save fetuses. And even if the Court were so brazen, lower federal court rulings requiring such exceptions, and dissents in jurisdictions that do not, would be useful in building a body of case law that a future Supreme Court could draw from to establish robust constitutional protections. The *Dobbs* Court, after all, relied heavily on dissents to build its case. The same strategy can be used in the future to reclaim reproductive rights.

Professional organizations must also come together and directly oppose abortion bans as a matter of protecting maternal health. Delegates to the Interim Meeting of the American Medical Association (AMA) House of Delegates, for example, recently adopted policies that oppose criminalization of pregnancy loss (against providers or patients) and civil or criminal liability that results from medically necessary care.³⁴⁰ The group also committed to advocating for public and private coverage of abortion services and efforts to “urge lawmakers to codify legal protections for physicians who provide

³³⁸ See *supra* text accompanying note 79.

³³⁹ Alan Morrison, *Abortion Ban Exceptions and the Problem of Vagueness*, NAT’L L.J. (Aug. 8, 2022, 10:00 AM), <https://www.law.com/nationallawjournal/2022/08/08/abortion-ban-exceptions-and-the-problem-of-vagueness>. Oklahoma’s confusing abortion legislation is a prime example of this problem. See *supra* text accompanying notes 106–113.

³⁴⁰ Press Release, AMA, AMA Announces New Adopted Policies Related to Reproductive Health Care (Nov. 16, 2022), <https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care>.

abortion services.”³⁴¹ The statement also clarified ethical guidance regarding abortion bans, emphasizing that the principle that “physicians must have latitude to act in accord with their best professional judgment” and expressly permitting physicians “to perform abortions in keeping with good medical practice.”³⁴² As AMA President Dr. Jack Resneck stated, “[u]nder extraordinary circumstances, the ethical guidelines of the profession support physician conduct that sides with their patient’s safety and health, acknowledging that this may conflict with legal constraints that limit access to abortion or reproductive care.”³⁴³ In addition, as physicians and medical students directed the AMA to do, professional organizations must provide legal support and “develop policies, strategies, and resources to assist physicians in navigating between ethical duties and legal requirements.”³⁴⁴ State professional organizations and medical boards should mirror these efforts to encourage legal reform and protection of the ability of providers to continue offering appropriate medical care to pregnant patients.

Another possible strategy is for physicians to test the limits of the laws. Health care providers are in a difficult situation with anti-abortionists blaming them for not providing medically required care, claiming they misunderstand the meaning of the laws,³⁴⁵ and legal counsel pushing them to be especially conservative in complying with the laws.³⁴⁶ But the risks of testing the limits are great for the providers. As Dr. McHugh puts it starkly:

There is no way that I would risk my personal freedom and jail time for providing medical care. . . . I would love to show my children that I am brave in the world, but our society will not allow me to be a civil-disobedient citizen in the way that some of these articles suggest, because I would be imprisoned, I would be fined, I would lose my license and I very well could be assassinated for doing that work.³⁴⁷

³⁴¹ *Id.*

³⁴² *Id.*

³⁴³ *Id.*

³⁴⁴ *Id.*

³⁴⁵ Walker, *supra* note 116 (describing abortion opponents as blaming doctors for not “treating patients who qualify” under exceptions within the law and that “those doctors are to blame for overinterpreting the law”).

³⁴⁶ See *supra* text accompanying notes 191–195.

³⁴⁷ Selena Simmons-Duffin, *Doctors Who Want to Defy Abortion Laws Say It’s Too Risky*, NPR (Nov. 23, 2022), <https://www.npr.org/sections/health-shots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky>.

Not only are the risks significant, but there is no reason to think this strategy would be effective at persuading the Court to overturn *Dobbs*,³⁴⁸ at least now.

A safer and likely more effective strategy is to practice “up to the limit of the law.”³⁴⁹ As bioethicist and law professor Katie Watson argues, “interpreting life and health exceptions to be consistent with standard medical practice is not lawbreaking” because most state laws have exceptions for medical emergencies and EMTALA requires stabilization of patients in emergent conditions.³⁵⁰ This strategy, which she acknowledges is not without risk, requires physicians “to better understand the legal protections they do have.”³⁵¹

If we ask physicians to practice up to the limit of the law, however, they need full support. They need legal counsel to be clear about the institutions’ commitments to its patients and its providers. The challenge for some providers is that even if they want to practice up to the edge of the law, their employers may not allow them to, or a colleague could report them.³⁵² Physicians might, therefore, think about unionizing to gain the power to resist institutional forces that may pressure them to retreat too easily from their ethical obligations to provide optimal medical care for their patients.

Physicians also need a clear articulation of the laws in advance of treatment and ongoing discussions with lawyers about what should fall within the exceptions and why. As one scholar has suggested, there is value in developing something akin to medical legal partnerships in this context.³⁵³ Such partnerships could help abortion providers navigate these tricky issues, with the providers bringing their expertise about the kinds of dilemmas they face and the lawyers helping them decipher the laws and promote better laws.³⁵⁴

Finally, stories must be told and widely disseminated to make clear how much maternal health and well-being are at stake in the post-*Dobbs* world. And empirical data must be collected to monitor the health and other socioeconomic effects of abortion restrictions. In May 2023,

³⁴⁸ *Id.*

³⁴⁹ *Id.*

³⁵⁰ *Id.*

³⁵¹ *Id.*

³⁵² *Id.*

³⁵³ Symposium, *Post-Dobbs: Institutionalizing Support for Women and Children*, 53 SETON HALL L. REV. (2023) (citing comments made by Liz Tobin-Tyler during the panel on maternal health).

³⁵⁴ *Id.*

researchers published preliminary findings of the “Care Post-*Roe* Study.” The report described fifty anonymous submissions “from health care providers describing detailed cases of care that deviated from the usual standard due to new laws restricting abortion.”³⁵⁵ These deviations “contributed to delays, worsened health outcomes, and increased the cost and logistic complexity of care” and often led to complications that were preventable.³⁵⁶ The more the public learns about the harms of the many abortion bans, the less political support there will be for them.

If the Court insists on leaving the issue of abortion to the people,³⁵⁷ the people must be fully informed voters. They must understand the broad implications of abortion bans for all of society: for pregnant people, for people who want to become pregnant, for women who are underrepresented in research, for children born into systems that do not support them, and for everyone else who suffers in a world where half of the population—those who can become pregnant—are treated as second-class citizens.

Finally, while much of this Article has focused on the particularly egregious maternal health impacts when laws have no exceptions for maternal health or fetal anomalies, it is also important to remember that bans of abortions even with such exceptions are harmful to women and their children in all respects—medically, emotionally, economically, etc. The powerful research from the Turnaway Study highlighted the detrimental long-term effects on women and their existing children in being denied wanted abortions, whether or not they were sought for medical reasons.³⁵⁸ After following nearly 1,000 women for several years, the study found worse health impacts for those denied abortions compared to those granted abortions, including “more severe physical health complications from birth,

³⁵⁵ DANIEL GROSSMAN ET AL., ANSIRH, CARE POST-*ROE*: DOCUMENTING CASES OF POOR-QUALITY CARE SINCE THE *DOBBS* DECISION 3 (2023), <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.

³⁵⁶ *Id.*

³⁵⁷ *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2259 (2022) (“[W]e thus return the power to weigh those arguments [about abortion] to the people and their elected representatives.”); *id.* at 2279 (“*Roe* and *Casey* must be overruled, and the authority to regulate abortion must be returned to the people and their elected representatives.”); *id.* at 2284 (“We now overrule [*Roe* and *Casey*] and return that authority [to regulated abortion] to the people and their elected representatives.”).

³⁵⁸ FOSTER, *supra* note 8.

including most tragically, two women who died after delivery.”³⁵⁹ But it also found that abortion restrictions were associated with notable harms to socioeconomic well-being. For example, in comparison to women granted abortions, those denied abortions were close to four times more likely to have household incomes below the federal poverty line and three times more likely to be unemployed.³⁶⁰ They were also more likely to be unable to pay for “basic family necessities like food, housing and transportation”; to remain in contact with violent partners, which endangers the women and their children;³⁶¹ and to be raising children alone.³⁶² In addition, the children they already had when being denied abortions were “more than 3 times more likely to live in households below the federal poverty line and . . . less likely to achieve developmental milestones” compared to the children women had when granted an abortion.³⁶³ In short, the denial of abortion rights harms women, their children, and their families in all respects, and the stories about abortions must address all of this.

CONCLUSION

As this Article has shown, the impact of the *Dobbs* decision is far reaching with respect to maternal and women’s health. There is much work to be done to ensure that people who can become pregnant are protected with respect to their medical care and with public health efforts to understand disease as it affects women. There is no question that the morass of draconian abortion laws and vague restrictions are imposing an enormous toll on health care providers, but most especially on the patients who are denied essential care. Without collaboration on multiple fronts—professional organizations, lawyers, and doctors working together; patients and physicians coming forward with their stories; researchers demonstrating the harmful effects of these laws; etc.—the state of maternal health will decline in tragic and

³⁵⁹ Megan Burbank & Emily Kwong, *A Landmark Study Tracks the Lasting Effect of Having an Abortion—or Being Denied One*, NPR (May 15, 2022), <https://www.npr.org/sections/health-shots/2022/05/15/1098347992/a-landmark-study-tracks-the-lasting-effect-of-having-an-abortion-or-being-denied> (quoting the author of the Turnaway Study, Dianne Green Foster).

³⁶⁰ *Turnaway Study: Long-Term Study Shows that Restricting Abortion Harms Women*, ANSIRH https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited May 15, 2023).

³⁶¹ *Id.*

³⁶² Burbank & Kwong, *supra* note 359 (quoting Diane Greene Foster).

³⁶³ *Turnaway Study: Long-Term Study Shows that Restricting Abortion Harms Women*, *supra* note 360.

utterly preventable and predictable ways. This ultimately impacts everyone, and all must come forward to fight on behalf of the fundamental rights that *Dobbs* has dismantled.