

Episode: *Ethics Talk* Series on US Abortion Care After *Dobbs*: Exclusion of US Women From Constitutional Protection

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[mellow theme music]

TIM HOFF: Welcome to a special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

This multipart series examines ethical and clinical fallout from the recent United States Supreme Court holding for *Dobbs*, *State Health Officer of the Mississippi Department of Health v Jackson Women's Health Organization*. This decision upends 50 years of legal and clinical precedent established on abortion, privacy, and other rights foundational in everyday health care practice. *Dobbs* challenges clinicians and organizations everywhere in the US in unprecedented ways, including whether, where, and when to defy law to give their patients standard health care, and how far to go to offer standard care to patients who are medical refugees from restricted states.

Abortions, when delivered by health care professionals, are safe, common, and until recently, legal. Whether as a request to end an unwanted pregnancy or in response to complications indicating risk to a patient's health, abortion is part of standard health care practice. In places where abortion care is restricted or banned, abortions will likely remain common. We know this from global research showing that regardless of changes in legality, abortion frequency remains steady, but that medical risk to women and legal risk to women, clinicians, and organizations increase when abortion is restricted to unduly infringe upon decision making and care planning that have, up until *Dobbs*, taken place within patient-clinician relationships. Regardless of legality, abortions are often clinically indicated standard of care for pregnant people, especially in response to incomplete miscarriages or secondary to fetal development anomalies or complications. And regardless of legality, all clinicians are still legally and ethically required to practice according to standard of care. Though in restricted states, this is now extremely difficult for most clinicians who are motivated clinically to continue to provide safe abortion care and motivated ethically to prioritize their patients' best interests above the intrusive demands of an unjust law.

When abortions occur naturally and spontaneously, they're called miscarriages, which are common. Once straightforwardly managed according to clinical indications, miscarriage management in restricted states now requires navigating a labyrinth of unscientific legal requirements. For example, restriction exceptions allowing abortion to, "save the life of the mother" de facto incentivize clinicians to watch their patients decompensate, that is become increasingly ill, to the point at which a complication

formerly safely managed with an abortion becomes a life-threatening emergency. Though it is worth noting that these kinds of exceptions are increasingly rare, as many have or look to simply ban abortion without any nod to a pregnant person's right to life or to a clinician's duties to do no iatrogenic harm and to provide standard of care.

In this series we'll cover what students and clinicians need to know about how the changing legal landscape of abortion influences their practices. This series also considers how restrictions will influence health professions and a generation of students and trainees now at risk for possibly never learning how to manage according to standard practice complications from one of the most common human experiences: pregnancy.

In this first episode of the series, we're joined by Professor Katie Watson, an Associate Professor of Medical Education, Medical Social Sciences, and Obstetrics and Gynecology at the Feinberg School of Medicine at Northwestern University in Chicago, Illinois, where she is also a faculty member in the Medical Humanities and Bioethics Graduate Program. Professor Watson is here to discuss what clinicians need to know about changes to the post-June 2022 legal landscape of abortion care in the US. Professor Watson, thank you so much for being on the podcast. Welcome to the show.

DR KATIE WATSON: Hi, Tim. [music fades out]

HOFF: So first, let's start obviously with the thing that everybody's talking about. What do you see as the top three clinically relevant upshots of the *Dobbs* opinion?

WATSON: That's such a great question, and it's going to be hard for me to limit it to three. So, I'll do my best. I think that the first is just we have to look at the entire United States and the use of abortion care and understand historically, abortion bans have not stopped abortion, and it's not going to stop them now. What it will change is a group will travel from states that have banned abortions. The increase in travel will push more people to later gestational ages. So, just under 90 percent of all abortions currently happen in the first trimester. And travel delay, and the delay that comes with having to raise more money, organize childcare, get time off work, will push people later and later. So, sadly, for those patients and for those who think second trimester abortion is more ethically concerning than first, these bans will push our national averages on gestational age later. That's clinically relevant because then it means people having more second trimester procedures out of state. Those are more, potentially, time consuming procedures. We're also going to see more travel for medically complex patients who have underlying health conditions of their own being pushed to later gestational ages trying to get care. So, that's one clinically relevant upshot for our pregnant population that is seeking abortion care.

A second clinically relevant upshot is in the maternal-fetal medicine world because it's already the case in Texas that MFMs are struggling with the law, saying, okay, let's say PPROM, my patient has, the bag of waters has broken. There's no way to have a successful pregnancy and delivery here. This is fill in the blank 18 weeks pre-viable. But there's still fetal cardiac activity, and so my state law says I can't empty the uterus. So, I

either have to wait for the cardiac activity to go away or for my patient to become incredibly ill. And that's just, I mean, malpractice. Here, it would be required by law, but just will cause a real danger for those patients and an utter crisis of conscience for those physicians of I'm choosing between do I want to be potentially a felon and stand here and watch my patient get sicker and sicker? And that's how patients have died in Ireland and Poland, not because of a lack of medical care, because people standing and staring at them saying, "Are they sick enough?" And then the infection goes too far.

And it's really important to note that the *Dobbs* opinion returning the criminal-, allowing states to criminalize abortion does not require a life exception or a health exception, doesn't require rape, incest, any exception. So, every state's laws only have to pass a rational basis test. And the court has said states have a legitimate state interest in protecting embryonic life from the moment of conception. So, I'm hopeful. I'll make the argument that not having a health exception or even a life exception violates a rational basis test, but I'm not sure that will fly in court. So, in that moment, what would any kind of conscientious emergency room doctor or obstetrician do? I think, I hope they would save the patient's life. So, that is incredibly clinically relevant and I think just is such an incredible threat to the practice of medicine overall.

A third area is ER visits for self-managed abortion. Those who can't travel, many will seek to do an abortion outside the formal medical system, and they will likely, many of them or most of them will do this by ordering medication abortion from the Internet, from a pharmacy, say, in India or elsewhere. And they will take those pills in the privacy of their own home and have something that looks like a first trimester miscarriage. Now, some of them, that's a low complication rate. But some will need medical care for complications, and some will just need reassurance that their symptoms are normal. So, in the past, if you were having a medication abortion that was prescribed by a physician and you could call that clinic or that physician's number and say, "Is this too much bleeding? Is this the right amount of pain? I'm vomiting a lot. Is that normal?" You would have that reassurance. If you order pills from the Internet, hopefully people are calling helplines like the Miscarriage + Abortion Helpline to talk to clinical folks for guidance. But more and more of them are going to be showing up in the emergency room.

And let me just say, I think there's this interesting study of multiple years of emergency room admissions coded for abortion issues. I think it's about 51 percent just had observation. So, these are people who had medical access, presumably, someone prescribed their pills, and in that study, they thought, oh, by coding, 1 percent were self-managed. And they were still coming to the ER to say, "Is this bleeding normal? This feels like too much to me." And so, I think we're going to see more of that. Also, we won't necessarily have the screening for folks with bleeding disorders or other contraindications. So, increase in ER visits and also the need to increase, you know, be sure to keep those confidential is another clinical upshot. And then we're past three, but I can't not mention training, you know?

HOFF: [chuckles] Sure.

WATSON: Like, just a generational gap in training for abortion care.

HOFF: Mmhmm.

WATSON: And miscarriage management is not going to be sufficient. And so, it's a really difficult issue for the entire profession of medicine. How do you get young clinicians, students, and residents in states with abortion bans trained? I don't believe just numerically they can all come to standard of care states to get the training. And so, how do you handle that gap?

HOFF: Mmhmm.

WATSON: So, that's clinically relevant in a very macro way.

HOFF: Right, right. Yeah. And the cascading effects that this decision is going to have on health professions education is definitely something we're going to be talking about in a future episode of the series.

So, many states have enacted abortion bans in response to *Dobbs*, including so-called trigger laws that anticipated the reversal of the Roe precedent. So, which features of these bans are so important as to warrant some states clinicians' immediate awareness, attention, or response?

WATSON: So, I think the features one would look for first is the gestational age. So, for example, Florida, right now, it's enjoined, but they have a 15-week ban, and that allows most abortions. And that's very different than a six-week ban or Missouri's total ban. So, you first want to know at what point is abortion banned? You want to look at what exactly is prohibited. So, earlier I mentioned the life and health exceptions: Does your ban have any kind of exceptions and what are they? So, what is prohibited and what is not prohibited? So, the life and health exception that I discussed, it may or may not be there, rape and incest may or may not be there, looking for certain exceptions. Also looking at what is not prohibited. So, what is the definition of an abortion in that law? Does it require embryonic cardiac activity? If there's not cardiac activity, is it not an abortion anymore? Could we just call that straight-up miscarriage management? And I think there's going to be a lot of fear and confusion about miscarriage management. So, I think getting clarity on that will be helpful. Being clear about what's not prohibited as speech and how you're allowed to speak as a physician. You still retain your First Amendment rights to counsel, to explain, to advise. Looking at the aiding and abetting provisions will be really relevant to what's the line between giving information and aiding and abetting? And then who is prohibited from doing what?

So, we say they're abortion bans, but what I find really interesting and troubling in a confusing way, I'll be honest, is they typically criminalize the physicians' behavior, and many criminalize aiding and abetting, so someone who helps fund the abortion or drives the person to the appointment. But they typically, so far, do not criminalize the patient. And so, for example, if you're a physician in a standard of care state treating an out-of-state patient, at the moment, you don't need to be concerned because your jurisdiction—you and I are speaking in Illinois, so let's use our example—an Illinois physician is governed by Illinois law, and they are standing in Illinois, within the state of

Illinois. A patient comes from another state. The Illinois physician that the abortion is happening in Illinois. So, that's really important jurisdictionally, but I think it's also interesting that the patient themselves is, under these statutes so far, typically not committing a crime, getting even an illegal abortion in her home state. And the reason I say.... So, I think it's important to be secure even when you're in a standard of care state to understand that you can see anyone who walks in your door.

As a lawyer, I want to invite people to think about different layers and levels of social control. And so, we've already talked about a legislature passes a statute. That's one level. Do police officers and prosecutors enforce it? That's another level. Then there's the social control and cultural and control that works through structural stigma. And so, someone, say, who's come into an emergency room and has had a spontaneous miscarriage, didn't take medication abortion, will she be hazed and interrogated by health care staff who have appointed themselves some sort of guardians of the realm [chuckles] and made up their own sort of hazing and local quote-unquote "law" to try to ferret out who's used pills and then shame them and treat them poorly as a local punishment? So, it's not just it's criminalized by the state legislature, or you're treated wonderfully at the hospital, because health care workers are people in our communities, too. And we hope and expect them to perform at a different standard, and they also live in the same communities where these bans are being passed and may share some of those attitudes.

HOFF: Right. Yeah. And I think that tracks with the increased criminalization of other actions like drug use, although that's a different conversation in a number of ways, that exacerbate existing health inequities in the US.

WATSON: Yes.

HOFF: So, what are some of the health equity considerations of eliminating the constitutional protections for abortion and shifting that responsibility for creating and enforcing laws governing abortion care to state governments? What are the health equity consequences that clinicians should know about?

WATSON: Well, I think that we should just start from the facts of the profile of the average abortion patient, or I should say the demographics of the population of people who get abortions. Currently, 49 percent have incomes under the poverty level. Another 26 percent have incomes from 100-200 percent, that's quote-unquote "low income." Fifty-nine percent are people of color. The majority are young women. And let me just say out loud, they're almost all people who identify as women. So, you already have sort of a classic health disparities profile. And I wrote an article about this in *AJB* that why we don't, in interrogating, why we don't think about it or frame it as a health disparities issue. So, we already have that population. Now cut off access, let's say, for half or more of those folks. And those with means will travel, but those without means—and I mean both financial resources, but also the social resources to access the information, to figure out how to organize their lives and other people's lives to actually make travel happen—those are the people who will be left behind and doing self-managed abortion. So now, there will be people with advanced degrees and high

incomes doing self-managed abortions, too, because they prefer that to traveling, but I'm just saying the folks who don't have a choice to travel. So, when we think about disparities, these bans hurt poor women the most, women who can't travel.

It's tragic to me that the states currently, before *Dobbs*, that had the most restrictive abortion policies invested the least in maternal and child health. There's multiple reports out that talk about this. And so, we already have an issue with child welfare policy. So, in terms of equity and disparities, I think pediatricians are going to need to get ready for a new wave of births of children who were not, those pregnancies weren't planned and would've been terminated if the parent had been able to in states that have the most limited resources for those children and their parents. So, in terms of disparities, I'm concerned about that.

It's also the case that the maternal mortality profile is very difficult. The minority opinion in *Dobbs* cites Lisa Harris's *New England Journal* article from this year referring to the fact that 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. So, I believe that's partly because of people continuing pregnancies that end up threatening their health. We already have this maternal mortality issue with continuing pregnancies.

And lastly, if I may just add when you think of an equity issue, I know we're talking about health care, but this is an issue of symbolic violence to all women whether you are a person capable of pregnancy, you are post-menopausal, you are a nun, or you are a woman who sleeps with women. As the minority put it, the curtailment of women's status as free and equal citizens is what happened in the *Dobbs* opinion. So, I don't have any statistics for this. We'll see how things work out. But I also wonder about the equity issue of depression. What does it mean for all women in the United States to be told, "The Constitution doesn't protect you" in the year 2022! We all grew up, or those of us who are older, saw the fight and saw the tide turn where we thought it did. [laughs] And so, this is like the Supreme Court reversing *Brown vs Board of Education* in 2003, 49 years later and saying, "Oh, separate can be equal. It's up to the states." And how would that affect the psyche of African-American people and their allies? And for women who are capable of pregnancy, we routinely cite the statistic that one in four will have an abortion before menopause, but you don't know whether you're the one or you're in the three until menopause.

And so, the stress of, hopefully, or let's say, the stress of trying to enjoy a happy and healthy sex life, whatever that means to you, whether that means one sexual partner for your entire life in an environment of marriage, or whether it means as many partners as you prefer over whatever amount of time, that that hanging over you all the time, "Could I have an accidental pregnancy, an unwanted accidental pregnancy? And how would that change my life?" I don't know how to quantify or describe the mental health impact on all American women of living in that kind of oppressive regime. And how it affects decision makings about where you go to college, where you take a job, and when you're pregnant, can you travel for work? Is it safe to leave if you live in a standard of care

state? Is it safe to leave the state or go on vacation? I mean, we used to be 50 states that you could travel freely among, and now we are not, for women.

HOFF: We'll be talking about federal and constitutional protections for pregnant people in a future episode, but as you note, the state level creation and enforcement of these laws are what are going to affect people most immediately. So, what state level protection should clinicians and patients know about?

WATSON: So, many people understand that every state has its own constitution and that states can give you more rights under their constitutions. So, the federal constitution regards the federal government, but also is a floor in terms of the rights the states must give you. But it's not a ceiling. So, states' constitutions have, some of them have the same language as the US Constitution in different provisions and others have different language. And there's a robust explosion in state constitutional litigation right now. And sometimes it's the equivalent language of the 14th Amendment being interpreted by state Supreme Courts saying, no, we think this liberty encompasses women's right to self-determination. And in other situations, or they can do that equal protection analysis, and say, huh. It's so funny. Only women get pregnant, and men never do. So, this does seem like an equal protection issue. Huh! Weird! We don't have to follow *geduldig*. We think that that's different. And so, that's possible. Some state constitutions have language that does not appear in the US Constitution like the word "privacy" and other concepts that are directly applicable. So, the litigation isn't over. It's just going to happen more and more in state courts.

And to offer some examples, the Kansas Supreme Court in 2019 found that abortion was a constitutional right under the state constitution. And so, Kansas is a standard of care state currently. Now, what's very timely and concerning is that on August 2nd, so less than a month from now, there's a ballot initiative on the ballot in Kansas at the same time as their primary to amend their state constitution to take any protection for abortion out of it. So, there's a huge political fight happening there.

In Michigan, Governor Whitmer, as well as Planned Parenthood, filed separate lawsuits arguing that the Michigan State Constitution included a constitutional protection for abortion as a way to defeat their trigger law. And they were successful at the district court levels, with the district court concluding they had a likelihood of merit on this, excuse me, with the district court concluding they had a likelihood of success on the merits. And Michigan advocates have been gathering signatures to get an initiative on the Michigan November ballot to add language to their constitution to make that protection explicit.

So, those are two examples where we have both state court involvement and voter involvement circumventing the state legislatures. So, Kansas and Michigan are states you might think of as being more restrictive, and from a legislative perspective, they are. But we'll see. And Kansas also has a pro-choice Democratic woman governor, which I find so interesting. So, we'll see if the voters can rally to extract their states from the special interests' hold.

HOFF: Is there anything in the minority opinion that the Justices have indicated how federal or state governments might respond in ways that can help clinicians take care of patients?

WATSON: I think that it is a well-reasoned and heartfelt explanation of why the majority's wrong on its analysis of the 14th Amendment. And it offers, the majority offers, us an analysis that says, well, abortion isn't protected in the Constitution because that's not what the framers were thinking about, and that's not what the men who ratified the 14th Amendment were thinking about in 1868. And the minority opinion points out how that mires us in the past, and the Constitution is not a grocery list. It is an articulation of much larger principles that are meant to be elastic and to change with history. The Constitution doesn't use the word "contraception," it doesn't use the word "marriage," and yet, the Supreme Court striking the laws against miscegenation, interracial marriage, or on bans against same sex marriage, bans against contraception, identifying that there are spheres of liberty that are not meant for majoritarian rule.

And for me, I think of this as the return of morality laws. Really, there were cases in that same era saying states couldn't penalize children legally for being born out of wedlock, these quote-unquote "bastard laws" or illegitimacy laws. The revolution of why should the state care if you get divorced? I mean, that's sad, but should they be able to ban it? There's a whole sea change in American life around morality laws, and that's my framing. But the minority opinion really points out the flaw of this granularity. So, when you say is the right gay sex, when you say is the right contraception, when you say the right is abortion, the answer's going to be no on anything. But when you talk about liberty and adult relationships and self-determination and flourishing and all these principles that, for me, as a constitutional scholar working in a medical school, part of what I'm drawn to is it's all about bodies and flourishing and the relationship with the state that these are the principles of medicine, of helping your patients live their values, whatever those are, if they're within the scope of your values. That's what we do in a pluralistic society.

And so, I just want to, from the minority opinion, I mean, I just want to emphasize, the Supreme Court has just made such a grave error. It's one we're going to live with for some years to come. And I think what happens in the next few years will be critical. [mellow theme music gently returns] And I hope that the medical profession will join in the resistance of while we simultaneously care for patients every day and live within the limits that we have, we seek to change those limits to increase the freedom of our patients and to restore our country's pluralism.

HOFF: Professor Watson, thank you so much for your time today and for being on the podcast.

WATSON: Thank you for doing this.

HOFF: That's all for the first episode of the *Abortion Care Series* of *Ethics Talk*. Thanks to Professor Katie Watson for joining us. Music was by the Blue Dot Sessions. We'll be back next week with an episode that considers clinical encounter and health service



delivery implications of how the current US Supreme Court interprets the US Constitution. Talk to you then.