BANNING ABORTION, CORRUPTING CARE: IMPACTS ON PROVIDERS

Lisa C. Ikemoto*

I. INTRODUCTION

In *Prosecuting Poverty, Criminalizing Care*, Professor Wendy Bach details the direct harms of politicizing fetal personhood.[1] Not surprisingly, Bach's analysis of the effects of Tennessee's fetal assault law[2] evokes comparisons to the criminalization of reproductive health care—abortion, in particular. Both the fetal assault law and criminalization of reproductive health care draw from interwoven, often inconsistent narratives that cast women[3] and other pregnant people as dangerous, ostensibly to their own pregnancies. These narratives center the fetus-as-person as vulnerable and at risk. Bach shows that these narratives justify use of criminal law—the most liberty-intrusive state power—to protect the fetus and society from the danger that women pose.[4] Predictably, structural inequalities and reinforcing social norms make people who are pregnant, poor, and/or racialized, the targets of these laws.[5] Bach states, "the United States has a set of rules and systems that assume that whole categories of deeply stigmatized poor people do not deserve what this book broadly terms care—economic security, housing, healthcare, safety or support."[6] Rather, these narratives demonize women and other people for the "bad" decisions they make, without

* Martin Luther King, Jr. Professor, U.C. Davis School of Law. Thanks to participants of the UC Davis School of Law "Schmooze." Thanks also to Cailin Lechner and Yenna Ahn for excellent research assistance. Special appreciation to the S.W. L. Rev. members and faculty advisors who made this symposium happen

1. WENDY A. BACH, PROSECUTING POVERTY, CRIMINALIZING CARE 6 (2022).

2. *Id.* at 1.

3. I use the "woman" and "women" most often in this essay, but I recognize that trans men and gender-nonconforming individuals also need abortion services.

4. Bach, *Supra* note 1, at 31.

5. Norlissa M. Cooper, et al., *Social Construction of Target Populations: A Theoretical Framework for Understanding Policy Approaches to Perinatal Illicit Substance Screening*, 23 POL'Y, POL., & NURSING PRAC. 56, 58 (2022).

6. Bach, *supra* note 1, at 2.

acknowledging the structural, institutional, and cultural forces that constrain their options.

The book documents the effects of the Tennessee fetal assault law on those prosecuted under the law, and the institutions that implement the law.[7] The fetal assault law was ostensibly intended to reduce "neonatal abstinence syndrome" by reducing barriers to drug treatment for pregnant people.[8] Bach has shown that the law actually multiplied harms to those prosecuted.[9] For most, the law severed parent-child relationships and increased economic precarity and legal jeopardy. Despite claims that the law would improve health, it degraded quality of health care, largely by shifting authority for health care from providers and patients to state actors, and by substituting political goals for evidence-based medical standards of care. In the process, the law simultaneously entangled and warped the criminal justice, child welfare, and health care service delivery systems.

Bach identifies a series of steps that produced and multiplied law's harms.[10] The steps formed a pathway to corrupted care of those deemed unworthy to receive it. The pathways that criminal abortion bans create are still in formation. Yet it has already become clear that, like the fetal assault law, criminalizing abortion ultimately corrupts care. It disproportionately degrades care of people who are pregnant, poor, and racialized.[11] And it distorts the role of individual and institutional providers in delivering health services. This essay borrows from Bach's analytic framework to explicate the corrupting forces of abortion bans on health care.

More specifically, this essay focuses on health care providers and the medical profession. I take Carole Joffe's point that abortion care implicates not just the person seeking abortion, but also those providing abortion services.[12] Attention to providers acknowledges both the fact that abortion typically takes place through a provider-patient relationship and that

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7. *See id.* at 7.

8. *Id.* at 11.

9. *Id.* at 1.

10. *See id.* at 7.

11. *See* MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD x-xi (2020); *see also* Bach, *supra* note 1, at 56–58 (noting that it is important to acknowledge that criminalization is also used against white women. Khiara Bridges's explanation points to the role of racism in establishing the pattern and processes of criminalization, which then capture white women. Bach explains that white women deemed "bad mothers" by virtue of poverty and substance use direct that capture).

12. *See* CAROLE JOFFE, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE ix-x (1995); *see also* Carole Joffe, *The Social Status of Abortion Providers: 'Doctors of Conscience' Revisited*, BEACON BROADSIDE (Oct. 30, 2013), https://www.beaconbroadside.com/broadside/2013/10/the-social-status-of-abortion-providers.html.

providing as well as obtaining abortion care has been politicized. Consider, prosecuting drug use during pregnancy directly criminalizes the behavior of women and other pregnant people. In contrast, most abortion bans and restrictions directly criminalize providing health care. The bans and restrictions, too often divorced from medical need, undercut quality of care and medical professionalism.

Part II explicates the social construction of the problem that abortion bans and restrictions ostensibly address. It highlights narratives that target pregnant women seeking abortion and providers of abortion services as the dangers that justify laws that bar access to comprehensive care. Part III sketches a few ways in which abortion bans and restrictions corrupt or distort care, and how that process impacts providers. Part IV briefly discusses what the analytical framework and its application in this essay suggest for future work. Part V concludes.

II. THE CONSTRUCTION OF DANGER

In *Prosecuting Poverty*, Professor Bach's analysis reveals how the problem of neonatal abstinence syndrome and the solution—creating a crime to enable access to care—were co-constructed.[13] Similarly, criminal abortion laws both respond to and inform the claimed dangers of abortion. In addition, the sources of danger—women seeking abortion and providers of abortion services—are constructed in mutually reinforcing narratives. The obvious point is that the abortion debate is not about health risks to women or sloppy abortion providers. It is well-known, or should be, that extensive, well-documented evidence shows that both abortion procedures and medication abortion are safe.[14] Yet, the narratives of danger have served as drivers of more restrictions and ultimately, bans.

A. Constructing Danger

Abortion has been constructed as a social problem through extended, highly-politicized, public discourse. The U.S. Supreme Court's 2022 decision in *Dobbs*[15] marks a new phase in that discourse. Fifteen states banned abortion by August 2023.[16] Before and after *Dobbs*, many more

13. Bach, *supra* note 1, at 11.

14. Editorial, *Access to Safe Abortion is a Fundamental Human Right*, 46 THE LANCET, Apr. 2022, at 1.

15. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

16. *Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INST., https://states.guttmacher.org/policies/ (last updated Jan. 24, 2024).

states enacted restrictions that substantially limit abortion care.[17] These laws ostensibly address a high-profile social problem—abortion, by targeting the sources of risk or danger.

What are the dangers that abortion laws purport to address? Surveys show that individuals and organizations support legal restrictions for a wide range of reasons.[18] Similarly, among those who identify as abortion opponents, some support absolute bans on abortion while many oppose abortion under some circumstances but not all.[19] In other words, there may or may not be a consensus on justifications or dangers that abortion bans and restrictions address. Yet the laws clearly target those who seek abortion and those who provide abortion services.

Over time, the legal standards and analytical frameworks of *Roe*[20] and *Casey*[21] have shaped legal and movement challenges to abortion rights. In those cases, the Supreme Court recognized two state interests or justifications for restricting abortion: protecting potential life and protecting the health of women seeking abortion.[22] Restrictive statutes and arguments made in their defense elaborate on those two state interests in ways that paint pregnant women and abortion providers as the sources of danger.[23] *Dobbs* both affirms and expands that list of dangers.[24]

B. Dangerous Women

The immediate post-*Roe* period occurred during a time of significant social anxiety about young, unmarried, sexually active women, gender roles in marriage, and irresponsibility among poor women.[25] Public discourse about the problems of adolescent pregnancy, the threat of gender equality to

17. *Id.*

18. *America's Abortion Quandary*, PEW RSCH. CTR., https://www.pewresearch.org/religion/2022/05/06/americas-abortion-quandary/ (May 6, 2022).

19. *Id.*

20. Roe v. Wade, 410 U.S. 113 (1973).

21. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).

22. *Id.* at 837.

23. This essay does not examine the role of conservative Christianity and the rise of fetal personhood in these narratives. Obviously, the history and politics of those forces are important but many excellent analyses of these topics are available. I particularly recommend, Randall Balmer, Bad Faith: Race and the Rise of the Religious Right (2021).

24. *See Dobbs*, 142 S Ct. at 2284 (the list includes "respect for and preservation of prenatal life at all stages of development . . . the protection of maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; and the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.").

25. *See* KRISTIN LUKER, DUBIOUS CONCEPTIONS: THE POLITICS OF TEENAGE PREGNANCY 15 (1997).

traditional family, and threats to society by welfare mothers created profiles of bad mothers.[26] Reproductive health restrictions reflect these narratives. For example, early post-*Roe* laws targeted minors' access to abortion,[27] mandated information to dissuade women from abortion,[28] and banned use of federal Medicaid dollars for most abortions.[29]

The plurality opinion in *Casey* reflected anti-abortion advocates' success in expanding the scope of abortion's purported dangers.[30] The Court's rejection of the trimester framework and adoption of the undue burden standard allowed restrictions from the beginning of pregnancy, justified by both state interests.[31] This spurred anti-abortion organizations, lawmakers, and legal advocates to spin more extreme narratives of danger to justify new restrictions[32] and expand old ones.[33]

Many of the post-*Casey* laws have been what Reva Siegel labeled "woman-protective."[34] They depict pregnant women as vulnerable, in need of protection, often from themselves.[35] For example, laws based on the justification of protecting the health of the pregnant woman included long waiting periods, mandated disclosures containing false information, and ultrasound viewing requirements. Ostensibly, these requirements assumed that women needed extra time and information to make decisions.[36] The mandated disclosures of false claims that abortion increases risk of breast cancer or depression presented abortion as an event so dangerous that women could not comprehend it without assistance. Requirements that providers

26. *Id.* at 37; *see* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 18 (1997).

27. *See* Belloti v. Baird, 443 U.S. 622, 623 (1979); *see also* City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 416–418 (1983).

28. *See Arkron*, 462 U.S. at 416.

29. *See* Harris v. McRae, 448 U.S. 297, 297 (1980).

30. *See Casey*, 505 U.S at 871–72.

31. *Id.* at 872.

32. *See*, *e.g.*, Gonzales v. Carhart, 550 U.S. 124, 128, 141 (2007) (federal ban on specific abortion procedure that Congress suggests "brutal and inhumane" held valid).

33. *See, e.g.*, Webster v. Reproductive Health Servs., 492 U.S. 490 (1989); Hodgson v. Minnesota, 497 U.S. 417 (1990); Rust v. Sullivan, 500 U.S. 173 (1991).

34. Reva Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1642–43 (2008).

35. *Id.* at 1680; Alesha E. Doan & Corinne Schwarz, *Father Knows Best: "Protecting" Women through State Surveillance and Social Control in Anti-Abortion Policy*, 48 POL. & POL'Y 6, 8 (2020) (content analysis of 282 anti-abortion bills passed by a state House or Senate from 2010 to 2015 showed that of 727 anti-abortion measures, 622 "socially construct women as a dependent population in need of government protection.").

36. Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 242–43 (2009).

present ultrasound images of the pregnancy seem to assume that women cannot understand the moral significance of abortion without pictures.

C. Dangerous Doctors

"Woman-protective" laws have also positioned doctors as a source of danger. Content analysis of 282 bills containing 727 abortion restrictions showed, "[a]cross these policies, women are portrayed as an uninformed group in need of protection on two fronts: from their own ignorance and from the practices of abortion providers who are constructed as unethical health-care practitioners."[37] In addition, the danger that abortion providers pose, within this anti-abortion discourse, is both to the fetus and to the women seeking abortion services. The Court deployed an extreme version of this narrative in *Gonzales v. Carhart*.[38] In *Carhart*, the Court upheld a federal ban on a specific abortion procedure.[39] The majority opinion described that procedure in terms that cast it as a physical act of violence against the fetus.[40] Notably, the opinion rarely used the word "woman." More often, the opinion described specific parts of the female reproductive tract. When the opinion did use "women," it did so, not with respect to the right of privacy, but while explaining the interest balanced against that right—the state interest in protecting women's health.[41] There, the Court acknowledged that despite any lack of evidence, women must come to regret their decision to obtain abortion.[42] The majority thus suggested that abortion providers simultaneously harm "infant life"[43] and the woman who sought abortion care.

The two narratives of danger are mutually reinforcing. In *Carhart*, the majority validated the myth of abortion regret.[44] This simultaneously emphasizes the vulnerability of pregnant women,[45] which validates the danger that doctors pose to women seeking abortion. Many post-*Casey* abortion restrictions emphasize that point. Mandated waiting periods and disclosures, for example, suggest that doctors cannot be trusted with the

37. Doan & Schwarz, *supra* note 35, at 8–9.

38. *See Carhart*, 550 U.S. at 128–29, 160 & 163.

39. *Id.* at 124.

40. *Id.* 139–41.

41. *See id.* at 157–60.

42. *Id.* at 159–60.

43. *Id.*

44. *Id.*

45. *See* Susan Frelich Appleton, *Reproduction and Regret*, 23 YALE J.L. & FEMINISM 255, 318 (2011); J. Shoshanna Ehrlich, *Turning Women into Girls: Abortion Regret and the Erosion of Decisional Autonomy*, 35 WOMEN'S RTS. L. REP. 329, 350–51 (2014); Jody Lyneé Madeira, *Aborted Emotions: Regret, Relationality, and Regulation*, 21 MICH. J. GENDER & L. 1, 50–51 (2014).

informed consent process. This account of vulnerable women and dangerous doctors positions the state as protector or rescuer.

Abortion providers present at least three types of danger in these narratives. As indicated, abortion providers perform a dangerous procedure, and do so, unethically. Anti-abortion legislatures enacted Targeted Regulation of Abortion Provider ("TRAP") laws, presumably to protect vulnerable women from providers. TRAP laws include requirements that doctors who provide abortion services have admitting privileges at nearby hospitals and clinics where abortions take place and meet ambulatory surgical center requirements.[46] The requirements convey the false idea that abortion regularly results in serious complications[47]—dangers the state must mitigate.

Anti-abortion narratives also demonize doctors. TRAP laws evoke stories about notorious providers like Kermit Gosnell, found guilty of first-degree murder of three babies born alive during illegal late-term abortions, and involuntary manslaughter of a woman patient.[48] As the media noted, the Gosnell case "became a grisly flashpoint in the abortion debate in the US."[49] In that debate, Gosnell became the iconic abortionist, despite the exceptional nature of his actions in a post-*Roe* setting.

The third danger is also constructed out of whole cloth. It presents abortion as a tool of eugenics.[50] This narrative thread turns civil rights language and advocacy against providers. It rests on a claim that abortion is used to limit the Black population. This account resonates, in part, because it echoes an actual practice based on eugenic ideology. From the early twentieth century, doctors have performed coerced or involuntary sterilization.[51] Nonconsensual sterilization has been used on people who are

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46. *Targeted Regulation of Abortion Providers*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers (Aug. 31, 2023).

47. The Supreme Court found the need for admitting privileges and clinic compliance with ambulatory surgical center requirements unconvincing. *See generally,* Whole Women's Health v. Hellerstedt, 579 U.S. 582 (2016); June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2124 (2020).

48. Sarah Kliff, *The Gosnell case: Here's what you need to know*, WASH. POST (Apr. 15, 2013, 2:24 PM), https://www.washingtonpost.com/news/wonk/wp/2013/04/15/the-gosnell-case-heres-what-you-need-to-know/.

49. *Abortion doctor Kermit Gosnell found guilty of murder*, THE GUARDIAN, (May 13, 2013, 5:16 PM), https://www.theguardian.com/world/2013/may/13/kermit-gosnell-found-guilty-murder.

50. *See* Melissa Murray, *Race-ing Roe: Reproductive Justice, Racial Justice, & the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025, 2028 (2021); Dorothy Roberts, *Dorothy Roberts argues that Justice Clarence Thomas's Box v. Planned Parenthood concurrence distorts history*, PENN CAREY L., (June 6, 2019), https://www.law.upenn.edu/live/news/9138-dorothy-roberts-argues-that-justice-clarence.

51. *See* Philip R. Reilly, *Eugenics & Involuntary Sterilization: 1907 –2015*, 16 ANN. REV. OF GENOMICS & HUM. GENETICS 351, 352–53 (2015); Mary Elizabeth Dial, *Two Steps Forward, One*

poor, racialized, institutionalized, or living with disability.[52] Most have been women.[53] Despite the persistence of eugenic reproductive control, abortion has not been one of its tools. Yet, the eugenics claim uses race and disability to frame abortion as a civil rights violation against those who seek abortion care.[54]

D. Doctors as Risk to Medical Profession

In *Dobbs*, the majority concluded that "[a] law regulating abortion, like other health and welfare laws, is entitled to a strong presumption of validity."[55] The opinion identifies rational basis as the appropriate constitutional test for abortion laws and then sets out an expanded list of possible state interests.[56] The list includes "the preservation of the integrity of the medical profession."[57] This state interest is not unheard of in other cases about medical care. For example, courts considering withdrawal of life-sustaining treatment and medical aid-in-dying typically weigh the integrity of the medical profession against patient autonomy claims.[58]

Adding the state interest to the abortion context suggests that abortion providers threaten their own profession. More specifically, integrity of the medical profession has been used to evaluate medical protocols that fall into a gray area of medical practice. In *Cruzan*, the Court considered a state evidentiary standard used to evaluate testimony that Nancy Cruzan would have wanted life-sustaining treatment withdrawn when she entered a persistent vegetative state.[59] *Glucksberg* raised issues about constitutional protection of patient decisions to use medical aid-in-dying (physician-assisted suicide).[60] Both cases raise ethical concerns about the appropriate role of health providers whose actions enable patient death. The end-of-life

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Step Back: The Story of Eugenics in America, Past & Present, 11 ALA. CIV. RTS. & CIV. LIBERTIES L. REV. 177, 180–81 (2019).

52. LISA C. IKEMOTO*, Infertile by Force and Federal Complicity: The Story of Relf v. Weinberger*, *in* WOMEN & THE LAW STORIES 180, 180–86 (Elizabeth Schneider & Stephanie Wildman eds., 2011).

53. LISA C. IKEMOTO, *Infertile by Force and Federal Complicity, in* WOMEN & THE LAW STORIES, *supra* note 52*,* at 180.

54. *See* Murray, *supra* note 50, at 2062.

55. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2239 (2022) (citation omitted).

56. *Id.* at 2283–84.

57. *Id.* at 2284.

58. Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 277–81 (1990); Washington v Glucksberg, 521 U.S. 702, 723 (1997).

59. *Cruzan*, 497 U.S. at 285.

60. *Glucksberg*, 521 U.S. at 723.

protocols raised questions of first impression for the Court.[61] The cases produced different outcomes. In each case, however, taking the integrity of the medical profession into account seemed appropriate. In contrast, safe, legal abortion is not a recent practice that falls into a gray zone of medical care. Abortion is well-established as essential to comprehensive care.

III. ABORTION BANS AND RESTRICTIONS: CORRUPTING CARE

Reports from states banning abortion about how bans have harmed patient health and interfered with their lives have proliferated since *Dobbs*. As a result, we know that pregnant patients must wait to become sick enough to fit the emergency exception to abortion bans or scramble to find the resources and appointments for out-of-state care.[62] Other people with conditions like rheumatoid arthritis now have difficulty obtaining treatment because the same drug is used in abortion care.[63] Of course, providers have faced corollary difficulty determining when and how they can provide services that meet the standard of care.

A. Corrupted Care

Professor Bach aptly used "corrupted care," to describe the distorting effects Tennessee's fetal assault law has had on treating those prosecuted for substance use while pregnant.[64] Similarly, Lois Shepherd and Hilary D. Turner showed how TRAP laws impose "corrupted medicalization" of abortion.[65] TRAP laws and other requirements, with the putative purpose of mitigating danger, exaggerate abortion as a medical service. The

61. *Cruzan v. Missouri Department of Health (1990)*, CORNELL L., https://www.law.cornell.edu/wex/cruzan_v_missouri_department_of_health_(1990) (last updated July 2022).

62. *See* Claire Connolly, *A Year After Dobbs More People Than Ever Are Traveling For Abortion Care*, NAT'L ABORTION FED'N. (June 7, 2023), https://prochoice.org/a-year-after-dobbs-more-people-than-ever-are-traveling-for-abortion-care/; German Lopez & Ashley Wu, *Abortions After Dobbs,* N.Y. TIMES (Sept. 7, 2023), https://www.nytimes.com/2023/09/07/briefing/abortion-dobbs.html; Abigail Abrams, *'Am I a Felon?' The Fall of Roe v. Wade Has Permanently Changed the Doctor-Patient Relationship,* TIME (Oct. 17, 2022), https://time.com/6222346/abortion-care-after-roe-doctors-lawyers/.

63. *See* Katie Shepherd & Frances Stead Sellers, *Abortion bans complicate access to drigs for cancer, arthritis, even ulcers,* WASH. POST. (Aug. 8, 2022), https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis/.

64. Bach, *supra* note 1, at 185–86.

65. Lois Shepherd and Hilary D. Turner, *The Over-Medicalization and Corrupted Medicalization of Abortion and Its Effect on Women Living in Poverty*, 46 J.L. MED. & ETHICS 672, 672–73 (2018).

exaggeration diminishes abortion as an exercise of autonomy, one necessary to gender equality.

Here, I use "corrupted care" to capture how abortion bans distort health care delivery. Most of this analysis focuses on providers and the profession. However, abortion restrictions also amplify the longstanding, deeply rooted effects of structural inequality on health care. In general, that means that the harms and burdens of abortion bans fall disproportionately on people who are poor, racialized, and/or living with disability.[66] The selective amplification of harms and burdens is a feature, not a bug, of corrupted care.

B. Practicing Without a License

One way that abortion restrictions and bans corrupt care is by imposing non-evidence-based care requirements, thus removing authority from health providers to use standard of care. Bach calls this "practicing without a license."[67] Under restrictive abortion bans, those practicing without a license include state legislatures and the lawyers who counsel providers.[68]

1. First Check With The Risk Assessment Lawyer

Shortly after the Court decided *Dobbs*, the American College of Obstetricians and Gynecologists ("ACOG") issued a statement on medical emergency exceptions. The statement addressed the dilemma that vague and narrow exceptions to abortion bans create for providers.[69] They must interpret the statutory language and calculate the likelihood of prosecution before offering care.[70] ACOG's statement included, "ACOG has long affirmed that medical knowledge is not static, and laws must not interfere with a patient's ability to be treated by a physician according to the best currently available medical evidence and the physician's professional medical judgment."[71] But once those laws are in place, providers are forced

66. Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of Roe is Deepening Existing Divides*, GUTTMACHER INST., (Jan. 17, 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides.

67. Bach, *supra* note 1, at 167, 172–73.

68. *Id.*

69. *See Understanding & Navigating Medical Emergency Exceptions in Abortion Bans & Restrictions*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, (Aug. 12, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

70. Emily 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.

71. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 69.

to seek legal counsel to determine what care they can provide. The statutory language "may create difficulties for physicians, as it is unclear how much risk of death or how close to death a pregnant patient may need to be for the exception to apply."[72] Lawyers or facility administrators, not health professionals, are making the call based on legal risk assessment rather than evidence-based medical standards. An AMA report described institutional administrators who removed emergency contraception "from kits that are used in the care of sexual assault survivors because they believe the legal risk is too unclear," despite the fact that emergency contraception is not an abortifacient.[73] Lawyers and administrators lack the medical expertise to make health care decisions. Despite the fact that lawyers and health care professionals are both trained in preventing risk, minimizing legal exposure undercuts the medical goal of minimizing health care risk in this context. Abortion bans and restrictions force a distinction between what providers should do based on standard of care and what they can do under abortion restrictions and bans.[74]

2. Legislative Overreach

Professor Bach characterizes legislative or official overreach into health care as practicing without a license.[75] Professor Shepherd and Turner define corrupted medicalization as a similar process—"medical practice corrupted by law."[76] In effect, law shifts decision-making to the state or the clinician's institution.[77] Most, if not all abortion restrictions and bans discussed above illustrate this phenomenon. They flow logically from the narratives of danger but serve no real medical need.

For example, mandated disclosure, ultrasound viewing, and TRAP laws are imposed on providers. Disclosure and ultrasound viewing laws require that physicians rather than other providers perform these statutory duties, thus forcing providers to provide communicate information and engage in other practices inconsistent with standard of care. Performing these duties

72. Mabel Felix et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/.

73. Tanya Albert Henry, *Ambiguous anti-abortion laws are putting patients at risk*, AM. MED. ASS'N, (Sept. 16, 2022), https://www.ama-assn.org/delivering-care/population-care/ambiguous-anti-abortion-laws-are-putting-patients-risk.

74. *See* Felix et al., *supra* note 72; *see also*, Amended Petition for Declaratory Judgement, Zurawski v. Texas, No. D-1-GN-23-000968, 2023 WL 4994644 (Tex. Dist. May 22, 2023).

75. Bach, *supra* note 1, at 171–72.

76. Shepherd & Turner, *supra* note 65, at 673.

77. Felix et al., *supra* note 72.

takes time and resources without corresponding benefit to patient health or patient autonomy. Rather, the requirements have two other effects. They create barriers to care. And they conscript providers into imposing those barriers.

C. Degrading Care

Corrupted care includes the effects of abortion bans and restrictions on quality of care. Media and health scholars have been documenting how abortion bans and restrictions have degraded the quality of patient care, and the harm and suffering corrupted care imposes on patients.[78] Reports also show that restrictive laws negatively impact providers in a wide variety of ways.[79] Like harmful impacts on patients, negative impacts on providers are likely to produce ripple effects.

In states that ban or restrict abortion, law requires providers to deny care or delay care.[80] The Preliminary Report of the Care Post-Roe project is based on physician experiences and provides important detail.[81] In the first year after *Dobbs*, physicians reported the effects of denying, compromising, and delaying care of patients.[82] Denial of abortion services is not surprising given the content and intent of abortion bans. However, the breadth and vagueness of statutory language means that providers deny more than abortion care itself. For a patient in advanced labor of a pre-viability pregnancy, a physician reported, "[a]nesthesiology colleagues refused to provide an epidural for pain. They believed that providing an epidural could be considered [a crime] under the new law."[83] As mentioned, abortion bans with exceptions compel providers to delay abortion care until the risk to the patient's life fits the narrow statutory definition of emergency.[84] Providers,

78. *See, e.g.*, Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor Quality Care Since the* Dobbs *Decision*, ADVANCING NEW STANDARDS IN REPROD. CARE at 4–5 (May 16, 2023), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

79. *See* Fiona de Londras, Amanda Cleeve et al., *The Impact of Provider Restrictions on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence*, REPROD. HEALTH at 8–9 (Apr. 18, 2022), https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-022-01405-x; *See* Enze Xing, Rieham Owda, Charisse Loder & Kathleen Collins, *Abortion Rights Are Health Care Rights*, JCI INSIGHTS (Jun. 8, 2023), https://insight.jci.org/articles/view/171798.

80. *See* Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/.

81. *See* Grossman et al., *supra* note 78, at 4–6.

82. *Id.* at 4.

83. *Id.* at 8.

84. *Id.*

then, do not simply wait for time to pass, but do so knowing that delaying pregnancy termination for the patient with ectopic pregnancy, miscarriage, pre-eclampsia, or other complication will not change the outcome—end of the pregnancy. Rather, the delay prolongs patient suffering, may result in medical complications, and higher hospital costs.[85] Many providers banned from performing abortion services advise patients about out-of-state options, but do so knowing that if the patient can travel for care (and many patients lack the resources to do so), the patient will still face delay of care, the attendant risks, and may not have family and friends nearby.[86]

The Preliminary Report, along with media and academic research on patient impacts, also reveal some aspects of how corrupted care negatively affects not just the quality of care, but providers themselves.[87] Providers describe their experience under abortion bans as "caught in a bind"[88] or working while their "hands are tied."[89] Denying and delaying makes them fear for their patients' health and lives.[90] Some, including providers who live in receiving states, states that receive patients from states with bans, fear for their personal safety.[91] As mentioned, given the uncertainty that vague statutory language and politicization create, some providers fear prosecution or civil lawsuits.[92] The reluctance to help creates professional frustration.[93] Both providers who help patients arrange out-of-state care and providers in receiving states spend extraordinary time and resources to deal with logistical challenges and other aspects of arranging care. That takes a toll. One physician stated, "[t]he burden placed on health care providers should also be noted . . . The degree of coordination between Ob/Gyns in different states was heroic; however, this effort took away from other patients that our providers were caring for."[94] Providers in states with bans or restrictions face a similar toll extracted by the time and work needed to seek approval for care

85. *See id.* at 7–10.

86. *Id.* at 10.

87. *Id.* at 4.

88. Jamie Durana, *Physician Perspectives and Workforce Implications Following the Repeal of Roe v. Wade: Proceedings of a Workshop in Brief*, NAT'L ACAD. SCI., ENG'G. & MED., at 3 (2023), https://nap.nationalacademies.org/catalog/27211/physician-perspectives-and-workforce-implications-following-the-repeal-of-roe-v-wade.

89. Grossman et al., *supra* note 78, at 8.

90. *Id.* at 7; *see also*, Lucy Ogbu-Nwobodo et al., *Mental Health Implications of Abortion Restrictions for Historically Marginalized Populations*, 387 NEW ENG. J. MED. 1613, 1615–16 (2022).

91. *See* Durana, *supra* note 88, at 2.

92. *See* Baumgaertner, *supra* note 70.

93. Grossman et al., *supra* note 78, at 8.

94. *Id.*

from lawyers or committees.[95] Perhaps the most consistently reported impact is moral distress by providers who became health care professionals in order to help people.[96]

D. Ripple Effects

Media and other reports of *Dobbs*' impact on care in the first year following the Court's decision show that corrupted care has already caused ripple effects.[97] Certainly, reproductive health clinics have closed.[98] Some clinics have relocated to states without bans.[99] In addition, Ob-Gyns in particular, have considered or actually moved to non-ban states.[100] Two hospitals, both in Idaho, are closing their obstetrics units, due in part to physician departures prompted by Idaho's abortion ban.[101] Highly impacted receiving states like New Mexico are also experiencing provider shortages due to increased patient loads.[102] Hospitals in receiving states are seeing a significant increase in high-risk patients.[103] Providers in states with bans[104] and in receiving states recount stress and fatigue. This is taking place in a profession already experiencing workforce shortages and burnout that the COVID-19 pandemic aggravated.[105] Not surprisingly, a majority of medical students say they "are unlikely to apply to a residency program located in a

95. Durana, *supra* note 88, at 3–4.

96. *See* Grossman et al., *supra* note 78, at 7 ("The anesthesiologist cries on the phone when discussing the case with me—if the patient needs to be intubated, no one thinks she will make it out of the [operating room]"); *see also*, de Londras, et al., *supra* note 79, at 6–9 (showing similar effects in four countries: Australia, Ethiopia, Nepal, and the United States).

97. *See* Risa E. Kaufman & Katy Mayall, *One Year Later: Dobbs v. Jackson Women's Health Organization in a Global Context*, AM. BAR ASS'N (July 26, 2023), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-end-of-the-rule-of-law/one-year-later-dobbs-in-global-context/.

98. Allison McCann & Amy Schoenfeld Walker, *One Year, 61 Clinics: How* Dobbs *Changed the Abortion Landscape*, N.Y. TIMES (June 22, 2023), https://www.nytimes.com/interactive/2023/06/22/us/abortion-clinics-dobbs-roe-wade.html.

99. *Id.*

100. Grossman et al., *supra* note 78, at 9.

101. *See* Brittany Shammas & Marisa Iati, *Idaho Hospital to Stop Delivering Babies, Partly Due to 'Political Climate'*, WASH. POST (Mar. 21, 2023), https://www.washingtonpost.com/politics/2023/03/21/idaho-hospital-baby-delivery-abortion/.

102. *See* Sophie Putka, *Planned Parenthood of New Mexico Limits Non-Abortion Care Due to Surge from Texas*, MEDPAGE TODAY (Aug. 18, 2023), https://www.medpagetoday.com/special-reports/exclusives/105962.

103. *See* Kristen Schorsch, *Abortion Bans Are Fueling a Rise in High-Risk Patients Heading to Illinois Hospitals*, NPR (Aug. 23, 2023), https://www.npr.org/sections/health-shots/2023/08/23/1193898181/abortion-bans-are-fueling-a-rise-in-high-risk-patients-heading-to-illinois-hospi.

104. *See id.*

105. Durana, *supra* note 88, at 4.

state with abortion restrictions."[106] Workforce shortages may become more acute in states with abortion bans and restrictions.

IV. THOUGHTS GOING FORWARD

This essay adapts Professor Bach's insights to organize initial reports of *Dobbs*' effects on health care in the year since the Court overturned *Roe*. This essay sketches how criminalizing abortion care starts with constructing the sources of danger and produces corrupted care. The framework helps describe law's impact on health care, providers, and patients more precisely and systematically. It also helps to identify initial ripple effects and how they interact with other challenges that providers and patients face.

This analysis suggests possible directions for advocacy, policy work, and additional research. More accurately, it might confirm or challenge strategies that reproductive rights and justice advocates and other health care policy experts already have developed. For example, evidence of corrupted care might fuel efforts to de-medicalize abortion. In addition, the concept of corrupted care and practicing without a license raise important questions for health policy experts. We need processes and criteria for determining the appropriate relationship between law and evidence-based standards of medical care. Despite what the majority said in *Dobbs*, these issues should not be left entirely to state legislatures. Public surveys conducted during the past couple of years show that voters trust the integrity of physicians.[107] In addition, recent elections and surveys show that most people oppose abortion bans, even in abortion-ban states.[108] In the meantime, this analysis enumerates a rough typology of corrupted care that might suggest or affirm law and policy targets for intervention. The analysis confirms what many already know about health care workforce issues. And, at the very least, this essay calls for continuing in-depth attention to how corrupted care impacts providers.

Finally, this essay raises questions for the medical profession. In 1978, Paul Starr, noted sociologist of U.S. medicine, highlighted the waning of

106. Ariana Traub et al., *The Dobbs Decision and Its Geographical Effect on Future Physician Training*, 141 OBSTETRICS & GYNECOLOGY 100S, 100S (2023); *see also*, Durana, *supra* note 88, at 4.

107. *See* Jenny A. Higgins et al., *The Importance of Physician Concern and Expertise in Increasing Abortion Health Care Access in Local Contexts*, 111 AM. J. PUB. Health 33, 33–34 (2021).

108. *See* Kate Zernike, *How a Year Without Roe Shifted American Views on Abortion*, N.Y. TIMES (June 23, 2023), https://www.nytimes.com/2023/06/23/us/roe-v-wade-abortion-views.html.

professional sovereignty.[109] In the 21st century, providers work subject to multiple constraints on decision-making. Many do not consistently enhance either quality of care or patient autonomy. These limits include payor cost-containment mechanisms such as prior authorization requirements and capitation, institutional rules, and conditions in employment contracts.[110] Abortion bans, and more recently, bans on gender-affirming care implement intrusions that are not incremental, but are extraordinary and different-in-kind. Professional sovereignty is gone. Few patients or policy experts mourn that loss. The *Dobbs* opinion suggests that abortion undercuts the integrity of the medical profession. But the dedication of providers during the long assault on *Roe* and in the wake of *Dobbs* suggests that integrity, not sovereignty, is the profession's true foundation.[111] Protecting professional integrity should anchor efforts to prevent corrupted care.

V. CONCLUSION

Abortion bans and restrictions produce corrupted care. The denials, delays, and degrading of care harms women and other pregnant people seeking care, and it does so in ways that amplify structural inequalities embedded in day-to-day life. This essay acknowledges those harms and focuses on providers. Bach's analysis sheds light on how bans and restrictions impose non-medical standards into care. This essay uses Bach's process-based approach to highlight some of the impacts on providers' ability to deliver health care, on providers as human beings, and on the medical profession. This is an effort to provide a more complete account of *Dobbs*' harms, in hopes of stimulating fruitful exchange about moving forward.

109. *See* Paul Starr, *Medicine and the Waning of Professional Sovereignty*, 107 DAEDALUS 175, 175–76 (1978

110. *See generally* Niharika Namburi & Prasanna Tadi, *Managed Care Economics*, NAT'L LIBR. MED. (Jan. 30, 2023), https://www.ncbi.nlm.nih.gov/books/NBK556053/?report=printable.

111. I confess that much of my own work questions the integrity of doctors and researchers, especially in settings where neoliberalism and social conservatism prevail. The major exception, in more than 30 years of my own research, are providers dedicated to maintaining access to reproductive health care.