For years, Kara Cadwallader, MD, had noticed tensions rising in Boise, Idaho. In particular, she was struck by a widening political divide and loss of civil discourse that seemed to mirror so many other parts of the country.

But the situation for Cadwallader, a Boise family medicine physician and the chief medical officer for Planned Parenthood Great Northwest, Hawai’i, Alaska, Indiana, and Kentucky, took on another dimension in September 2021. Texas had passed a new law—one that explicitly targets clinicians who provide abortion care. Within 6 months, Idaho followed suit when its governor, Brad Little, signed a “copycat bill” into law in March. Now, Cadwallader’s clinics and the physicians who work there have been walking a precarious tightrope between practicing medicine and staying out of jail.

“This vigilante law—it was the first really evident example of someone saying, ‘We’re coming to get you,’” she said in an interview with JAMA.

The recently enacted laws in Texas and Oklahoma are directed at those who “aid or abet” or otherwise facilitate abortions after 6 weeks’ gestation. In interviews this past spring, legal experts and health policy researchers said that health care professionals around the country—from obstetricians and emergency physicians to geneticists and family medicine physicians—were struggling to interpret what the laws meant for them.

In Oklahoma and Texas, the laws depurate citizens to turn in anyone who aids or abets an abortion, allowing for $10 000 or more in damages plus legal fees for bringing a successful civil lawsuit. In Idaho, the law states that a successful civil lawsuit brought by certain relatives—the father, grandparent, sibling, aunt, or uncle of a “pre-born child”—of a patient who has had or attempted to have an abortion will award at least $20 000 in damages.

Some other differences also distinguish the states’ laws. In Texas and Idaho, abortions are illegal at any point after a fetal heartbeat is audible on ultrasound (usually around 6 or 8 weeks), while the Oklahoma law makes abortions illegal outright.

However, within days of the Supreme Court’s Dobbs decision, judges in several states including Louisiana, Kentucky, Florida, and Texas temporarily blocked enforcement of restrictions or bans on abortion. In some states, the bans were quickly
reinstated. An executive order that President Joe Biden signed 2 weeks after the Dobbs decision pledged to organize private pro bono legal services for health care professionals, patients, and third parties involved in seeking or providing reproductive health care services, including care that involves out-of-state travel.

Even so, given the novelty of some of the laws, there is little legal precedent for what “aids and abets” means in practice, Stephen Vladeck, JD, a law professor at the University of Texas at Austin, noted in an interview.

The bills don’t define this clause. If the laws are interpreted narrowly, Vladeck said, it’s possible that only individuals performing abortion procedures such as dilation and curettage would come under legal scrutiny.

But if the laws are interpreted expansively, they could potentially implicate anyone who directly or indirectly assists in an abortion. That theoretically could extend to a clinic’s front desk staff, a rideshare driver who brings a patient to a procedure, or a mail carrier who delivers prescription medication to terminate a pregnancy.

“Part of the tricky part here is that the laws are so capacious and are drafted—quite deliberately—so open-endedly,” Vladeck said.

What happens in emergency situations involving pregnant patients is another big open question.

Although medical emergencies to save the pregnant person’s life are exempted under the bills, what qualifies as such is left to interpretation. When do incidents during pregnancy like vaginal spotting, hypertension, or headaches become life-threatening? The laws don’t have the answers. Although Vladeck said he suspects that, in most cases, prosecution for emergency care won’t result in conviction, the mere threat may be enough to change physician behavior.

“If and when that case goes to court, the provider is going to win,” he said. “But the problem is that by the time that happens, the provider has had to absorb the cost of defending themselves....They’re going to lose a whole lot just by winning.”

Those costs may include more than just litigation. Where lawsuits go, licensure issues often follow, cautioned David Cohen, JD, a law professor at Drexel University. State licensing boards require physicians to report any ongoing suits that implicate them. They consider any legal action when deciding whether to approve or renew clinicians’ paperwork, so even a baseless abortion suit could affect a physician’s ability to practice medicine.

Thus far, only Idaho specifies penalties that affect licensure—suspension for at least 6 months on a first offense and permanent revocation on a second offense. Elsewhere, it’s not clear what action licensing boards may take, or whether they’ll consider a given lawsuit’s merit.

Reached by email, Jerica Stewart, communications officer for the State Medical Board of Ohio, where abortions are now illegal after 6 weeks with few exceptions, did not offer specifics: “The board is complaint-driven and considers a complaint to be any allegation of licensee misconduct,” she wrote. “If the findings of an investigation support that a violation(s) of Ohio laws or regulations has occurred, the board may pursue disciplinary action of a license.”

Some state boards, however, appear to be taking a hard line.

In North Dakota, almost all abortions will be banned as of July 28 unless a lawsuit succeeds in barring enforcement of the state’s trigger law. Before the lawsuit was filed, the state board of medicine’s executive director, Sandra DePountis, wrote in an email that the board “may discipline licensees” for performing an abortion “prior to determining...a detectable heartbeat.”

Careers and Care in the Balance

The risk of prosecution also poses a considerable threat to physicians’ and health systems’ reimbursements and liability insurance.

Medical malpractice insurers often view legal action as a proxy for risky behavior. Under that framework, if clinicians become vulnerable to litigation by providing any type of abortion care, “[insurers] might take that into account regarding raising rates—or ending a policy,” Cohen said. And because insurance companies flag patterns of legal involvement as signals of high-risk behavior—regardless of culpability—experts are concerned that any abortion-related prosecution could increase physicians’ premiums to an extent that they might simply stop performing the procedures.

As with licensing boards, it’s unclear how malpractice insurers will handle abortion-related lawsuits.

“We don’t have a response for this,” a representative from ISMIE, one of the largest US medical malpractice insurers, wrote in an email. Coverys, another major national malpractice insurer, also declined to comment. Seven other insurers could not be reached for comment.

On the other side of physicians’ balance sheets, the threat of legal action also may put reimbursement in jeopardy.

Under the Emergency Medical Treatment & Labor Act (EMTALA), physicians in urgent care or emergency care facilities are required to perform “appropriate medical screening” and “treatment as required to stabilize the individual.” As such, physicians in emergency settings who alter care for pregnant people to shield themselves from liability—for example, by delaying abdominal ultrasounds or magnetic resonance imaging scans, by transferring patients elsewhere, or by denying care outright—could expose themselves and their hospitals to financial sanctions from payers including the Centers for Medicare & Medicaid Services (CMS).

Avoiding or deferring those services because of concerns about facilitating what may lead to an abortion could result in a fine or loss of reimbursement from CMS, Vladeck said.

Shortly after the restrictive Texas law went into effect in September 2021, CMS issued a memorandum reminding medical professionals of their responsibilities under EMTALA. The document stated that “a physician’s duty” to stabilize patients who have an emergency medical condition “preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment.”

The uncertainties surrounding these issues could affect clinical care. “Anything that threatens [physicians’] freedom, their license, or their malpractice insurance is something they take note of—and change their practice in response to,” Cohen said. Vladeck agreed, adding that he expects “a significant chilling effect even for circumstances that are actually not prohibited.”

There’s ample evidence of such “defensive medicine” during periods of high-volume litigation. A 2005 study in JAMA surveyed practice patterns among Pennsylvania physicians in emergency medicine, general surgery, orthopedic surgery,
neurosurgery, obstetrics/gynecology, and radiology—all specialties at high risk of litigation—in the early 2000s when the state’s courts were particularly sympathetic to malpractice claimants. Of 824 respondents, 42% reported taking steps to protect themselves from such claims, such as “eliminating procedures prone to complications” and “avoiding patients who had complex medical problems or were perceived as litigious,” the authors wrote.

Research has also documented how litigation can harm physicians’ careers over the longer-term. Studies have found that rates of burnout and dissatisfaction are higher in the face of increased prosecution. Perhaps as a result, physicians working in high-litigation settings are more likely to leave their practice, either by moving elsewhere or by retiring.

“Training for This Moment”
The outlook on abortion may appear bleak following the Dobbs decision, but physicians are not without options.

States including Oregon, California, Illinois, and Vermont have already positioned themselves as sanctuary states for abortion access, enacting laws specifically designed to protect birthing peoples’ right to choose—including those from other parts of the country. For example, Oregon lawmakers allocated $15 million in April for “reproductive health equity,” which includes paying for those seeking abortions from out of state. Private abortion funds have also raised millions more dollars to support travel, accommodation, and care related to abortions.

Physicians from states where abortion is illegal can play a critical role in connecting patients with these types of resources. Although, according to Vladeck, there is a theoretical risk of extradition under these circumstances, groups like the American College of Obstetricians and Gynecologists continue to encourage clinicians to use the resources at their disposal—like referrals to clinics and social service organizations operating in states with less restrictive laws—to advance abortion access.

Even though Planned Parenthood’s Cadwallader now works in a state where abortion is illegal, she is dedicated to counseling patients with an unplanned pregnancy and providing comprehensive care for those who decide to carry the pregnancy to term. In other cases, she’s committed to ensuring that patients who choose to terminate an unintended pregnancy have a safe, legal place to go since she can no longer help them herself.

“I guess I never thought I’d live to see this happen in my lifetime,” she said. “But we’ve been training for this moment for a long time.”

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Conflict of Interest Disclosures: Dr Cadwallader reports being a trainer for Organon’s contraceptive implant Nexplanon Insertion. Mr Vladek reports being an employee of the State of Texas. Mr Cohen reports being a board member of the Abortion Care Network and a consulting attorney for the Women’s Law Project. No other conflicts were reported.

Note: Source references are available through embedded hyperlinks in the article text online.