

Episode: *Ethics Talk Series on US Abortion Care After Dobbs: Wait. What? Some Clinicians Agree to Watch Their Patients Get Sicker?*

Guests: Rebecca Cohen, MD, MPH and Katie Watson, JD

Host: Tim Hoff

Transcript by: Cheryl Green

[Access the podcast.](#)

DR CHRISTY RENTMEESTER: Part of what is ethically painful about tragedy is that it is preventable. This podcast series is offered to educators in solidarity with all women, to all who have or will ever experience pregnancy, and to all who are motivated to care well and avoid harms of unnecessary illness, injury, or excess death. May the best of science, liberty, and equality inform and nourish how and according to whose will the world is peopled.

[mellow theme music]

TIM HOFF: What does it mean to save the life of a pregnant person by ending their pregnancy? How sick should a pregnant person have to get in order for their death to be considered imminent in order to warrant a “life-saving intervention” by clinicians? For pregnant persons in states that ban or severely limit access to abortions, which are called restricted states, the actual practices of life saving needs special ethical consideration. The US Supreme Court holding in *Dobbs v Jackson Women’s Health Organization* should prompt us to think carefully about “life-saving” as a set of acts constitutive of what could be an actual rescue. We pause here, however, on “could be” to wonder, should we call a series of clinical interventions a rescue if a different series of clinical interventions, if applied earlier, would’ve prevented the need for a rescue in the first place?

This question prompts us to consider the ethical value of carefully distinguishing between clinical need for unpreventable, what we’ll call here an actual rescue, and enacting what some have identified as a rescue fantasy, as clinical salvation worthy of portrayal on any medical drama episode that you’ve seen on TV. We should also carefully distinguish between physicians who are appalled by the *Dobbs* ruling and find it to be an ethically unacceptable source of intrusion on their relationships with patients and the physicians who find it acceptable. The *Dobbs* ruling has created social conditions in which clinicians in restricted states who want to be allowed to play what we’ll call a savior role. Clinicians in restricted states who refuse to play the savior role reject what *Dobbs* requires of them and are appalled by not being free to offer their patients standard abortion care to keep them safe.

Let’s consider the specifics of clinicians willing to play the savior role in restricted states, the clinicians who find the *Dobbs* ruling’s influence on their practices acceptable. In this specific post-*Dobbs* social and cultural context, playing the savior role is a part of a rescue fantasy in which the pregnant person who needs an abortion has to play the stock character of the proverbial damsel in distress. Keep in mind that their distress is avoidable through safer actions, in this case, a timely abortion. So, consider this ethical question: Is a pregnant person’s death by abortion ban ethically better or worse than a pregnant person’s iatrogenically-facilitated near-death induction that is followed by willing clinicians’ efforts to “save their life” by finally performing an abortion that was clinically indicated hours or even days ago? The upshot here, ethically, is that *Dobbs* has created a legal and cultural landscape in which clinicians unwilling to offer patients standard abortion care are damned if they do and damned if they don’t. And

willing clinicians are now free in restricted states to offer poor care to pregnant persons with impunity.

One kind of poor care practice being done by some clinicians in restricted states is what we'll call observed decompensation of a pregnant person's health status. This is the practice we're considering in this podcast interview. What happens in observed decompensation cases is that a pregnant person in need of an abortion to save their life is allowed to become increasingly ill, to decompensate toward death.

Let's take a minute for some explanation of what's ethically and clinically at stake here. We must straightforwardly recognize the clinical and ethical impact on health care professionalism that the *Dobbs* holding introduces to the current health law landscape, since there's now no federal, constitutionally protected right to abortion. Remember from the prior episodes of this podcast series that the *Dobbs* holding means that individual states get to decide what used to be decided between patients and clinicians. In restricted states, exceptions allow abortion to "save," as the saying goes, "the life of the mother." Such exceptions de facto incentivize clinicians willing to do so to allow their patients to decompensate to the point at which a complication formerly safely managed with an abortion becomes a life-threatening emergency.

A key ethical and clinical point here is that abortion restrictions and bans are not just health legal changes. They fundamentally alter how patients and clinicians are allowed to interact. They constitute upheaval of core ethical values—values like trust, patient privacy, patient autonomy, patient dignity, informed consent, fiduciary duty, and more—that have framed health professionalism ever since patients have had codified rights and since clinicians have had codified duties to care.

Joining me on this episode to discuss observed decompensation are Professor Katie Watson, an Associate Professor of Medical Education, Medical Social Sciences, and Obstetrics & 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; and Dr Rebecca Cohen, an Assistant Professor of Obstetrics and Gynecology and Division Chief in the Department of Family Planning at the University of Colorado in Aurora. Dr Cohen, Professor Watson, thank you so much for being on the podcast with me today.

DR REBECCA COHEN: Yeah, thank you so much for having us. I really appreciate the opportunity to talk about this important topic. [music slowly fades]

KATIE WATSON: Happy to be here. Thank you.

HOFF: To begin, would you please describe for our listeners the data that's currently available about how many pregnant people have been harmed or have died as a result of clinicians' participation in medically observed decompensation?

COHEN: Yeah, and that's so important because as a clinician, I have seen harm. Thankfully, I have not seen anyone directly yet die from lack of access to abortion. But it is out there, and we have definitely seen harm come to people. Even pregnancy-related mortality, or pregnancy-related death, is very difficult to capture because the data is collected essentially voluntarily and in different ways across different states. There is a lot of kind of misclassification: so, deaths that are initially reported as being related to a pregnancy when they're not, deaths not initially attributed to pregnancy when they are. And it does rely on someone noticing and remarking upon that in a way that the data can be collected.

There is a huge element of stigma in that someone who has been harmed as related to lack of access to abortion may not be willing to provide that information or come forward, and organizations that are complicit in that harm have really extra motivation to not provide that information. So, there is, in some ways, benefit to people from not reporting with social or societal harm from reporting. And there's not a good system for anything that relates in a harm less than death. So, someone who ends up with potentially a hysterectomy, whereas they wouldn't have needed that if an abortion had been provided earlier, someone who needs a blood transfusion that they wouldn't have needed if the abortion had been provided earlier, those are not things that are mandated to be reported, and there's not a systemic way that that information is collected. So, we see it, but we don't have good numbers and we may not.

WATSON: I would like to add that when we say "people who have been harmed," there's also the medically inflicted psychological trauma of waiting while you are pregnant when you know this pregnancy will inevitably end, but no one will end it for you until you are "sick enough." And that is also very hard to capture when we add this medical trauma to the trauma of pregnancy loss itself. I think most of the reporting on this is through news organizations. And so, I don't know if we'll get into the Catholic health care system that's been denying this care for decades, but in 2016, the ACLU did a report called *Health Care Denied* talking about the threat to women's lives in Catholic hospitals and shared three cases of harm and close-to-death experiences. NPR and *People Magazine* and other media outlets have reported on cases in Texas in the last few months. And actually, just on November 2nd, the Center for American Progress did a report on women's health in the new landscape that includes citations to several cases. So, we don't have it cataloged, but we do have what physicians call anecdotal data that is strong. And it relies on patients coming forward and sharing their stories with media or advocacy groups, and that's not how we do things in the rest of medicine and is worth reflecting on.

HOFF: I'm glad you brought up the psychological harm that these laws create and the difficulty of tracking that.

WATSON: Mmhmm.

HOFF: I think that conversation about what we care about enough to track and what kind of data we even have the ability to collect is likely worth its own separate conversation.

WATSON: Exactly.

HOFF: But I'd like to turn now to what clinicians and students should think about when considering whether and when watching a pregnant person decompensate constitutes medical neglect or iatrogenic harm or perhaps even iatrogenic torture.

COHEN: And truly, that's something that we think about every day, and I don't have a good answer that is suitable for public consumption. Because to me, as someone who practices in this space, it absolutely is neglect, and it absolutely is harm. But there are several levels of kind of what is our professional responsibility, and how do we meet it? And to this point, that has always involved practicing within the boundaries of law, practicing within the boundaries of your scope of practice, and practicing in the boundaries of what is considered the safest and best care. And there's always been debate among health care professionals about what constitutes the best course of treatment in many medical situations. And people can argue that if they are not prepared to safely offer an abortion, that they shouldn't be offering abortion, that someone without the expertise, without the comfort, without the proper equipment to safely offer a patient

an abortion—and there are many settings in the United States where that is the case—risks doing more harm than not providing the abortion, and instead referring, transferring, doing something that the patient receives the best care. But the challenge is there are also providers who don't think that abortion is the best care, even when most medical professionals would think that they are.

And so, for those of us that are practicing abortion providers or people that had been able to offer abortion care before the laws changed, they were able to say, "The law is in concordance with what I feel is the standard of care, the best thing for this patient." But when there's a conflict, I think the most important thing for students and other trainees to do is to gain a better understanding, to understand what has changed in the system, to understand their own discomfort, to understand the boundaries of the system, how they can safely work within it, or if they need to work outside of it, to resolve the conflict and get the best care for patients. I think it's also important for learners to understand that their preceptors, their teachers, their role models may be acting in ways that don't initially appear to be ethical and to be able to have those conversations as well of what is it that we are navigating, what are the values in conflict, and what are the things that we are doing to still get care for our patients within an unjust system?

WATSON: I, as a lawyer, want to raise up the issue of statutory interpretation. And as Dr Cohen eloquently said, sometimes there's a conflict between the law and your medical obligation, but sometimes that conflict is unclear or it's actually nonexistent. And clinicians overinterpret the law out of fear of liability. And let me first say that fear is understandable, in some cases founded. But what I want to say to the point of medical neglect is you have to ask yourself, am I interpreting the law like a risk manager in the narrowest way possible to avoid any possibility of liability, or am I interpreting the law the way a defense attorney would do and argue to give the broadest latitude to patients? And I would say in this moment, physicians need to stand strong and interpret these vague laws as in the broadest possible way to the benefit of patients. And I'll give you two reasons for that. But interpreting life and health exceptions to be consistent with standard medical practice, in many cases, is not law breaking; it's proper statutory construction. And the first reason has to do with the statutory rationale.

Now, I disagree with these laws, so let me just be very clear. But if I'm just being a lawyer analyzing them to the broadest benefit to patients, I want to look at legislative intent. The legislative end goal of these laws is a) to prevent the ending of pregnancies that could end in live birth, b) to allow that when women's life or health are at risk. And so, when we talk about the category of what clinicians call inevitable abortions, and that's where like, the classic example of someone's water breaks at 17 weeks, that's never going to make it to a live birth. That's in Category A, right? If the legislative goal was to prevent ending pregnancies that could end in live birth, we're not even there. We're not in a life and health exception category, for me as a lawyer thinking to patient benefit. So, prosecutors are not coming for you for those cases, probably. And that gets me into my second point about the enforcement rationale. But so, in statutory construction, I think it's an overbroad interpretation to suggest broken waters, you have to sit and stare at someone for three days until they start discharging foul smelling odor. And then with the life and health exception, the classic statutory interpretation texts say you assume goodwill of the legislature; you assume constitutional scope of a statute. And so, statutes that have room for interpretation about risk, what's a medical emergency, physicians need to embrace the ambiguity rather than asking legislatures to make a list for them and say, "If I say it's a medical emergency, it's a medical emergency."

And then the second reason is an enforcement rationale. And I don't mean to be crass, but I do not believe prosecutors are coming for hospital physicians doing lifesaving or health saving work with women with wanted pregnancies. These statutes target women who don't want to continue their pregnancies. They have accidental pregnancies they don't want to continue. And the goal of the legislature was to avoid using health exceptions as "excuses" to do abortions in those instances. So, if there's no argument that the person wanted to end the pregnancy because they didn't want to have a baby as opposed to a health reason, it fails the headline test to prosecute these doctors. Now, if I were a doctor, I'd be very anxious about liability, so I don't mean to minimize concerns at all. But when you have a very, very, very strong argument that caring for your patient falls within the law, I do think it's medical neglect and a gross conflict of interest to stand there and watch them decompensate so that you have absolutely no possibility that you could get in trouble.

HOFF: So, let's talk a little bit more about the fears that clinicians might have, especially students and trainees who are just trying to start their careers amidst all of this uncertainty. They might be asking, "Even if I might not be the target of prosecution for this or that particular case, how is this kind of practice in general not malpractice or a reasonable cause of wrongful injury or death or even potentially human rights abuse?" What do you say to students and trainees who have those kinds of concerns?

COHEN: Yeah, absolutely. And that is something that my hospital has really emphasized to trainees that we will do our best to sort of shield them from potential consequences, so ensuring that it is always an attending physician that is involved, that is making the decision. And that's true of training environments in general, is that learners ideally are not ever in a setting that they are committing malpractice. But that what defines malpractice varies, and it's really at the mercy sometimes of this conflict between legal restrictions and best medical practice. And so, defining malpractice—and I'm not a lawyer. Thank you, Professor Watson—but as I've always learned, is sort of the reasonable person standard. So, if you took a well-trained, qualified health care provider, would they act similarly in a similar circumstance? And so, someone can argue that when there are safe medical alternatives, that someone with an infection could potentially be treated with antibiotics, someone with cancer could potentially be given a chemotherapy and maintain their pregnancy, that a reasonable person could choose those medical alternatives to not be in violation of the legal environment. And so, it's not as straightforward as there is one best thing for this patient, and that is the only best thing for this patient. And that is why those debates and the concern about the vagueness in the law has persisted in that we are seeking guidance for what is a medical emergency, what are the bounds of treatment. Because two reasonable people can come to very different conclusions, that one physician can say, "Yes, this person needs an abortion," and someone else can come back and say, "Actually, no, there were other things that you could have done, should have done."

And so, I think, again, I just keep coming back to engaging in conversation with learners of what are the bounds of malpractice in this situation? Who have we consulted? How can we get the best counsel, get the best course of action for this patient? And then we do talk a lot about documentation because that is, for better or worse, a big part of what we're doing when we are caring for people who need abortion care in emergent situations. There's also a lot of discussion, and Professor Watson alluded to it earlier, in what are your local resources, your local restrictions? Catholic hospitals, again, have had these restrictions for many, many, many years. And what are your responsibilities in that situation? Is that what decisions do you make as a health care provider that when everyone is making them really add up to this systemic harm for the patient? So, I think that absolutely, you can and should make the case that

sometimes not acting is malpractice, that this is wrong, but also understanding what people may say, that it is not a wrong, so that you can counteract those arguments.

WATSON: Tim, I'm going to start with a lawyer's answer. And let me be clear. I don't like this answer, but the bad news is when students or others say, "Well, how is this not malpractice? How is this not wrongful injury or death," those are legally defined, and the legislature can change the definitions of what constitutes malpractice or wrongful injury or death. It's up to them. And we live in a country with no constitutional right to health care, so it's hard to make a counter claim. So, imagine being in a state where physician-assisted aid in dying, excuse me.... Imagine being in a state where medical aid in dying is illegal and trying to sue for malpractice that this was a case where medical aid in dying should've been offered. That just doesn't fly. Now, we're used to 49 years of a constitutional right to abortion, so that feels very different to us. But I think that's a hard legal case to make.

And when we look at Catholic health care, for decades, again, the legislatures have carved out an exception that to say this is a situation where the legislature prioritizes something higher than women's health and lives. And in that case, it was religiously based objection to abortion care. And today, post *Dobbs*, it's embryos and fetuses are more important than women's lives and health. I disagree with that legislative stance, but the Supreme Court has empowered legislatures to make it.

Now, the second part of your question, you said, how is this not a human rights abuse? It is! Right? This is a human rights abuse, and human rights are bigger than US law. And so, it brings other repressive regimes in history to mind where physicians are forced to choose between human rights or medical ethics and following the law. But the law's not malpractice or wrongful injury. That's not the law, right, the legal framework. We might talk about EMTALA violations, and that's being litigated right now.

HOFF: Is there anything about those EMTALA litigations that our listeners should know or might find interesting, or is it sort of too early to tell in these cases?

WATSON: Well, it's early in the process. I mean, so, emergency rooms are safety nets and very special places. I want to call them sacred places, but I don't want to make it a religious thing. But in the medical sense are hallowed places where people can come and have their confidences kept and be vulnerable and get care whether they have insurance or can pay for it or not. And we have a federal statute that arose to prevent patient dumping that required that of any hospital receiving federal funds, which is basically every hospital in the country. And it requires them to stabilize patients, and sometimes stabilizing a patient requires emptying their uterus.

And so, Idaho has the strictest ban in the country, a total ban with no health exception. And the Biden administration sued to say that contradicts EMTALA. And there's our slightly arcane legal concept that now many people have become familiar with called federal preemption, meaning the federal law always supersedes the state law when they are conflict. So, a federal law says stabilize this patient's health, and the state law says you can't do it if that means emptying her uterus, federal law wins. A district court judge sided with the Biden administration. That's in the Ninth Circuit. In the Fifth Circuit in Texas, the Texas Attorney General proactively sued in response to an EMTALA guidance letter saying, well, we have a health exception, and it's roughly consistent with EMTALA. And we get to interpret and define these in favor of embryonic and fetal life. And the federal district court in that case sided with Texas, saying that the federal government had overreached in this case.

So, if those cases proceed up the ladder to the appellate courts, and the Ninth Circuit is understood to be more liberal and the Fifth Circuit is understood to be more conservative and very anti-abortion, it could create a circuit split that the US Supreme Court would have to resolve regarding the scope of EMTALA. And I think people, so many people never thought that a collateral damage of *Dobbs* would be the EMTALA statute. Like, do emergency rooms, do states just get to pick and choose who's treated and what treatment they receive in emergency rooms? That would just be a radical dismantling of EMTALA. Or the Supreme Court could dodge it saying, well, the issue in Idaho was there was no health exception at all, and the issue in Texas is like, how do you interpret health? And Texas has given [audio drops] in this context. But it's not inconsistent with EMTALA. So, I don't know that it's a guaranteed circuit split, but that's where that litigation stands now.

HOFF: Hmm. Yeah, that does seem like something we should be paying attention to. So, thank you for laying that out for us.

Dr Cohen, you mentioned that an important part of helping students and trainees navigate the uncertainty around abortion care in restricted states is making sure that documentation is done particularly well. Can you talk a little bit more about the role of good documentation in the provision of abortion care post *Dobbs*?

COHEN: No, absolutely. I work in a state where the right to abortion care is protected. And what that means is we've seen a huge surge in volume from patients that are coming from places where abortion care is restricted or banned. And as of yet, while patients are not able to be sued or prosecuted unless there is suspicion of self-managed abortion, there is concern and there is threat that that may happen. And so, there's been a lot of discussion about what is appropriate documentation, what should go in a medical record, what should not go in a medical record, balancing that we are documenting accurately, appropriately, but not putting in things that are conjecture or are potentially legally harmful to a patient or a health care provider. When it comes to things like threat to health, threat to life, pregnancies that are not viable, meaning unlikely to survive for any length of time past delivery or birth, all of that documentation has always been thoughtful because, again, we recognize that there are sort of degrees and potentially people with different viewpoints, but now it's even more imperative. And so, those are things that are coming up on an almost daily basis, especially as electronic medical records are often able to be viewed across systems in different states.

HOFF: Mm. Mmhmm. So, can you talk a little bit more about how cases now post *Dobbs* tend to play out and how many and which clinicians are involved in these decompensation cases and sort of what clinical evidence specifically you're looking for?

COHEN: Yeah, absolutely. And so, these are things that, that decompensation can play out over the course of minutes. Somebody may be having a miscarriage and losing so much blood that their life is imminently in danger. It can play out over the course of hours as someone is developing a more severe infection or is experiencing something like an ectopic pregnancy, although even though it is not viable, sort of falls within that sphere of fear, seeing that they're having internal bleeding, that their blood counts are steadily dropping over hours or even weeks; someone whose cancer is not responsive to a first-line chemotherapy or the only chemotherapy that's safe in pregnancy; or someone who is developing an infection after their water has broken. And so, it could be upwards of 50 or 100 clinicians if that is happening over the course of weeks as teams change, as different consultants are involved.

But really, although OB-GYNs are often central to these discussions and these decisions, emergency medicine docs are often involved. Anesthesiologists are involved. So, if we have someone who is caring for a medically complex patient or who chooses to participate or not participate in what they see as providing abortion care. And then if someone's health is decompensating for a medical condition like cancer, like having a significant cardiac defect, that they're worsening throughout pregnancy, someone with a severe infection, that there can be consultants from many different specialties like critical care, oncology, cardiology. And there is also often pediatricians involved. So, the neonatal ICU docs that are often brought on board as "advocates" for the fetus, and ethics consults have been called in, in some hospitals as well.

And the evidence is varied, changing over time. But the things that are looked at most frequently are lab work. So, often the cause of saying that yes, someone is that sick is that they are bleeding heavily. So, seeing that their hemoglobin or hematocrit is dropping to a point that it's becoming unsafe or that there is clinical evidence of infection. So, that foul smelling discharge is often used as something that someone will say, yes, this is an infection. Increasing white blood cell counts. And then just assessing as we would for any patient the interventions that we're trying, are they working? So, is someone responding to medication? Are they getting better? Are they getting worse? Are they staying about the same? And those things really are in a lot of ways subjective. So, there is potential for a lot of people to be involved and a lot of parameters to be interpreted in one way or another to say that, yes, this person, this pregnancy is now a threat to their life.

HOFF: Some pregnancies could end in a live birth but with an infant that will die shortly after the umbilical cord is cut because it has a condition that's incompatible with life, such as missing kidneys or anencephaly. Pregnancy always poses a health risk greater than not being pregnant. So, before *Dobbs*, and currently in states where abortion is still legal, many patients in this situation choose to end their pregnancy. In the post-*Dobbs* era, some clinicians have been willing to delay diagnosis of some of those complications of pregnancy. In your view, why is this happening, and how have you been seeing this kind of diagnostic delay playing out?

COHEN: Yeah, absolutely. So, I think it is important to acknowledge that there's often a diagnostic delay when we are looking at complications of pregnancy or pregnancies that are not developing normally. On average, it takes about two weeks to get a genetic diagnosis back after something like an amniocentesis. So, not all delays are caused by clinicians that are impairing access to abortion care. That being said, I absolutely have seen it. And really, for some people, it's a way of avoiding moral conflict. So, as Professor Watson mentioned, there really is now this culture of fear that the law is vague on purpose. And while in retrospect, people often say that they want that to be interpreted in a way that doesn't harm patients, clinicians fear that it is going to be interpreted in a way that does harm patients. So, to say that, yes, you cannot intervene unless these conditions are met, but the conditions are not spelled out. And so, for clinicians that are afraid of being in a situation where they either medically should counsel a patient on abortion care as an option or feeling conflict that they know that they should mention that but can't because of the laws in their area, that that would be perceived as aiding and abetting abortion care, it's sort of a logical step that if you aren't making a diagnosis that would lead to potentially counseling about abortion care, you don't have to counsel on abortion care.

And so, we have seen people say, "Hey, this ultrasound isn't clear. Why don't you come back in a couple weeks? We'll do another ultrasound." Or "That sample got lost on the way to the lab," which does happen, again. So, it's hard to say this is definitely what happened. But we have had patients have diagnostic delay, which leads both to a higher burden on them, because once they get the sense that, "Hey, maybe I'm not getting all of the information, I need to seek out a

second opinion. I need to go find something else. I need to kind of take a different route. The person who's supposed to be caring for me isn't caring for me. And the distrust of the medical system that my doctor said this. I later found out it was that. Like, how can I trust anybody?" And we've seen that play out a few times.

I have cared for someone from Texas who actually had an early pregnancy that was not viable. She'd had an early ultrasound that showed a gestational sac with no further development of the embryo. And standard of care is that you repeat that ultrasound in about two weeks, and if there is no further growth, you can say conclusively that the pregnancy is not viable, is not growing, and you can proceed with miscarriage management. But this patient's doctor continued to say this is a potentially viable pregnancy, did ultrasounds actually more than eight weeks, so, really delaying the patient's care, increasing her risk of bleeding, infection, and eventually leading her to go out of state to get the care that she needed.

WATSON: I would add there that in a situation where someone is not making a diagnosis because they don't want to talk about abortion, that is malpractice, straight-up, clear malpractice because we live in a country where abortion is completely legal in approximately half the states, and people have a right to travel. And so, to withhold that information because of a potential fear of liability, which is a grossly overstated fear of liability, it's there, but it again, put it in a conflict-of-interest framing. To simply do your testing or your imaging and to tell the patient, "This is the condition of your pregnancy. This is the issue with your fetus," full stop, period. Even if you're in a state where you feel limited in terms of discussing other options that follow, to withhold the information about their bodies is full-blown, straight-up malpractice. And if and when that is happening, I hope... I'm sympathetic to the doctors, but at the same time, we need to see those suits to make it clear that this is the case.

HOFF: For those to whom the *Dobbs* holding is a dreadful mistake, which clinical or legal strategies should be implemented as soon as possible and over the long term?

COHEN: So, I just, I want to be very clear. It was not a mistake. It was very, very, very intentional. This has been a decades-long campaign to restrict abortion care. And so, for some people, this is seen as a good. And so, to just sort of approach it in almost good faith as we're going to fix this mistake, I think, does miss a central component that there is often sort of organized pushback to continue the restriction of the right to abortion care. But really, there's a lot of different angles that need to be addressed in order to restore that right to people. In the immediate term, what we're really seeing the need for is clarification: so, people working with their institutions to understand the boundaries, to be able to treat patients in those medical emergencies, to be able to intervene before it becomes a threat to life. So, understanding those rules and also having referral pathways before they're needed in emergency. So, if your institution won't provide abortion care under any circumstances, and a patient comes in, how can you get them the care that they need quickly while you are addressing that systemic wrong? Education is important because again, as many people aren't able to get training in abortion care, they can say, "This is not safe for me to offer because I've not been trained in it," therefore further restricting the access. Really de-stigmatizing abortion care in general and stronger protections in places that are supportive of abortion care.

In the longer term, really codifying Roe, making sure that that access is maintained across the United States, often through both legislation but also, election, a fair judicial system, the big things. And then ensuring as well that people are not criminalized for abortion outside of the formal medical system or miscarriage, because those often appear very similar and are another opportunity for prosecution. And then just the greater systemic health care needs of access to

primary care, of access to birth control, of access to abortion care through all of those avenues. So, it is, it's a big, big lift. And I think that's why for me, it's also just important to know or to understand really that people have been working to overturn Roe since it was enacted. And so, making sure that we have things to protect access now while ensuring the system changes for the longer term.

WATSON: Yes, I think clinically in the short term, something we haven't discussed is self-managed abortion. In over 50 percent of abortions done in clinics or with medical support in 2020, people used medication abortion, which is used in the United States to 11 weeks of pregnancy and is approved by the WHO to 12 weeks of pregnancy. And now people with unwanted pregnancies have the opportunity to order pills from international pharmacies and do this at home, typically very safely. But they will also need medical support to know whether their symptoms and experiences are normal or whether they're one of the rare but real people with complications who need extra medical support. And so, for clinicians getting up to speed with how their patients might be confronting their unwanted pregnancies, some will travel, but many won't. So, it's an interesting moment for the demedicalization of abortion, which I have mixed feelings about, because people do need medical support in some cases or want the safety of the medical system. They shouldn't have to do it outside the medical system, but many will. And so, making sure to, what can people in ban states do to support those folks? Legally, in the short term, I already noted the idea of don't overinterpret the law. Don't do their job for them, right?

And I'll offer two more examples of that about how just following the actual law could help. I heard of one case of a woman with a wanted pregnancy in a forced childbearing state who was seeking psychiatric care because she was facing significant depression. And she said to her clinician, I think talking about her mental health, she said, "Maybe I shouldn't continue this pregnancy. Maybe this is not a good time for me to become a mother." And that mental health professional immediately cut off her care and said, "I can't discuss this with you because now I'd be aiding and abetting abortion if I talked about that with you." So, they cut off her mental health care out of a fear of being prosecuted under an abortion law. And that woman, I mean, she had the means to do this, but she traveled over 2,000 miles to get psychiatric treatment in a standard of care state that would allow abortion care. She gets stabilized, gets her meds organized, decides to keep the pregnancy, and returns to her home state. To me, I was apoplectic when I heard this because that was so utterly unnecessary, expensive, and ridiculous for someone trying to navigate a wanted pregnancy with mental health challenges.

Another category of cases is sonographers who won't do dating on pregnancies because they're afraid that'll be aiding and abetting because the patient will then use that information to book an appointment at an out-of-state abortion clinic.

COHEN: Yep. We've seen it.

WATSON: You have seen that, Dr Cohen?

COHEN: We have seen that. Yep, there was a patient in Texas whose doctor refused to see her and give that information once she disclosed that she was considering abortion.

WATSON: Yes. And I've heard of states, patients who show up in another state, make an appointment, do all that travel, and then their gestational age is past that clinic's cutoff date. They've wasted a trip, and then they're having an even later abortion elsewhere, assuming they

can afford the second trip. And I'm hearing this from clinicians at the second and third clinic, you know.

COHEN: Yeah, I've seen that, too.

WATSON: You've seen that as well? So, that—

COHEN: We've also seen someone who wasn't pregnant because her doctor refused to see her to confirm the pregnancy. And so, she traveled 16 hours when we told her that she was not pregnant.

WATSON: See, that just.... I don't know if that's a fear of liability run amok. I don't know what's behind that, and I guess I'll refrain from speculating. But those cases almost make me the maddest, right?

COHEN: Mmhmm.

WATSON: Because it's the chilling effect just gone on steroids where [chuckles] these people are not doing their jobs. And I think they're a little too quick to not do their jobs. Are they fine with that? And this becomes the true enactment of abortion stigma. You mentioned the concept of, "I might not want this pregnancy, and I won't touch you," right?

COHEN: Mmhmm.

WATSON: I mean, it's like the new leprosy.

The third is when we think long term legally, we have to argue for women's personhood. I think this whole issue hinges on whether biology is destiny and whether women's reproductive capacity must be the primary or central thing in their lives, or whether they get to decide its role in their lives. And we have, we don't think about abortion care as a new technology, and I think that's a mistake. Because in bioethics, we talk about dialysis, the invention of dialysis, the invention of ventilators, how that changes end-of-life care. Is it murder now to take someone off a ventilator? We have to think those things through. Abortion has always been with us, but safe and very effective pregnancy termination has not been. And it has, just like the contraceptive pill was a revolution in women's autonomy, so is abortion. Both are the prevention of unwanted childbearing, and it has caused a social revolution where women can take control of their biology in a different way. And access is not equal, and we have many barriers aside from the law as well.

But you have to make the argument that women are autonomous people, and our brains and our hearts are as or more important than our uteruses, and that we get to decide how they are used. That's still, historically speaking, a relatively, a somewhat new idea, and it's obviously a contested idea. So, for me, *Dobbs* is not about embryonic or fetal personhood, although that's what the case lands on. The conflict or challenge there is are women people under the Constitution? And the *Dobbs* court amazingly said no. And that's the fight, I think, that is the long-term fight.

And then the last point I'll make is that the conversation we're having today is utterly crucial about people with wanted pregnancies who are facing life and health threats that lead them to make decisions they never wanted to confront to end those pregnancies. And it's crucial because it highlights the disregard for women's actual physical existence when we say women's

lives, not just their health and happiness and self-determination, but like their actual continued living on this earth lives. So, it's really important that we're having it, and I'm glad we are. But the point I want to lead with is notice how this conversation and the amount of focus in the press and the medical profession on it keeps our focus on the really small minority of abortions, which are for women who wanted to be pregnant, and then that pregnancy went wrong. The vast majority of abortions are for women who did not want to be pregnant, or their circumstances, their social circumstances changed during the pregnancy, but they didn't want to be pregnant.

And in my work, I focus on what I call ordinary abortion. And it's interesting because we have hospital physicians who aren't used to working in risk environments as compared to clinicians who work in abortion clinics who are used to always having to navigate the law. They don't like it, but the idea of a risk environment is not new to them. And again, this conversation is crucial. [mellow theme music slowly returns] But I also want to keep it in perspective that the long-term legal issues, the short-term is go back to the legislature, try to get broader exceptions for life and health, not necessarily clearer, but broader. But the long term is these cases aren't my focus. My long-term focus is on women's personhood and self-determination and the right for anyone to continue a pregnancy if they want to have a child or to end a pregnancy if they don't, on their own terms, regardless of their medical status.

HOFF: Dr Cohen, Professor Watson, thank you so much for joining me today and for your expertise on this topic.

WATSON: Thank you.

COHEN: Thank you.

HOFF: That's all for this special series on the clinical and legal landscape of abortion care in the post-*Dobbs* US. Thanks to Professor Watson and Dr Cohen for joining me on this episode. Music was by the Blue Dot Sessions. If you missed them, be sure to check out episodes one through four in this series at our website, JournalofEthics.org or on the usual streaming platforms. Special thanks to Professor Watson for her help in developing this series and her input on questions. The Journal's Managing Editor, Dr Christy Rentmeester wrote and delivered the epigram at the beginning of this episode. Follow us on [Twitter](https://twitter.com/JournalofEthics) and [Facebook](https://facebook.com/JournalofEthics) [@JournalofEthics](https://twitter.com/JournalofEthics) for all of our latest news and updates, and we'll be back soon with another episode of *Ethics Talk*.