Legal Risks and Ethical Dilemmas for Clinicians in the Aftermath of Dobbs

The Supreme Court’s ruling in Dobbs v Jackson Women’s Health Organization, overturning Roe v Wade and Planned Parenthood v Casey, triggered abortion bans or restrictions in half of states. Some laws are so broad that they prohibit common medical procedures, such as medication abortions and emergency health services related to abortion, and make no exceptions for abortion in cases of rape or incest. Such laws pose serious legal risks to clinicians and present major ethical dilemmas.

State Abortion Restrictions
Twenty-six states have total or near-total abortion bans, although courts have blocked 8 of these laws (eTable in the Supplement). Only Georgia, Mississippi, Utah, and West Virginia provide exceptions for rape or incest. Nine states do not grant explicit exceptions for nonfatal risks to the pregnant person’s physical health. Abortion bans subject clinicians to harsh civil penalties, including fines up to $10,000, criminal punishments, or suspension of medical licenses. Texas imposes a maximum penalty of life imprisonment, 10 states impose penalties of up to 10 to 15 years, and 10 states impose penalties of up to 1 to 5 years. Texas, Idaho, and Oklahoma authorize citizen enforcement of abortion laws, empowering private citizens to sue clinicians. Texas and Oklahoma laws apply to anyone who “aids or abets” an abortion, including clinicians and family members. Citizen enforcement increases the risk of intrusive surveillance and criminal liability.

Surveillance and Privacy
Abortion bans could enhance the profiling and surveillance of patients and their families, friends, and clinicians. Law enforcement, and even citizen enforcers, may use covert surveillance to identify individuals providing or aiding and abetting an abortion. Surveillance could include accessing data held by private insurers and on cell phone applications and monitoring social media posts, as occurred when Nebraska prosecuted a teenager who used medication to induce an abortion and her mother who assisted her.

Medication Abortions
The US Food and Drug Administration (FDA) permits medication abortion through 10 weeks’ gestation. Yet state abortion bans are written broadly and prohibit many medication abortions. Fifteen states with gestational limits of 6 weeks or less would effectively prohibit all medication abortions. Although the FDA allows remote dispensing of mifepristone, telehealth for abortion medication varies by state, with 7 states explicitly prohibiting the practice. Additional states curtail access to medication abortion, including 19 states that require the prescribing clinician to be physically present. Other states have ultrasonography and counseling requirements, waiting periods, and specific in-person dispensing mandates that also limit telehealth prescriptions.

Clinicians could face legal jeopardy even in states that permit abortions. Although out-of-state enforcement of abortion bans has practical barriers, bills in some states would prohibit out-of-state abortion assistance. Clinicians who counsel their patients about out-of-state abortion facilities or directly contact out-of-state clinicians to transfer patient information could be subject to legal penalties.

Urgent Reproductive Health Services
All abortion bans include exceptions for the pregnant person’s life, but 9 states do not include nonfatal health risks. In states without maternal health exceptions, clinicians will be forced to choose between conflicting legal obligations. Many states prohibit clinicians from abandoning their patients. The federal Emergency Medical Treatment and Labor Act (EMTALA) requires Medicare-participating hospitals that offer emergency services to provide a medical screening, examination, or treatment for emergency medical conditions, including active labor. The Centers for Medicare & Medicaid Services’ recent EMTALA guidance affirmed that if a pregnant patient has an “emergency medical condition” and an abortion is necessary to stabilize that patient, EMTALA preempts any contrary state law. However, a federal court in Texas recently issued a temporary injunction against enforcement of Centers for Medicare & Medicaid guidance.

In providing urgent care, clinicians may be unsure whether the services a patient requires are "lifesaving"
or when a patient's life is in sufficient danger to warrant an abortion. State bans are pushing clinicians to delay abortions until the patient's condition becomes life-threatening or fetal cardiac activity is no longer detectable.6 For example, some clinicians reportedly are waiting until a patient becomes critically ill before treating an ectopic pregnancy or septic miscarriage.7

Miscarriage Management, Assisted Reproductive Technologies, and Cancer Therapy

Because miscarriages occur in up to an estimated 30% of all pregnancies and miscarriage management and abortion services are often clinically similar, clinicians may be unsure of what the law allows.8 For example, the American College of Obstetricians and Gynecologists recommends a combination of misoprostol and mifepristone for early-term miscarriages. Yet, some pharmacists reportedly have been reluctant to fill patients' prescriptions in early pregnancy loss.

Abortion bans may also affect assisted reproductive technology services. Abortion restrictions in at least 27 states include fetal personhood or personhood-type language9; for example, many define life as beginning at “the moment of fertilization.” Although feticide laws explicitly exempt assisted reproductive technology or fertility treatments, many abortion bans lack such exceptions, leaving the interpretation and application to state or county attorneys general.9 These laws may implicate in vitro fertilization preimplantation embryos, affecting decision-making around their storage and disposition, disallowing their discard, and prohibiting “compassionate transfers” (embryo transfers for nonreproductive purposes). Pre-implantation genetic testing may also be at risk, with fertility clinicians uncertain how to deal with embryos carrying a genetic disease.

Oncologists may also encounter dilemmas. Diagnosis of cancer during pregnancy requires oncologists to weigh risks both to patients and fetuses: to the pregnant person if cancer treatment is delayed and to the fetus for serious complications associated with chemotherapy. In some situations, the risk of delayed treatment should guide a clear recommendation for pregnancy termination.

Training in Reproductive Medicine

In states that ban abortions, medical students will have fewer opportunities to learn safe, evidence-based reproductive health procedures, which could save the life of a pregnant person. Abortion care training as a resident is an important predictor of a clinician's ability to provide the full range of miscarriage management services. Beyond inadequate or incomplete training, there is a shrinking workforce for high-quality abortion and pregnancy loss services, which could have far-reaching consequences for maternal and infant health outcomes.

Maternal Mortality and Racial Inequalities

Lack of access to high-quality reproductive health services will disproportionately affect low-income individuals, especially Black and Hispanic individuals, who are more likely to lack health insurance and to face barriers to traveling long distances for abortion services (eg, time off of work, childcare, travel costs). Abortion bans will likely increase pregnancy-related deaths, and nationally Black individuals are 3 times more likely than White individuals to die of pregnancy-related causes.10 In states with abortion bans, racial disparities in maternal mortality and morbidity are compounded and magnified. Maternal mortality rates increased significantly (from 44 to 55 maternal deaths per 100 000 live births) for Black individuals between 2019 and 2020.10 Abortion bans may also exacerbate racial inequities in perinatal and infant health.

Ethical Dilemmas

State abortion bans undermine core bioethics principles, including autonomy, confidentiality, and duty of care. Competent patients have a right to control their own body and to make meaningful medical choices. Patients also have an expectation of privacy that deserves respect. Legal and ethical duties of care require clinicians to provide high-quality medical services.

Yet, state abortion laws directly and immediately threaten the health of pregnant persons and impede evidence-based medical care. Abortion bans undermine clinicians’ ability to counsel patients honestly and to provide care guided solely by their best clinical judgment and evidence of effectiveness. Abortion bans therefore erode trust at the heart of the physician-patient relationship.

The American Medical Association’s Code of Medical Ethics states that “in some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust, they should work to change the law.”7 In the face of unjust laws, clinicians’ ethical responsibilities should supersede legal dictates, including civil disobedience in defense of their medical code of ethics.