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Pregnancy Risk and Coerced Interventions after *Dobbs*

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PREGNANCY RISK AND COERCED INTERVENTIONS AFTER *DOBBS*

Elizabeth Kukura*

ABSTRACT

Only nine months after the Supreme Court eliminated the federal constitutional right to abortion in Dobbs v. Jackson Women’s Health Organization, fourteen states had banned abortion entirely, and experts estimate the ultimate number of states imposing complete or near-complete restrictions on abortion care will likely rise to twenty-four. Millions of people with the capacity for pregnancy now (or will soon) live in places where getting pregnant means there is no choice other than to carry the pregnancy to term and give birth. One underappreciated, though critically important, impact of Dobbs is the extent to which newly enacted abortion restrictions will increase both the number of people with high-risk pregnancies and, relatedly, the number of people who are coerced into medical treatment during labor and delivery. Such mistreatment in the form of coerced interventions will compound the harm of forced pregnancy after Dobbs with negative consequences for the physical and emotional well-being of birthing people and their babies.

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I. INTRODUCTION

SHORTLY after the Supreme Court eliminated the federal constitutional right to abortion in June 2022,¹ a number of states made abortion illegal, either through existing trigger bans going into effect or through the passage of new legislation made possible by the *Dobbs* decision.² By April 2023, fourteen states had banned abortion entirely,³ and experts estimate the ultimate number of states imposing complete or near-complete restrictions on abortion care will likely rise to twenty-four.⁴ These laws contain very limited exceptions, often designed to be difficult to invoke, and seeking an abortion elsewhere is possible only for people who have access to the resources and time necessary for out-of-state travel.⁵ The result is that millions of people with the capacity for pregnancy now (or will soon) live in places where getting pregnant means there is no choice other than to carry the pregnancy to term and give birth.⁶ This massive shift in the legal and healthcare landscape in the United States has wide-ranging implications for the health, dignity, and

1. See *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2234 (2022).

2. See Martha F. Davis, *The State of Abortion Rights in the US*, 159 INT'L J. GYNECOL. & OBSTETS. 324, 325 (2022).

3. *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST. (Feb. 1, 2023) [hereinafter *State Bans on Abortion*], <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions> [<https://perma.cc/H67E-68KP>]; Ava Sasani, *North Dakota Governor Signs Total Abortion Ban*, N.Y. TIMES (Apr. 24, 2023), <https://www.nytimes.com/2023/04/24/us/abortion-ban-north-dakota.html> [<https://perma.cc/P6ZC-UPXG>] (noting recent enactment of fourteenth abortion ban).

4. Elizabeth Nash & Isabel Guarnieri, *Six Months Post-Roe, 24 US States Have Banned Abortion or Are Likely to Do So: A Roundup*, GUTTMACHER INST. (Jan. 10, 2023), <https://www.guttmacher.org/2023/01/six-months-post-ro-24-us-states-have-banned-abortion-or-are-likely-to-do-so-roundup> [<https://perma.cc/TMS3-59E3>].

5. Elizabeth Nash, *Focusing on 'Exceptions' Misses the True Harm of Abortion Bans*, MS. MAG. (Dec. 13, 2022), <https://msmagazine.com/2022/12/13/abortion-ban-exceptions-rape-incest-health-life> [<https://perma.cc/GX7C-GLGM>]; Yelena Dzhanova & Jason Lalljee, *Gas, Food, and a Hotel: Americans Seeking an Abortion Out of State Already Shell Out Up To \$10,000 for the Procedure. Experts Warn That Cost Could Rise.*, BUS. INSIDER (June 24, 2022, 12:00 PM), <https://www.businessinsider.com/abortion-costs-ro-ve-wade-out-of-state-supreme-court-2022-5> [<https://perma.cc/2MEX-AUPH>] (noting that costs of out-of-state abortion travel may include airfare, gas, car rentals, childcare, petcare, food, and hotels, as well as the lost earnings associated with missing work).

6. A pre-*Dobbs* study estimated that, in the first year following the reversal of *Roe*, between 93,546 and 143,561 women would be prevented from accessing abortion care. Caitlin Myers, Rachel Jones & Ushma Upadhyay, *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100 CONTRACEPTION 367, 372–73 (2019) (reflecting a prediction that twenty-one states would ban abortion). It is important to note that not all people who stay pregnant, whether because they want to or because they are denied abortion care, will give birth to a live baby. See *What Is Stillbirth?*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/stillbirth/facts.html> [<https://perma.cc/2VSU-TSWF>] (noting approximately 1 in 175 pregnancies results in stillbirth, which is pregnancy loss that occurs after twenty weeks of gestation); Michelle Starr, *New Research Shows Most Human Pregnancies End in Miscarriage*, SCI. ALERT (Aug. 1, 2018), <https://www.sciencealert.com/meta-analysis-finds-majority-of-human-pregnancies-end-in-miscarriage-biorxiv> [<https://perma.cc/ACQ5-3AUF>] (noting that miscarriage, which occurs before twenty weeks of gestation and is referred to medically as spontaneous abortion, occurs in 10%–20% of known pregnancies).

life trajectory of individual pregnant people, along with the well-being of their families and communities.⁷ One underappreciated, though critically important, impact of *Dobbs* is the extent to which newly enacted abortion restrictions will increase both the number of people with high-risk pregnancies and, relatedly, the number of people who are coerced into medical treatment during labor and delivery. Such mistreatment in the form of coerced interventions will compound the harm of forced pregnancy after *Dobbs* with negative consequences for the physical and emotional well-being of birthing people and their babies.⁸

II. PREGNANCY RISK AFTER *DOBBS*

Public discourse about abortion sometimes employs vague or euphemistic language about broad concepts like “choice” or “autonomy.” While these values are central to the debate over reproductive self-determination, their use can obscure the harsh reality that losing the “right to choose” means millions of people will be forced into pregnancies and births against their will. These forced pregnancies have important health consequences.

Research conducted before *Dobbs* shows that giving birth poses significantly greater risk of health complications than abortion.⁹ In fact, the risk of dying in childbirth is approximately fourteen times higher than the risk of death associated with abortion.¹⁰ Not only has the relative safety of abortion increased since nationwide legalization in 1973¹¹ (due in part to the increased use of medication abortion¹²), but the United States is a

7. See, e.g., DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING—OR BEING DENIED—AN ABORTION* 6–7 (2020); Naomi Cahn & June Carbone, *Supporting Families in a Post-Dobbs World: Politics and the Winner-Take-All-Economy*, N.C. L. REV. (forthcoming 2023); Lauren Hoffman, Osob Ahmed & Bela Salas-Betsch, *State Abortion Bans Will Harm Women and Families' Economic Security Across the US*, CTR. FOR AM. PROGRESS (Aug. 25, 2022), <https://www.americanprogress.org/article/state-abortion-bans-will-harm-women-and-families-economic-security-across-the-us> [<https://perma.cc/9J2P-QQC5>].

8. In certain places, this Article refers to pregnant and childbearing people as women, but it is important to recognize that some men and nonbinary people also get pregnant and give birth. See, e.g., Heidi Moseson et al., *The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women's Health*, 135 *OBSTETS. & GYNECOL.* 1059, 1061–62 (2020); Elizabeth Kukura, *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*, 50 *J.L. MED & ETHICS* 471, 472–73 (2022) (discussing research on the childbearing experiences of trans, non-binary, and gender-expansive people and highlighting areas for further research). For accuracy, this Article will use the terms “pregnant people” or “birthing people” in general discussion and “women” when discussing particular cases, explicitly gendered aspects of childbirth-related care, or research involving only women, even though the research findings may be applicable to all pregnant people.

9. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *OBSTETS. & GYNECOL.* 215, 216 (2012).

10. See *id.*

11. See *id.* at 217.

12. See, e.g., *The Availability and Use of Medication Abortion*, KAISER FAM. FOUND. (Feb. 24, 2023), <https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion> [<https://perma.cc/W86E-NPK8>].

notable outlier among high-resource nations for its high maternal mortality and morbidity.¹³ In fact, the maternal mortality rate has increased in recent years, reaching 32.9 deaths per 100,000 live births in 2021, which is a significant increase from 23.8 deaths per 100,000 live births in 2020.¹⁴ The 2020 rate was already nearly triple the rate reported by France, the country with the next highest number of deaths from pregnancy and childbirth.¹⁵ Additionally, childbirth in the United States is associated with a significantly higher risk of morbidity than abortion, with as many as 60,000 women each year reporting serious childbirth-related complications short of death.¹⁶ Pregnancy-related mortality and morbidity are experienced disproportionately by Black and Native American women, who die at 3 and 2 to 4.5 times the rate of non-Hispanic White women, respectively.¹⁷

Looking ahead to the post-*Dobbs* era, researchers have estimated that a complete nationwide abortion ban would increase maternal mortality by 24% across the pregnant population and by 39% for Black women specifically.¹⁸ A state-by-state breakdown shows that Florida and Georgia would experience the highest increases in maternal deaths, reflecting a 29% jump in their mortality rates.¹⁹ Notably, these mortality projections do not account for increased morbidity resulting from pregnancy and childbirth.²⁰ Concern about *Dobbs*'s negative impact on childbearing

13. Jamila Taylor, Anna Bernstein, Thomas Waldrop & Vina Smith-Ramakrishnan, *The Worsening U.S. Maternal Health Crisis in Three Graphs*, CENTURY FOUND. (Mar. 2, 2022), <https://tcf.org/content/commentary/worsening-u-s-maternal-health-crisis-three-graphs/?session=1> [<https://perma.cc/AGU2-MYBT>].

14. Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, NAT'L CTR. HEALTH STATS. (March 2023), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf> [<https://perma.cc/2PP6-8HBB>].

15. Taylor et al., *supra* note 13.

16. EUGENE DECLERCQ & LAURIE ZEPHYRIN, COMMONWEALTH FUND, SEVERE MATERNAL MORBIDITY IN THE UNITED STATES: A PRIMER 1 (2021), https://www.commonwealthfund.org/sites/default/files/2021-10/Declercq_severe_maternal_morbidity_in_US_primer_db.pdf [<https://perma.cc/437C-KVSZ>]; *see also* Raymond & Grimes, *supra* note 9, at 217.

17. *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> [<https://perma.cc/8ERD-UXPU>] (reporting 41.4 deaths per 100,000 live births for Black women, 26.5 for Native American women, and 13.7 for White women between 2016 and 2018); Mary Annette Pember, *Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support*, REWIRE NEWS GRP. (July 9, 2018, 11:05 AM), <http://rewire.news/article/2018/07/09/amid-staggering-maternal-infant-mortality-rates-native-communities-revive-traditional-concepts-support> [<https://perma.cc/Q3F4-FGZL>] (“Data from the Urban Health Institute collected from the organizations’ 33 nationwide health-care locations found that maternal mortality rates for Native women was 4.5 times greater than non-Hispanic [W]hite women.”).

18. Amanda Jane Stevenson, Leslie Root & Jane Menken, *The Maternal Mortality Consequences of Losing Abortion Access* 6 (June 29, 2022) (unpublished manuscript), osf.io/preprints/socarxiv/7g29k [<https://perma.cc/AP5C-BUW8>] (noting that projection does not include increased maternal deaths resulting from forced continuation of high-risk pregnancies, more unsafe abortions, or increased domestic violence homicides, among other factors).

19. *Id.*

20. *See id.*; Elyssa Spitzer, Tracy Weitz & Maggie Jo Buchanan, *Abortion Bans Will Result in More Women Dying*, CTR. FOR AM. PROGRESS (Nov. 2, 2022), <https://>

people's health is not merely hypothetical. Existing research on the impact of abortion denial shows that women who are refused abortion care are more likely to have worse health outcomes, some of which result in lifelong consequences.²¹ For example, women who are denied abortion care are more likely to develop gestational hypertension, which contributes to eclampsia, a life-threatening pregnancy complication that can cause seizures, stroke, and cardiac arrest.²² An analysis conducted shortly after the Supreme Court decided *Dobbs* found that Black and Native American women disproportionately live in the states that have banned or are likely to ban abortion, as are women with disabilities and women who are economically insecure—all of which will exacerbate existing racial and socioeconomic health disparities in maternal health outcomes in the coming years.²³

Overall, the maternal health crisis in the United States means that state abortion bans not only force people to carry their pregnancies to term but also compel them to assume a much higher risk of death or serious medical complication because childbirth is more dangerous than abortion. The risk is compounded for Black and Native American women because they are more likely to face barriers to accessing abortion²⁴ and are more likely to suffer adverse health outcomes during pregnancy and childbirth.²⁵ This fact alone should be troubling to anyone concerned about how abortion restrictions harm people with the capacity for pregnancy. But the constellation of risks associated with forced reproduction after *Dobbs* is far more complex and nuanced than the greater overall mortality risk of childbirth relative to abortion. This Article highlights three spe-

www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying [https://perma.cc/5U5F-UPTD].

21. Lauren J. Ralph, Eleanor Bimla Schwarz, Daniel Grossman & Diana Greene Foster, *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 ANNALS INTERNAL MED. 238, 238, 243 (2019).

22. *Id.* at 246.

23. KATHERINE GALLAGHER ROBBINS & SHAINA GOODMAN, NAT'L P'SHIP FOR WOMEN & FAMS., STATE ABORTION BANS COULD HARM NEARLY 15 MILLION WOMEN OF COLOR 2 (2022), <https://www.nationalpartnership.org/our-work/resources/economic-justice/state-abortion-bans-harm-woc.pdf> [https://perma.cc/2NPT-YGDB]. This report was published before developments in South Carolina and Michigan removed them from the list of states likely to ban abortion, putting the total number of such states at twenty-four. See Nash & Guarnieri, *supra* note 4. But the ultimate finding about disproportionate representation of Black and Native women in abortion-hostile states remains unchanged after removing South Carolina and Michigan women from the tally: 44% of women of reproductive age overall live in ban/ban-likely states while 50% of Black women of reproductive age and 55% of Native American women of reproductive age live in those states. See ROBBINS & GOODMAN, *supra* (recalculating percentages based on data contained within report).

24. See Jamila Taylor, *Women of Color Will Lose the Most if Roe v. Wade is Overturned*, CTR. FOR AM. PROGRESS (Aug. 23, 2018), <https://www.americanprogress.org/article/women-color-will-lose-roe-v-wade-overturned> [https://perma.cc/9TJ7-DH29]; Allison Herrera, *Long Before Roe v. Wade Was Overturned, Indigenous Women Faced Barriers to Abortion*, KOSU (June 28, 2022, 4:00 AM), <https://www.kosu.org/health/2022-06-28/long-before-roe-v-wade-was-overturned-indigenous-women-faced-barriers-to-abortion> [https://perma.cc/SG38-M24X].

25. See ROBBINS & GOODMAN, *supra* note 23.

cific categories of pregnancy- and childbirth-related risks resulting from *Dobbs* and argues that the increased pregnancy risk *Dobbs* created will mean more pregnant people are coerced by their healthcare providers into unwanted medical intervention—a recognized form of mistreatment with important health implications.²⁶ The risk categories of particular concern are (1) risks related to preexisting conditions; (2) risks related to complications arising during pregnancy; and (3) risks related to the burdens of forced pregnancy itself.

A. RISKS RELATED TO PREEXISTING CONDITIONS

Post-*Dobbs* abortion restrictions mean that more people will continue pregnancies despite preexisting health conditions that make pregnancy especially risky, and in some instances ill-advised, due to the high likelihood of adverse outcomes for the pregnant person and often the fetus.²⁷ This category consists of people who would have chosen abortion to protect their health (and in some circumstances to avoid harm to the fetus) but are now forced to remain pregnant contrary to medical advice and their own determination of personal safety. A variety of chronic conditions may increase the risk of complications during pregnancy for the pregnant person, the fetus, or both. These include autoimmune disorders (such as lupus or multiple sclerosis), blood clotting disorders, cancer, epilepsy, heart disease, hypertension, infectious diseases, kidney disease, mental illness, neurological disorders, and pulmonary conditions.²⁸ Some chronic conditions can be managed successfully during pregnancy with close monitoring, and perhaps medication, while others present such significant risks of death or severe morbidity that healthcare providers are encouraged to counsel patients about avoiding pregnancy altogether and discuss termination with patients who do become pregnant.²⁹ For some chronic conditions, variation in the severity of a diagnosis and the patient's overall health profile may mean that one patient finds the risk of pregnancy tolerable while another patient with the same condition determines the risk of adverse health consequences or death is too significant

26. See, e.g., Rachel G. Logan et al., *Coercion and Non-Consent During Birth and Newborn Care in the United States*, 49 BIRTH 749, 750–751 (2022); Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH, no. 174, 2019, at 1, 8; Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 776–78 (2018); Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, REPROD. HEALTH MATTERS, May 2016, at 56, 56.

27. See Stevenson, Root & Menken, *supra* note 18, at 3–4.

28. *Pre-Existing Maternal Medical Conditions*, UNIV. OF ROCHESTER MED. CTR., <https://www.urmc.rochester.edu/ob-gyn/maternal-fetal-care/maternal-care/maternal-conditions-we-treat.aspx> [<https://perma.cc/W5RB-58A4>]; Lynda A. Tyer-Viola & Ruth Palan Lopez, *Pregnancy with Chronic Illness*, 43 JOGNN 25 (2014).

29. See Sara Thorne, Anne MacGregor & Catherine Nelson-Piercy, *Risks of Contraception and Pregnancy in Heart Disease*, 92 HEART 1520, 1521 tbl. 1 (2006) (summarizing the World Health Organization's classification of risk in pregnancy for women with cardiovascular disease).

to continue with the pregnancy.³⁰

Of particular concern are certain congenital heart conditions and cardiac-related preexisting conditions that raise serious risk of complications due to the physiological and hormonal changes that occur throughout pregnancy.³¹ For example, pregnant women with aortic disease may have significant risk of developing an aneurysm or a tear in the aorta (known as aortic dissection), both of which increase the likelihood of death.³² Heart valve issues, which include reliance on an artificial heart valve, increase pregnancy risks like the possibility of developing a life-threatening infection of the heart lining (known as endocarditis) or the possibility that necessary adjustments in blood thinners will lead to thrombosis, which is the life-threatening clotting of heart valves.³³ Doctors recommend that patients with pulmonary hypertension and certain congenital conditions avoid pregnancy altogether.³⁴ Furthermore, the risks of pregnancy are additive, meaning that a patient with a relatively low-risk cardiac condition who also has another condition, such as poor ventricular function or diabetes, will be at higher risk for adverse health outcomes; the presence of additional risk factors often means that a patient with an otherwise small risk of maternal mortality or morbidity moves into the category of patients for whom pregnancy is contraindicated.³⁵

A particular patient's risk of pregnancy-related death or serious injury is the product of a variety of factors specific to each patient, so individualized counseling and support for patient autonomy in medical decision-making are necessary to ensure that pregnant people can make decisions

30. See, e.g., *id.* Risk tolerance may also vary by patient regarding whether to change or cease medication to maximize chances of healthy fetal development where doing so may increase the risk of harming the pregnant patient's underlying health.

31. Such changes include an increase in blood volume by 30%–50% during pregnancy, resulting in changes in blood pressure and heart rate. *Heart Conditions and Pregnancy: Know the Risks*, MAYO CLINIC (Nov. 23, 2022) [hereinafter Mayo Clinic], <https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20045977> [<https://perma.cc/EPQ5-2ZRR>].

32. Dorothy A. Smok, *Aortopathy in Pregnancy*, 38 *SEMINARS PERINATOLOGY* 295, 295 (2014) (calling for preconception counseling to determine which patients may “cautiously pursue pregnancy” and to identify “those in whom pregnancy is contraindicated”). See generally Luke J. Burchill et al., *Pregnancy Risks in Women with Pre-existing Coronary Artery Disease, or Following Acute Coronary Syndrome*, 101 *HEART* 525, 525 (2015).

33. Mayo Clinic, *supra* note 31.

34. *Id.* (discussing pregnancy as a contraindication for patients with pulmonary hypertension and Eisenmenger's syndrome). Another example is Turner syndrome, which affects one in 2,000 live-born girls, with up to 50% experiencing cardiovascular malformations, and which significantly increases the risk of death from aortic dissection or rupture during the perinatal period. See Prac. Comm. for the Am. Soc'y for Reprod. Med., *Increased Maternal Cardiovascular Mortality Associated with Pregnancy in Women with Turner Syndrome*, 97 *FERTILITY & STERILITY* 282, 282 (2012). “Turner syndrome is a relative contraindication for pregnancy; however it is an absolute contraindication for pregnancy in a patient with a documented cardiac anomaly.” *Id.*; see also Thorne, MacGregor & Nelson-Piercy, *supra* note 29, at 1521 (noting that pulmonary arterial hypertension carries a 50% risk of dying in childbirth).

35. See Thorne, MacGregor & Nelson-Piercy, *supra* note 29 at 1521 (detailing how, for patients with cardiac conditions, adding one risk factor increases the risk of an adverse cardiac event by 27% while two additional risk factors increase the risk by 75%).

that best protect their health and reflect their values. But post-*Dobbs* abortion bans eliminate an individual's ability to make meaningful decisions about whether a chronic condition poses too great a risk of death or injury to continue a pregnancy.³⁶ The fourteen states with complete or near-complete abortion bans provide for exceptions in the event of a life-threatening condition and, in some jurisdictions, also where the pregnant person's physical health is at risk.³⁷ But in practice, pregnant people have found it nearly impossible to secure abortion care by invoking a statutory exception for life or health endangerment.³⁸

Typically, statutory language enumerating these exceptions refers to a "medical emergency,"³⁹ the prevention of "death or substantial risk of death,"⁴⁰ or abortion that is "necessary to prevent the death of the pregnant woman."⁴¹ Such phrases are vague and require interpretation of the degree of medical risk, which can be a slippery concept and is difficult to capture precisely in legislative drafting. As a result, healthcare providers deny abortion care to pregnant people with risky chronic conditions due to the threat of criminal penalties in the event a court later disagrees with their interpretation.⁴² The nature of medical uncertainty is such that even when a statute defines the terms that delineate the exception, clinicians, hospital administrators, and risk management advisors may reach different conclusions about the risk of death the pregnancy poses or how necessary an abortion is to avoid a life-endangering physical condition.⁴³

36. See *State Bans on Abortion*, *supra* note 3.

37. *Id.*; *Tracking the States Where Abortion is Now Banned*, N.Y. TIMES, <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html> [https://perma.cc/MDX7-AWRZ] (last updated Apr. 28, 2023, 11:00 AM) (noting that fourteen states ban abortion at all stages and Georgia bans abortion starting at six weeks). As of April 2023, the complete-ban states with life and physical health exceptions are Alabama, Idaho, Kentucky, Louisiana, Missouri, North Dakota, Tennessee, Wisconsin, and West Virginia. *State Bans on Abortion*, *supra* note 3; Sasani, *supra* note 3. The following states exclude health endangerment and allow abortions only when the pregnant person's life is at stake: Arkansas, Mississippi, Oklahoma, South Dakota, and Texas. See *id.* Wyoming's ban includes exceptions for the pregnant person's life and health without explicitly limiting the health exception to physical health. *Id.* Georgia's six-week ban is similar in effect to the complete bans because it forbids abortion at a point when many people do not yet know they are pregnant and when it would be virtually impossible to identify the pregnancy, receive medical advice about the risks posed by a preexisting condition, decide to end the pregnancy, and secure an appointment for an abortion within the necessary timeframe. See *Tracking the States Where Abortion is Now Banned*, *supra*. In addition, Florida passed a six-week ban, though it is not currently in effect pending the Florida Supreme Court's review of the state's abortion laws. *Id.*

38. See Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted.*, N.Y. TIMES (Jan. 21, 2023), <https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html> [https://perma.cc/44QZ-YAJY].

39. OKLA. STAT. ANN. tit. 63 § 1-731.4(B)(1) (2022).

40. LA. STAT. ANN. § 40:1061(F) (2022).

41. IDAHO CODE ANN. § 18-622(3)(a)(ii) (2022).

42. See Walker, *supra* note 38.

43. For example, the Oklahoma statute defines "medical emergency" to mean a condition "in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness or physical injury including a life-endangering physical condition caused by or arising from the pregnancy itself." OKLA. STAT. ANN. tit. 63 § 1-731.4(A)(2). Healthcare providers may fear that if they perform an

Statutory language is typically vague about the degree of likelihood of harm necessary in order to invoke a life or health endangerment exception.⁴⁴ Notably, three states with life endangerment exceptions—Idaho, North Dakota, and Tennessee—require the physician to prove that the patient’s life was at risk, rather than placing the burden on the state to prove the patient’s life was not at risk, which may heighten provider anxiety about falling on the wrong side of the law.⁴⁵

Abortion bans also ignore a related dimension of risk posed by chronic and other preexisting conditions. Although a patient’s condition may pose a future threat to life or health, at the point in time when abortion would enable the patient to avoid that threat (and would be legal), the pregnant person’s health may not have deteriorated enough to invoke the exception.⁴⁶ This difficulty is underscored by the number of abortions reported by states since their bans went into effect. For example, Louisiana has exceptions for life, health, and birth defects but has reported zero abortions since its ban went into effect; Mississippi has exceptions for life endangerment and rape but has reported no more than two abortions since its ban was implemented.⁴⁷ Other states with such bans have reported similar results,⁴⁸ even though medical research suggests serious pregnancy complications arise with sufficient frequency that pregnant people in these states would be invoking life or health endangerment exceptions at higher rates if abortions were truly available under such circumstances.⁴⁹

Despite all of these complexities, instead of relying on physicians to provide care “according to the best currently available medical evidence

abortion under this exception, the state will later challenge the determination that there was no other means to preserve the patient’s life or that the patient’s life was truly endangered. Fear of severe criminal sanctions prompts healthcare providers to exercise caution and deny abortion care. *See generally* Kangmoon Kim & Young-Mee Lee, *Understanding Uncertainty in Medicine: Concepts and Implications in Medical Education*, 30 *KOREAN J. MED. EDUC.* 181, 181–83 (2018) (characterizing medical uncertainty as “an innate feature of medicine and medical practice”).

44. *See* Madeline Heim, *If Roe is Overturned, Wisconsin Law Would Allow Abortion Only ‘To Save the Life of the Mother.’ Doctors Say It’s Not Always So Clear-Cut.*, *POST CRESCENT* (May 10, 2022, 6:01 AM), <https://www.postcrescent.com/story/news/2022/05/10/doctors-say-wisconsin-abortion-laws-lifesaving-exception-vague-if-roe-v-wade-overturned/7402200001> [<https://perma.cc/C9GY-T9UQ>] (quoting doctors expressing their uncertainty about the level of risk a patient must be in before they can legally perform an abortion: “My question is, is it a 25 to 30% chance of dying? Is that enough threat to someone’s life . . . Or is the Legislature imagining ‘No, it has to be more, 50% or more than 50% or even 100%, always an ICU, imminent risk of dying situation?’”); Maggie Jo Buchanan, *Exceptions to Abortion Bans Further Restrict Access to Care*, *CTR. FOR AM. PROGRESS* (June 6, 2022), <https://www.americanprogress.org/article/exceptions-to-abortion-bans-further-restrict-access-to-care> [<https://perma.cc/8VGZ-3YYY>].

45. Walker, *supra* note 38. *But see* Sasani, *supra* note 3 (discussing elimination of affirmative defense under North Dakota’s newest abortion ban, which was passed in April 2023 and will likely be challenged in court).

46. Buchanan, *supra* note 44 (discussing, for example, a patient with a high risk of cardiac failure due to an underlying condition who is not yet exhibiting symptoms).

47. *See* Walker, *supra* note 38.

48. *Id.*

49. *See generally supra* notes 9–16 and accompanying text.

and the physician's professional medical judgment,"⁵⁰ *Dobbs* invites legislatures to interfere with medical practice by introducing legal ambiguity into the determination of when abortion care is justified to prevent death or serious bodily injury. In fact, at least one anti-abortion lawmaker has admitted that confusion in the statutory language is by design, with the goal of confusing and scaring doctors so that whatever exceptions exist are employed as rarely as possible.⁵¹ This ambiguity and the caution it engenders in healthcare providers means that more pregnant people will be carrying high-risk pregnancies to term with underlying chronic conditions in the post-*Dobbs* era.

B. RISKS RELATED TO PREGNANCY COMPLICATIONS

In addition to the increased risk of mortality and morbidity *Dobbs* will impose on many people with chronic conditions who do not want to continue their pregnancies, the erosion of abortion access *Dobbs* unleashed means that more people will carry to term despite serious complications that arise *during* pregnancy and for which termination would be the safest approach to protect life, health, and future fertility.

Certain complications make abortion necessary in the first trimester; these include ectopic pregnancies, where the embryo implants outside the uterus, cannot develop properly, and if untreated, damages the pregnant person's fallopian tube or other organs,⁵² or incomplete miscarriage, where continued bleeding after spontaneous abortion requires an abortion procedure to remove remaining tissue from the uterus.⁵³ But many pregnancy complications do not arise until the second trimester (or later).⁵⁴ A pregnancy may become high-risk because a patient's underlying chronic condition cannot be managed adequately and a patient who previously decided to continue the pregnancy then perceives that the risk of death or serious injury is too significant to carry to term.⁵⁵ Or a pregnancy may become high-risk because a previously healthy patient with a desired pregnancy develops unanticipated complications during the preg-

50. *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, AM. COLL. OF OBSTETS. & GYNECOLS. (Aug. 15, 2022) [hereinafter *Navigating Medical Emergency Exceptions*], <https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions> [https://perma.cc/25L2-FFMH].

51. See Walker, *supra* note 38 (quoting former Tennessee Republican representative and abortion opponent Bob Ramsey's criticism of the law).

52. See *Facts are Important: Understanding Ectopic Pregnancy*, AM. COLL. OF OBSTETS. & GYNECOLS., <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy> [https://perma.cc/PD29-LXAB].

53. See Özge Tunçalp, A. Metin Gülmezoglu & João Paulo Souza, *Surgical Procedures for Evacuating Incomplete Miscarriage*, COCHRANE DATABASE SYSTEMATIC REVIEWS, Sept. 2010, at 1, 3, Art. No. CD001993 ("Incomplete miscarriage is a major problem that should be effectively managed with safe and appropriate procedures.").

54. See Ralph, Schwarz, Grossman & Foster, *supra* note 21, at 241; *What Are Some Common Complications of Pregnancy?*, NAT'L INSTS. OF HEALTH, <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications> [https://perma.cc/AM69-EC8Z].

55. See *What Are Some Common Complications of Pregnancy?*, *supra* note 54.

nancy—sometimes caused by the pregnancy and sometimes distinct from but exacerbated by the pregnancy—that make termination the safest, most desirable option.⁵⁶ Abnormal fetal development leading to serious fetal complications can also increase the risk of continuing with pregnancy.⁵⁷ By stripping pregnant people of the ability to access abortion when facing a medically complicated pregnancy, state bans following *Dobbs* will increase the number of high-risk pregnancies that are continued despite a serious risk of maternal death or serious morbidity.

A common cause of such complications in previously low-risk pregnancies is high blood pressure, which can lead to preeclampsia and eclampsia, both of which can cause seizures, clotting disorders, organ failure, stroke, and death.⁵⁸ Pregnancy-induced hypertension complicates approximately 6%–10% of pregnancies.⁵⁹ In general, patients with pregnancy-induced hypertension have a greater risk of developing hypertension, cardiovascular disease, diabetes, and kidney disease later in life.⁶⁰ Black women and some Hispanic women have significantly increased risk for all hypertensive disorders in pregnancy compared to non-Hispanic White women, with Black women at a particularly higher risk of developing preeclampsia.⁶¹ Notably, research comparing Black women born in the United States with Black women who immigrated to the United States shows that it is not race alone—but rather a combination of biological, social, and cultural factors—driving racial disparities in hypertensive disease, as Black women born outside the United States who had lived in the country for fewer than ten years had a 26% lower chance of developing preeclampsia.⁶² Some forms of hypertensive disease pose such risk to pregnant people that healthcare providers counsel patients to consider terminating the pregnancy; for example, patients with gestational hypertension and mild preeclampsia can be monitored, but once preeclampsia becomes severe, there is no treatment other than abortion.⁶³ Fur-

56. *See id.*

57. *Id.*

58. *See Preeclampsia*, MAYO CLINIC (April 15, 2022), <https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745> (defining superimposed preeclampsia) [<https://perma.cc/CW2W-8TPA>].

59. Evangelia Kintiraki, Sophia Papakatsika, George Kotronis, Dimitrios G. Goulis & Vasilios Kotsis, *Pregnancy-Induced Hypertension*, 14 HORMONES 211, 212 (2015). Pregnancy-induced hypertension is a term used to refer to several different conditions related to high blood pressure, such as gestational hypertension, preeclampsia, eclampsia, and superimposed preeclampsia. *See* Gaurav Ghosh et al., *Racial/Ethnic Differences in Pregnancy-Related Hypertensive Disease in Nulliparous Women*, 24 ETHNICITY & DISEASE 283, 285 (2014).

60. Kintiraki et al., *supra* note 59, at 213 (“The risk of diabetes in later life [is] 2-fold higher in women with [preeclampsia] or gestational hypertension compared with women without them.”)

61. *See id.*; Ghosh et al., *supra* note 59, at 289.

62. *See* Ellen Boakye et al., *Nativity-Related Disparities in Preeclampsia and Cardiovascular Disease Risk Among a Racially Diverse Cohort of US Women*, JAMA NETWORK OPEN, Dec. 2021, at 1, 7–8, e213956.

63. Hiroaki Tanaka, Kayo Tanaka, Sho Takakura, Naosuke Enomoto & Tomoaki Ikeda, *Predicting Preeclampsia Pregnancy Termination Time Using sFlt-1*, 9 FRONTIERS MED., 2022, at 1, 2, Article No. 900639.

ther, women who are diagnosed specifically with pulmonary hypertension during pregnancy are advised to terminate the pregnancy due to the higher risk of mortality and morbidity.⁶⁴

Certain diabetes complications also pose significant risks to pregnant people such that abortion may be the only way to preserve their life and health. For example, gastroparesis occurs in people with long-standing diabetes who experience complications like retinopathy, nephropathy, and neuropathy.⁶⁵ Pregnancy is contraindicated for people with gastroparesis as it poses “extreme risk to maternal health, second only to coronary heart disease.”⁶⁶ Also, “[d]iabetic nephropathy is a long-term microvascular complication of diabetes,” which can cause renal failure and preeclampsia for the pregnant person, as well as intrauterine growth restriction, prematurity, or death for the fetus.⁶⁷ Pregnancy is “relatively contraindicated,” meaning the degree of risk depends on duration and the presence of other risk factors; in severe cases, it may be unsafe to continue the pregnancy.⁶⁸

Termination may also be advisable due to the status of the fetus. Some serious pregnancy complications relate to the diagnosis of a fetal defect that makes death likely, whether before or after birth.⁶⁹ Typically, pregnant people are offered an ultrasound with a fetal anatomy scan around twenty weeks of gestation, and this is a time when many fetal anomalies are first detected.⁷⁰ Some such conditions increase the risk of delivering at term (meaning at or after thirty-seven weeks) due to the status of the fetus; remaining pregnant with a fetus who will not survive and may suffer during or after delivery can also have a serious negative impact on the mental health of the pregnant person.⁷¹ In other situations, people pregnant with multiples may need to terminate one or more of the pregnancies in order to avoid serious health complications and maximize the chances of healthy delivery of one or more babies.⁷² The inability to have a multifetal reduction—the term used to describe abortion during a multiple pregnancy that does not terminate the pregnancy entirely—under such circumstances means greater maternal and fetal risk.⁷³

64. See P.G. Pieper & E.S. Hoendermis, *Pregnancy in Women With Pulmonary Hypertension*, 19 NETH. HEART J. 504, 504 (2011).

65. Gillian Hawthorne, *Maternal Complications in Diabetic Pregnancy*, 25 BEST PRAC. & RSCH. CLINICAL OBSTETS. & GYNAECOL. 77, 81 (2011).

66. *Id.*

67. *Id.* at 84.

68. *Id.* at 85.

69. See Walker, *supra* note 38.

70. See Boaz Weisz, *Early Detection of Fetal Structural Abnormalities*, 10 REPROD. BIOMEDICINE ONLINE 541 (2005).

71. Christina Caron, *Does Being Denied an Abortion Harm Mental Health?*, N.Y. TIMES (May 24, 2022), <https://www.nytimes.com/2022/05/24/well/mind/abortion-access-mental-health.html> [<https://perma.cc/M35V-3RXT>] (discussing the mental and emotional toll pregnancy complications can take on pregnant people).

72. See, e.g., Walker, *supra* note 38.

73. *Id.* (“Multifetal reductions are typically recommended for patients carrying triplets or more, because these pregnancies are always at higher risk.”).

Where there is risk of maternal harm or death, the standard of care includes counseling on the option to terminate the pregnancy.⁷⁴ However, second trimester abortion bans enabled by *Dobbs* will prevent many pregnant people from receiving the care they need to protect and preserve their health. In addition to the bans discussed above, two states currently ban abortion at fifteen weeks, one state bans abortion at eighteen weeks, one state bans abortion at twenty weeks, and six states ban abortion at twenty-two weeks.⁷⁵ These laws block access to abortion care for many pregnant people who develop serious health complications mid-way through pregnancy, including those people who receive a fatal fetal diagnosis at the twenty-week ultrasound or in the subsequent weeks.⁷⁶

Although states have included life and sometimes health endangerment exceptions in their abortion laws, the same vagueness concerns discussed previously also apply to second-trimester abortion bans. Providers are unsure what qualifies as “serious risk” that someone will suffer “substantial and irreversible impairment of a major bodily function,” just as they are not always able to say with absolute certainty that a pregnant person will die without an abortion but rather must counsel patients in terms of gradations of risk.⁷⁷ For example, Ohio law explicitly identifies preeclampsia as constituting a “serious risk” but does not explain whether the pregnant person must have preeclampsia or whether being at high risk for developing the condition will suffice.⁷⁸ Healthcare providers subject to these various bans may understand state law to require “continued escalation and deterioration” in the patient’s condition before a medical emergency exception applies.⁷⁹ This concern is not hypothetical.

74. *Id.*; see also J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion*, N.Y. TIMES (July 20, 2022), <https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html> [<https://perma.cc/94AD-JPR8>]. But see Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CAL. L. REV. 1255 (2020) (detailing comprehensive empirical study of state laws that establish procedural protections for healthcare providers who refuse to provide reproductive health services that violate their deeply held conscientious beliefs).

75. *State Bans on Abortion*, *supra* note 3. Arizona and Florida ban abortion at fifteen weeks, as Florida’s recently passed six-week ban is not currently in effect pending ongoing litigation before the Florida Supreme Court; Utah bans abortion at eighteen weeks; North Carolina bans abortion at twenty weeks; and Indiana, Iowa, Kansas, Nebraska, Ohio, and South Carolina ban abortion at twenty-two weeks. *Tracking the States Where Abortion is Now Banned*, *supra* note 37; see also Anthony Izaguirre, *Florida Senate Passes 6-Week Abortion Ban Backed by DeSantis*, PBS NEWS HOUR (Apr. 3, 2023), <https://www.pbs.org/newshour/politics/florida-senate-passes-6-week-abortion-ban-backed-by-desantis> [<https://perma.cc/P6D3-MZEZ>].

76. Even in states with twenty-two week bans, most pregnant people in this situation would find it difficult to receive the diagnosis, obtain counseling about treatment options, reach a decision about whether to terminate, and if choosing abortion, obtain an appointment all before the statutory time limit. See FOSTER, *supra* note 7, at 1.

77. See Elizabeth Cohen & Danielle Herman, *Ohio’s New Abortion Law Forces Doctor to Fight to Protect Her Patient’s Life*, CNN (Sept. 22, 2022, 2:05 PM), <https://www.cnn.com/2022/09/22/health/ohio-abortion-patient-doctor/index.html> [<https://perma.cc/4EYN-FQZ9>] (quoting Ohio’s abortion law).

78. *Id.* (quoting Case Western University School of Law professor Jessie Hill).

79. Olivia Goldhill, *Vague ‘Medical Emergency’ Exceptions in Abortion Laws Leave Pregnant People in Danger, Doctors Say*, STAT (May 20, 2022), <https://www.statnews.com/>

A study on the impact of Texas' six-week abortion ban that was in place immediately before *Dobbs* found that women with pre-viability pregnancy complications suffered significant maternal morbidity as a result of delayed care while doctors waited for the emergence of "complications that qualified as an immediate threat to maternal life" before providing an abortion under the statutory exception.⁸⁰ Abortion-restrictive statutes have prompted doctors to ask in the pages of leading medical journals: "'What does the threat of death have to be?' and 'How imminent must it be?'"⁸¹ As abortion becomes even more restricted, lack of clarity about what the statute requires for exceptional cases, combined with the severity of criminal penalties imposed for failing to comply, will result in sub-standard care for pregnant patients with medical complications.

Approximately one-third of existing abortion bans contain exceptions for fatal birth defects, but these laws also raise concerns regarding narrowness, vagueness, and providers' unwillingness to employ them out of fear of criminal prosecution.⁸² For example, Utah has an exception for fetal abnormalities if they are "uniformly lethal,"⁸³ but this language suffers the same problems related to prognostic uncertainty discussed above. Louisiana attempted to address these concerns by providing a list of specific conditions that qualify for a fatal defect exemption, yet they have already needed to amend the list after a woman was denied an abortion because her specific diagnosis did not appear on the list.⁸⁴

Given the unworkability of statutory abortion exceptions, the American College of Obstetricians and Gynecologists opposes efforts to create a list of conditions that qualify as "medical emergencies" to guide clinicians, noting that the "practice of medicine is complex and requires individualization," that "[n]o single patient's condition progresses at the same pace," that a "patient may experience a combination of medical conditions or symptoms that, together, become life-threatening," and "[t]here is no uniform set of signs of symptoms that constitute an 'emergency.'"⁸⁵ By contrast, anti-abortion advocates have promoted a false claim that abortion is never medically necessary, a view that runs contrary to medical science.⁸⁶ Such rhetoric not only serves to undermine the idea that

2022/05/20/medical-emergency-exceptions-abortion-laws-pregnant-people [https://perma.cc/69L5-9CTC] (quoting Texas perinatologist Amanda Horton, who treats patients with high-risk pregnancies).

80. Anjali Nambiar, Shivani Patel, Patricia Santiago-Munoz, Catherine Y. Spong & David B. Nelson, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 AM. J. OBSTETS. & GYNECOL. 648, 649 (2022).

81. *Id.*

82. Walker, *supra* note 38.

83. UTAH CODE ANN. § 76-7a-201(1)(b)(i) (2022), *enjoined by* Planned Parenthood Assoc. of Utah v. State, No. 220903886, 2022 WL 2314099 (D. Utah June 25, 2022).

84. Walker, *supra* note 38.

85. *See Navigating Medical Emergency Exceptions*, *supra* note 50.

86. *See* Ali Swenson, *Posts Falsely Claim Abortion is Never Medically Necessary*, ASSOCIATED PRESS NEWS (July 11, 2022), <https://apnews.com/article/fact-check-abortion-medically-necessary-342879333754> [https://perma.cc/G297-Z3QJ] (noting that attempts by

abortion is healthcare, but it also makes it easier to characterize maternal deaths and serious injuries as rare and unavoidable, instead of unnecessary harm that could have been prevented by terminating the pregnancy. The result is that many more people will carry high-risk pregnancies to term against their will as the result of complications that arise during pregnancy.

C. RISKS RELATED TO FORCED REPRODUCTION

Health complications that exist prior to—or develop during—pregnancy will increase the risk of harm for pregnant people who must carry to term and give birth in the absence of access to abortion. In addition, we can expect more high-risk pregnancies after *Dobbs* due to the fact that some people will be forced into childbearing under circumstances where being pregnant, giving birth, and parenting involve social stressors related to poverty, unstable housing or employment, violence, and barriers to accessing health services. Forcing someone to stay pregnant against their will under such conditions can lead to stress and anxiety that negatively impact both physical and emotional health, increasing the risks associated with carrying to term and giving birth.

Poverty is a factor that both drives childbearing decisions and is linked to adverse perinatal outcomes. Women who decide to terminate a pregnancy are disproportionately likely to report economic hardship at the time they seek abortion care, with one study reporting that 51% of abortion seekers were living below 100% of the federal poverty level and 76% lacked sufficient money to cover basic expenses.⁸⁷ Called the Turnaway Study, this landmark longitudinal study followed similarly situated women who were either able or unable to obtain the abortion care they sought due to gestational limits imposed by state law or clinic policy.⁸⁸ Forty percent of Turnaway Study respondents indicated that their abortion decision was driven by financial reasons, with an additional 36% of respondents indicating that “reasons related to timing,” including financial readiness, drove their decision.⁸⁹ The Turnaway Study shows that women seeking abortions—nearly two-thirds of whom were already

abortion opponents to recast medically necessary abortions as “preterm delivery . . . misuses medical terminology”).

87. Diana G. Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions*, 112 AM. J. PUB. HEALTH RSCH. 1290, 1292 (2022).

88. ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (ANSIRH), INTRODUCTION TO THE TURNAWAY STUDY (2022), <https://www.ansirh.org/sites/default/files/2022-12/turnawaystudyannotatedbibliography122122.pdf> [<https://perma.cc/ZWN9-QW8E>] [hereinafter *Turnaway Introduction*]. The Turnaway Study identified “large and statistically significant differences in the socioeconomic trajectories of women who were denied wanted abortions compared with women who received abortions.” Foster et al., *supra* note 87, at 1295.

89. M. Antonia Biggs, Heather Gould & Diana Greene Foster, *Understanding Why Women Seek Abortions in the US*, 13 BMC WOMEN’S HEALTH 29, 5 (2013). The authors noted that reasons given by Turnaway Study participants for choosing abortion were consistent with previous research on this question. *Id.* at 1–2, 11.

parents⁹⁰—correctly anticipate that the economic burden of childbearing will negatively impact their lives and their families’ lives when deciding whether to terminate a pregnancy. For example, researchers found that denial of abortion care was linked to an increase in household poverty for at least four years.⁹¹ Further, the Turnaway Study revealed that women denied abortion care were more likely to lack sufficient resources for basic expenses like food, housing, and transportation for years after the denial.⁹² Pregnant people denied abortions are more likely to rely on public assistance to meet basic needs.⁹³ Additionally, lack of access to abortion was also associated with subsequently having lower credit scores and more debt, bankruptcies, and evictions.⁹⁴

Compelled childbearing can also threaten pregnant people’s economic security by negatively interfering with their ability to keep their job or find meaningful employment.⁹⁵ Employment-related stress is of particular concern for pregnant people in low-wage service jobs that may be physically demanding and inflexible regarding breaks, scheduling time off for medical appointments, and other pregnancy-related accommodations.⁹⁶ Pregnant people working low-wage service jobs tend to have more burdensome physical demands related to their job requirements, prompting fear that physical exertion will harm the fetus or lead to pregnancy complications requiring additional medical care and loss of income altogether.⁹⁷

Regular employment and stable housing are linked for many people, with the loss of one often making the other more likely. Between four and nine percent of pregnant people report homelessness and even more

90. Foster et al., *supra* note 87, at 1292 (noting 63% of participants already had children).

91. *Id.* at 1293–94.

92. *Id.* at 1294.

93. *Id.* at 1291 (reporting significantly higher rates among those denied abortion care of receiving support from the federal programs Temporary Assistance for Need Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infants & Children (WIC)).

94. Sarah Miller, Laura R. Wherry & Diana Greene Foster, *The Economic Consequences of Being Denied an Abortion*, Nat’l Bureau of Econ. Research, NBER Working Paper No. 26662 (Jan. 2020).

95. Foster et al., *supra* note 87, at 1292 (noting that women who were denied abortions and gave birth were more likely to be unemployed six months into the study than those who obtained an abortion).

96. See Bryce Covert, *The American Workplace Still Won’t Accommodate Pregnant Workers*, NATION (Aug. 12, 2019), <https://www.thenation.com/article/archive/pregnant-workers-discrimination-workplace-low-wage> [<https://perma.cc/8YWF-KYFD>]; ACOG COMMITTEE OPINION NO. 733, EMPLOYMENT CONSIDERATIONS DURING PREGNANCY AND THE POSTPARTUM PERIOD (April 2018), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/04/employment-considerations-during-pregnancy-and-the-postpartum-period.pdf> [<https://perma.cc/Y3HP-KS2G>] (“The United States is the only developed country that does not have a national paid maternity or parental leave program, which leaves many pregnant women and their families without job protection, health insurance benefits, or wages at a vulnerable time.”).

97. See Covert, *supra* note 96.

experience housing instability.⁹⁸ Pregnant people with housing instability are more likely than pregnant people with stable housing to self-identify as Black, which compounds the risk for Black pregnant people who already have a higher risk of adverse pregnancy outcomes compared to their White counterparts.⁹⁹ There is a significant association between housing instability and homelessness during pregnancy and adverse health outcomes, including preterm birth, low birth weight, neonatal intensive care unit admission, and complications during delivery.¹⁰⁰ Compelled pregnancy under these circumstances is likely to increase stress and the likelihood that the pregnant person will develop a higher-risk condition as the pregnancy advances.

Forcing someone to continue a pregnancy when the man involved in the pregnancy (MIP) is violent or when the pregnancy resulted from abuse or incest can lead to stress related to being forever linked to someone violent through the child. Between six and twenty percent of women seeking abortions report recent intimate partner violence (IPV).¹⁰¹ The identity and involvement of the MIP drive childbearing decisions for many pregnant people.¹⁰² Specifically, 9% of Turnaway Study respondents chose abortion because they did not have “a ‘good’ or stable relationship with the father of the baby”; 8% said they did not have a supportive partner; 6% said they were with “the ‘wrong guy’”; 3% said their partner did not want the baby; and 3% said their partner was abusive.¹⁰³ Researchers found that women who had abortions experienced a reduction in physical violence by the MIP, whereas women who were unable to obtain an abortion experienced sustained physical violence from the MIP.¹⁰⁴ Researchers point to dynamics that make it harder to end an abusive relationship when the woman has a child with the violent partner.¹⁰⁵ When someone becomes pregnant as a result of or in the midst of violence, being forced to continue the pregnancy may compound the stress or trauma of that violence and lead to additional stress about being perpetually linked to the perpetrator. Violence during pregnancy increases the likelihood of adverse birth outcomes, such as low birth weight, preterm delivery, and neonatal death, as well as the risk of chil-

98. Julia D. DiTosto, Kai Holder, Elizabeth Soyemi, Molly Beestrup & Lynn M. Yee, *Housing Instability and Adverse Perinatal Outcomes: A Systematic Review*, 3 AM J. OBSTETS. & GYNECOL. MFM 100477 (2021). Five percent of Turnaway Study respondents said they chose abortion because their “living or housing context was not suitable for a baby.” Biggs et al., *supra* note 89, at 7.

99. See DiTosto et al., *supra* note 98.

100. *Id.*

101. Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC MEDICINE 144, 1 (2014).

102. See Biggs et al., *supra* note 89, at 6 (reporting that 31% of Turnaway Study respondents cited reasons related to their partners as driving their decision to have an abortion).

103. *Id.*

104. Roberts et al., *supra* note 101, at 5 (reflecting language used in the Turnaway Study to designate the partner involved in the pregnancy).

105. *Id.*

dren subsequently developing emotional and behavioral problems.¹⁰⁶ Pregnant people may fear the impact of IPV on their future children, further increasing their stress and anxiety levels.

The well-established research linking poverty and minority status with adverse infant health outcomes can itself be a source of stress for pregnant people forced to carry to term, knowing that their lack of resources, stable housing, regular access to food, or employment will not only negatively impact their ability to care for a child but increases the likelihood of chronic conditions and other health complications in infancy and childhood.¹⁰⁷ Pregnant people forced to stay pregnant may experience stress related to accessing prenatal care, including the lack of nearby providers in maternity care deserts¹⁰⁸ and the lack of accessible transportation to prenatal care appointments.¹⁰⁹ Research from the Turnaway Study confirms that being denied an abortion is linked with higher levels of anxiety, stress, and low self-esteem.¹¹⁰

Stress during pregnancy is linked to higher risk of medical complications.¹¹¹ Research shows that stress can cause allostatic overload, which disrupts the maternal-placental-fetal endocrine and immune system responses.¹¹² Stress can increase the pregnant person's blood pressure,¹¹³ which can lead to serious pregnancy complications like preeclampsia and eclampsia.¹¹⁴ Stress and allostatic overload are also linked to preterm labor, low birth weight, and both short-term and long-term neonatal mor-

106. N.N. Sarkar, *The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome*, 28 J. OBSTETS. & GYNECOL. 266 (2008); D.A. Wolfe, Claire V. Crooks, Vivien Lee, Alexandra McIntyre-Smith & Peter G. Jaffe, *The Effects of Children's Exposure to Domestic Violence: A Meta-Analysis and Critique*, 6 CLIN. CHILD FAM PSYCHOL REV. 171 (2003).

107. Janet Currie, *Inequality Before Birth Contributes to Health Inequality in Adults*, SCI. AM. (Oct. 1, 2020), <https://www.scientificamerican.com/article/inequality-before-birth-contributes-to-health-inequality-in-adults> [<https://perma.cc/FJ56-Q65L>] (discussing the links between poverty and conditions like low birth weight or preterm delivery, along with increased possibilities of asthma, heart disease, diabetes, obesity, and certain mental health conditions).

108. See Elizabeth Kukura, *Rethinking the Infrastructure of Childbirth*, 91 UMKC L. REV. 497, 510–42 (2023) (describing the problem of maternity care deserts).

109. See Joan Rosen Bloch, Sarah Cordivano, Marcia Gardner & Jennifer Barkin, *Beyond Bus Fare: Deconstructing Prenatal Care Travel Among Low-Income Urban Mothers Through a Mix Methods GIS Study*, 54 CONTEMP. NURSE 233 (2018) (discussing transportation as a barrier to accessing prenatal care).

110. *Turnaway Introduction*, *supra* note 88, at 2.

111. See *Stress and Pregnancy*, MARCH OF DIMES, <https://www.marchofdimes.org/find-support/topics/pregnancy/stress-and-pregnancy> [<https://perma.cc/WK38-YTPV>]; Biggs et al., *supra* note 89, at 12 (noting circumstances under which “continuing an unwanted pregnancy to term may be associated with even greater than normal risks of childbirth”).

112. Claire S. Traylor, Jasmine D. Johnson, Mary C. Kimmel & Tracy A. Manuck, *Effects of Psychological Stress on Adverse Pregnancy Outcomes and Nonpharmacologic Approaches for Reduction: An Expert Review*, 2 AM. J. OBSTETS. & GYNECOL. MFM 100229 (2020) (discussing the biological mechanisms linking stress and adverse pregnancy outcomes).

113. S. Kulkarni, I. O'Farrell, M. Erasi & M.S. Kochar, *Stress and Hypertension*, 97 WMJ 34 (1998).

114. See Section II.B *supra* (discussing the complications associated with hypertensive disorders in pregnancy).

bilities.¹¹⁵ Other research on the health impacts of stress during pregnancy shows that chronic stress associated with living in a racist society increases the risk of adverse health outcomes.¹¹⁶ After *Dobbs*, with more people carrying pregnancies to term in the face of poverty, low-wage employment, unstable housing, violence, and barriers to accessing care, it is likely that the stressors associated with forced childbearing will lead to more high-risk pregnancies.

III. RISK AND COERCED INTERVENTIONS

For the various reasons discussed in Part II, abortion restrictions passed in the wake of *Dobbs* will increase the number of pregnant people carrying high-risk pregnancies to term. When obstetric caseloads include more potentially medically complex patients, it is likely more patients will experience coercion to accept medical interventions, including unwanted treatment. Physician coercion in treatment decisions violates patients' right to informed consent and runs contrary to physicians' ethical obligations to respect patient autonomy—with significant implications for patients' self-determination in medical decision-making. Coercing pregnant patients to accept interventions can also lead to adverse health outcomes, including psychological trauma, poor postpartum adjustment, and other mental health concerns. Many obstetric providers will experience increased professional strain in the wake of *Dobbs*.¹¹⁷ But it is imperative that providers prioritize patient autonomy and resist any temptation to pressure pregnant people into accepting procedures during labor and delivery.

A. PROVIDER COERCION DURING CHILDBIRTH

Pressure to accept treatment during pregnancy and childbirth is not new since *Dobbs*. Extensive research over the last decade shows that a significant number of pregnant people experience provider coercion to accept medical intervention during perinatal care,¹¹⁸ part of a broader

115. Currie, *supra* note 107 (discussing other negative impacts on child development of exposure to high levels of stress during pregnancy); Traylor et al., *supra* note 112.

116. Tyan Parker Dominguez, Christine Dunkel-Schetter, Laura M. Glynn, Calvin Hobel & Curt A. Sandman, *Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress*, 27 HEALTH PSYCHOL. 194, 194 (2008) (finding experiencing stress related to racism was a significant predictor of birth weight in African Americans but not in non-Hispanic Whites); Rihitu Chatterjee & Rebecca Davis, *How Racism May Cause Black Mothers To Suffer the Death of Their Infants*, NPR (Dec. 20, 2017, 5:01 AM), <http://www.npr.org/sections/health-shots/2017/12/20/570777510/how-racism-may-cause-black-mothers-to-suffer-the-death-of-their-infants> [<https://perma.cc/9Z6A-DDKM>].

117. See Kukura, *supra* note 108, at 515–22 (discussing workforce shortage in obstetrics and the anticipated impact of *Dobbs* on the training, supply, and location of future OB/GYNs).

118. See, e.g., Christine H. Morton, Megan M. Henley, Marla Seacrist & Louise Marie Roth, *Bearing Witness: United States and Canadian Maternity Support Workers' Observations of Disrespectful Care in Childbirth*, 45 BIRTH 263 (2018) (reporting that 65% of birth workers in the United States and Canada had witnessed a lack of informed consent during perinatal care); Eugene Declercq, Carol Sakala, Maureen P. Corry, Sandra Applebaum &

phenomenon of the mistreatment of birthing people by their healthcare providers referred to by advocates as obstetric violence.¹¹⁹ Analysis of data from the landmark Giving Voice to Mothers (GVtM) study revealed that 31% of participants reported pressure to accept perinatal procedures, defined in the study as medication to induce or accelerate labor, epidural anesthesia, continuous fetal monitoring, episiotomy, pain relief medication, or cesarean surgery.¹²⁰ In addition, 10% reported pressure to agree to cesarean delivery, and 41% of participants reported nonconsented procedures, including artificial rupture of membranes, postpartum administration of medications to the baby, continuous external or internal fetal monitoring, or screening tests.¹²¹ Participants who delivered by cesarean reported provider pressure at a rate thirty times higher than respondents who delivered vaginally,¹²² reflecting other research that suggests providers are often successful in securing their desired outcome through coercive strategies.¹²³

Pregnant people of color experience coercion to accept medical interventions at higher rates than their White counterparts. For example, the GVtM Study reported that Black, Indigenous, and other people of color (BIPOC) disproportionately experienced pressure to accept procedures during perinatal care—at a rate of 39%, compared to 25% for White respondents—and disproportionately reported nonconsented procedures during perinatal care (51% to 36%).¹²⁴ When it comes to cesarean surgery—one of the most invasive interventions—BIPOC were pressured to have a cesarean more often than White people (14% to 9%).¹²⁵ And Black respondents in particular were significantly more likely to experience nonconsented procedures than White people.¹²⁶ The increased likelihood that pregnant people of color will experience provider coercion aligns with an extensive body of research on racial bias in healthcare more generally.¹²⁷

Ariel Herrlich, *Major Survey Findings of Listening to Mothers III: Pregnancy and Birth*, 23 J. PERINATAL EDUC. 9, 13–14 (2014) (reporting that 25% of pregnant women whose labors were induced or who delivered by cesarean experienced pressure to accept the intervention, with 63% of women who had their first cesarean reporting that their doctor made the decision on this mode of delivery).

119. See Vedam et al., *supra* note 26, at 77 (finding that 17% of birthing people experience at least one form of mistreatment by maternity care providers, and that Black, Indigenous, and other people of color report mistreatment at two to three times the rate of White people); Kukura, *supra* note 26, at 762–63 (discussing the history and use of the language of “obstetric violence”).

120. Logan et al., *supra* note 26, at 758.

121. *Id.* at 755 tbl. 2.

122. *Id.* at 757 tbl. 4.

123. See Declercq et al., *supra* note 118, at 14.

124. Logan et al., *supra* note 26, at 755 tbl. 2.

125. *Id.*

126. *Id.* at 756.

127. See, e.g., Joseph V. Sakran, Ebony Jade Hilton & Chethan Sathya, *Racism in Health Care Isn't Always Obvious*, SCI. AM. (July 9, 2020), <https://www.scientificamerican.com/article/racism-in-health-care-isnt-always-obvious> [<https://perma.cc/A4W7-BR6E>]; Kelly M. Hoffman, Sophia Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Dif-*

Researchers have found other ways to identify and quantify the incidence of coerced interventions during pregnancy and childbirth, including differences in treatment based on the patient's racialized identity. For example, a survey of birth workers reported over half had "witnessed a care provider engage in a procedure explicitly against the wishes of the woman," and nearly two-thirds of respondents had witnessed a physician "occasionally" or "often" perform procedures without the patient having a chance to give informed consent.¹²⁸ The GVM researchers found that while pregnant people of color and White people declined treatment at similar rates, healthcare providers were more likely to proceed with the procedure over the patient's objection when the pregnant person was Black than when the patient was White.¹²⁹

Researchers have observed complex dynamics surrounding a patient's decision to decline treatment and the response from healthcare providers. One study of more than one thousand patients identified four themes related to pregnant people's experiences of coercion during perinatal care: (1) "*contentious interactions*—combative relationships with practitioners when they declined care"; (2) "*knowledge as control and power*"; (3) "*morbid threats*—practitioners making extreme threats when pregnant people declined interventions"; and (4) "*compliance as valued*—social cues and indications that people were being a 'good client' if they suppressed questions or a desire to decline care."¹³⁰ There may be variation in how these themes manifest during clinical encounters, depending on the professional status of the healthcare provider (i.e., physician, midwife, or nurse), the identities of provider and patient, and the context in which disagreement over treatment arises. Notably, however, research suggests that patients experience pressure from their healthcare providers as coercion.¹³¹ The literature highlights that while "pressure occurs between equals," coercion is the proper term when pressure is applied against the backdrop of an existing or implied power dynamic, such as the relationship between patient and physician, where the physician (or other health professional) typically has greater knowledge, authority, and con-

ferences Between Blacks and Whites, 113 PNAS 4296 (2016); Elizabeth N. Chapman, Anna Kaatz & Molly Carnes, *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504 (2013); John F. Dovidio & Susan T. Fiske, *Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Contribute to Health Care Disparities*, 102 AM. J. PUB. HEALTH 945 (2012).

128. LOUISE MARIE ROTH ET AL., MATERNITY SUPPORT SURVEY: A REPORT ON THE CROSS-NATIONAL SURVEY OF DOULAS, CHILDBIRTH EDUCATORS AND LABOR AND DELIVERY NURSES IN THE UNITED STATES AND CANADA 37 tbl. 12 (2014), <https://maternitysurvey.files.wordpress.com/2014/07/mss-report-5-1-14-final.pdf> [<https://perma.cc/7ZZF-TYTR>].

129. Logan et al., *supra* note 26, at 758.

130. *Id.* at 751 (citing P. Mimi Niles, Kathrin Stoll, Jessie J. Wang, Stéphanie Black & Saraswathi Vedam, "I Fought My Entire Way": Experiences of Declining Maternity Care Services in British Columbia, 16 PLOS ONE e0252645 (2021)).

131. *Id.*

trol than the patient.¹³²

Patient perception of pressure as coercion may be associated with the types of strategies employed to secure patient acquiescence to the provider's recommended treatment. For example, one study reported that one-third of nurses and doulas occasionally or often observed providers threaten that the patient's baby might die if the pregnant person did not agree to treatment.¹³³ A different study on minimizing risk in maternity care noted that healthcare providers reported "'pulling the dead-baby card' when their need for control and power was more important than women's control, whether or not the baby was at risk."¹³⁴ When a physician invokes dead babies in order to convince a patient to accept treatment, the patient may understandably experience such counseling as coercive, given that the physician has framed the patient's choice as one of accepting the intervention or rejecting the intervention without regard for the baby's life—without room for discussion about any relative risks or benefits to either the baby or the pregnant person. Given the powerful salience of gendered stereotypes about what makes a "good" mother, such forms of provider pressure leave no meaningful choice for the pregnant person who is unwilling to be labeled a "bad" mother—with that deprivation of meaningful choice constituting coercion in medical decision-making.¹³⁵

Beyond the "dead-baby card," healthcare providers pressure their patients to accept treatment in a variety of different ways, such as withholding pain medication, enlisting a second provider to counsel the patient, or

132. *Id.* at 759 (citing Olav Nyttinges, Torleif Ruud & Jorun Rugkåsa, 'It's Unbelievably Humiliating'—Patients' Expressions of Negative Effects of Coercion in Mental Health Care, 147 INT. J. LAW PSYCHIATRY, 147 (2016)).

133. Morton et al., *supra* note 118, at 266. Researchers noted that the fact that both nurses and doulas reported such threats suggest that respondents are "able to distinguish between a truly emergent situation where concerns about fetal status are valid compared with when the threat is empty and used as a coercive mechanism to obtain compliance," a conclusion that is supported by the high rates of failure to obtain informed consent. *Id.* at 269; *see also* Niles et al., *supra* note 130, at 9–10 (discussing use of "morbid threats" to secure patient compliance with recommended treatment).

134. Wendy A. Hall, Jocelyn Tomkinson & Michael C. Klein, *Canadian Care Providers' and Pregnant Women's Approaches to Managing Birth: Minimizing Risk While Maximizing Integrity*, 22 QUAL. HEALTH RES. 575, 582 (2012).

135. *See* Kathrin Stoll et al., *I Felt So Much Conflict Instead of Joy: An Analysis of Open-Ended Comments From People in British Columbia Who Declined Care Recommendations During Pregnancy and Childbirth*, 18 REPROD. HEALTH 79, 10 (2021) (discussing implication that non-compliance with provider recommendations makes patients "unfit mothers"). Various scholars have analyzed gendered stereotypes related to "good" mothers. *See, e.g.*, Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1206–07 (1992) (identifying the "Code of Perfect Pregnancy," which captures the "idea and practice of controlling women with regard to conception, gestation, and childbirth in ways that express dominant cultural notions of motherhood"); April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 740–41 (2004) (discussing cultural norms that expect women to be altruistic and "sacrifice their own lives for their children or their fetuses").

threatening to deny care altogether.¹³⁶ Study participants use a variety of language to describe their experiences of provider pressure, including “‘persuaded,’ ‘ganged up on,’ ‘coerced,’ ‘badgered,’ ‘forced,’ ‘pushy,’ ‘convinced,’ ‘submitted,’ and ‘insisting.’”¹³⁷

Experts point to different explanations for why some providers resort to patient coercion during childbirth. For some, fear of adverse outcomes and subsequent litigation make the provider unable to trust the pregnant person’s decision, leading the provider to engage in more proactive, sometimes aggressive, means to secure patient compliance with the provider’s preferred treatment.¹³⁸ Other research emphasizes control in the provider–patient relationship, showing how the ability of healthcare professionals to engage in shared responsibility for treatment decisions with their patients is linked to how strongly the provider needs to feel in control.¹³⁹ Providers who express the view that their expertise makes them “solely responsible for the birth process” tend to “regard[] birth as a defective process and put their trust in interventions and surveillance, omitting input from women.”¹⁴⁰

B. PROVIDER COERCION AFTER *DOBBS*

While coercion in perinatal care is not a new phenomenon, the anticipated increase in high-risk pregnancies after *Dobbs* makes it likely that coerced interventions will become more prevalent. Accordingly, concerns about provider pressure to accept treatment should take on heightened significance, with appropriate provider education and training to limit the use of coercion in clinical settings.¹⁴¹

There are several reasons to expect more reports of coerced perinatal procedures by healthcare providers in the wake of *Dobbs*. First, even before considering broader changes to the maternity care landscape in the post-*Dobbs* era, simple math suggests that more pregnant people will experience provider coercion during labor and delivery. Applying the rates captured by existing research on coercion in childbirth to the increased number of pregnancies carried to term in the face of abortion bans results in an overall greater number of people facing pressure to accept interventions.¹⁴²

136. See, e.g., Stoll et al., *supra* note 135, at 8, 12; Hall, *supra* note 134, at 582.

137. Stoll et al., *supra* note 135, at 7.

138. Sandra Healy, Eileen Humphreys & Catriona Kennedy, *Midwives’ and Obstetricians’ Perceptions of Risk and its Impact on Clinical Practice and Decision-Making in Labour: An Integrative Review*, 29 *WOMEN & BIRTH* 107, 113 (2016).

139. Hall, *supra* note 134, at 579, 582. See also Healy et al., *supra* note 138, at 113 (“Those who were confident in sharing power and responsibility with women were more likely to be able to resist unnecessary interventions.”).

140. Healy et al., *supra* note 138, at 113.

141. See Nadia N. Sawicki & Elizabeth Kukura, *From Constitutional Protections to Medical Ethics: The Future of Pregnant Patients’ Medical Self-Determination Rights After Dobbs*, J. L. MED. & ETHICS (forthcoming 2023) (draft on file with author) (discussing implications for medical education regarding pregnant patients’ autonomy in medical decision-making after *Dobbs*).

142. See Section III.A *supra*.

Second, *Dobbs* is expected to exacerbate the existing workforce shortage in obstetrics, especially in states where abortion restrictions make the state a less appealing location to train or accept a permanent position.¹⁴³ The combination of higher obstetrics caseloads and an inadequate supply of obstetricians, at least in some parts of the country, will increase the strain on obstetrics providers in ways that make it more likely some providers will resort to coercion to secure patient acquiescence.¹⁴⁴ In particular, providers will have even less time to spend with each individual patient discussing the risks and benefits of a particular intervention so that the patient can make an informed choice. Research shows that time is an essential ingredient in building physician–patient trust, which in turn facilitates shared decision-making and provider respect for patients’ decisions to decline treatment.¹⁴⁵ Furthermore, it is likely that professional strain will cause more burnout among obstetricians, leading to more coerced treatment due to frustration on the part of providers.¹⁴⁶

Third, it is possible that some healthcare providers will misunderstand their legal obligations after *Dobbs*, incorrectly perceiving that the Supreme Court’s elevation of potential fetal life requires them to avoid forms of medical care that could pose a risk to the fetus.¹⁴⁷ The post-*Dobbs* legal landscape is confusing, especially as various conflicts among states and between the federal government and abortion-restrictive states are addressed by the courts.¹⁴⁸ However, physicians’ legal and ethical obligations to respect patient autonomy in medical decision-making have not changed, including for pregnant patients, and those obligations re-

143. See Kavita Vinekar et al., *Projected Implications of Overturning Roe v. Wade on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs*, 140 *OBSTETS. & GYNECOL.* 146, 146 (2022) (noting that when the Supreme Court decided *Dobbs*, 44% of all OB/GYN residents were training in states that planned to ban abortion); Alice Miranda Ollstein, *Abortion Doctors’ Post-Roe Dilemma: Move, Stay or Straddle State Lines*, *POLITICO* (June 29, 2022, 4:30 AM), <https://www.politico.com/news/2022/06/29/abortion-doctors-post-roe-dilemma-move-stay-or-straddle-state-lines-00040660> [<https://perma.cc/SWR4-3HJ9>] (discussing concerns about the “longer-term effects of a generation of OB-GYNs avoiding [abortion-hostile] states in the future”); *Abortion Ban States See Steep Drop in OB/GYN Residency Applications*, *WASH. POST* (Apr. 21, 2023), <https://www.washingtonpost.com/health/2023/04/21/abortion-ban-states-obgyn-residency-applications> [<https://perma.cc/S8FR-B5HL>].

144. See Kukura, *supra* note 108, at 522 (discussing various factors leading to obstetric provider burnout).

145. See Molly R. Altman, Monica R. McLemore, Talita Oseguera, Audrey Lyndon & Linda S. Franck, *Listening to Women: Recommendations From Women of Color to Improve Experiences in Pregnancy and Birth Care*, 65 *J. MIDWIFERY & WOMEN’S HEALTH* 466, 467–69 (2020) (“Time spent face-to-face with providers, particularly in the setting of being listened to and heard with empathy, was seen by women of color as a valuable mechanism for building trust and mutual respect.”).

146. See Emily Hutto, *How Dobbs is Making Healthcare Deserts Worse*, *MEDPAGE TODAY* (Jan. 18, 2023) <https://www.medpagetoday.com/opinion/faustfiles/102674> [<https://perma.cc/ANJ8-D4D9>] (discussing pressures on OB/GYNs that contribute to burnout and leaving the profession).

147. See Sawicki et al., *supra* note 141, at Part I.

148. See generally David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 *COLUM. L. REV.* 1 (2023).

quire a physician to accept a patient's decision to decline treatment, even when the provider disagrees.¹⁴⁹

Finally, and perhaps most significantly, pregnant patients designated as “high-risk” are at greater risk of experiencing provider coercion simply by virtue of their high-risk status. The GVtM Study reported higher rates of mistreatment reported by pregnant patients with complex health statuses than by those experiencing uncomplicated pregnancies (28% vs. 14%).¹⁵⁰ Other research on women considered “high-risk” during pregnancy also shows higher rates of mistreatment by healthcare providers.¹⁵¹ In this way, people with high-risk pregnancies experience multiple forms of vulnerability as they prepare to give birth.

The likely increase in coerced interventions in the wake of *Dobbs* has several important implications for the rights and health of birthing people. First, coerced medical treatment violates patients' right to informed consent, which is a bedrock principle of medical care and a central part of healthcare providers' legal and ethical obligations to their patients.¹⁵² Informed consent is the “willing acceptance of a medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention with its risks and benefits and of the alternatives with their risks and benefits.”¹⁵³ Because such disclosures require the sharing of information between physician and patient that is specific to the patient's treatment, experts distinguish informed consent to treatment from the forms that a patient signs upon admission to the hospital, which some healthcare providers mistakenly believe provides implied consent to all subsequent procedures.¹⁵⁴ While some have argued that physicians should be able to impose treatment they deem necessary for the sake of fetal well-being, the American College of Obstetricians and Gynecolo-

149. See Sawicki et al., *supra* note 141, at Part III.

150. Logan et al., *supra* note 26, at 758.

151. See, e.g., Andrea E. Bombak, Deborah McPhail & Pamela Ward, *Reproducing Stigma: Interpreting Overweight and Obese Women's Experiences of Weight-Based Discrimination in Reproductive Healthcare*, 166 SOC. SCI. MED. 94 (2016); Laura Attanasio & Katy B. Kozhimannil, *Patient-Reported Communication Quality and Perceived Discrimination in Maternity Care*, 53 MED. CARE 863 (2015).

152. See *Caterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (“True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.”); *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”); Marc D. Ginsberg, *Informed Consent: No Longer Just What the Doctor Ordered? The “Contributions” of Medical Associations and Courts to a More Patient Friendly Doctrine*, 15 MICH. ST. J. MED. & L. 17, 19 (2011) (noting that the requirement for a physician to disclose risks, benefits, and alternatives before any treatment is “grounded in patient autonomy and the notion that unconsented treatment constitutes an intentional tort or negligence”).

153. Am. College of Obstets. & Gynecols., *ACOG Committee Opinion No. 390: Ethical Decision Making in Obstetrics and Gynecology*, 110 OBSTETS. & GYNECOL. 1479, 1483 (2007) (quoting ALBERT R. JONSEN, MARK SIEGLER & WILLIAM J. WINSLADE, *CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE* (McGraw-Hill 6th ed. 2006)).

154. Morton et al., *supra* note 118, at 268.

gists (ACOG) Committee on Ethics states that “[p]regnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life.”¹⁵⁵ In fact, ACOG affirmatively “opposes the use of coerced medical interventions for pregnant women.”¹⁵⁶ The right of pregnant people to informed consent must be protected without exception in order to respect and promote autonomy in medical decision-making. Furthermore, tolerating departures from the principle of informed consent in obstetrics can reshape norms away from respect for patient autonomy in other areas of medical care—to the detriment of patients more broadly.

Second, an increase in coerced treatment is likely to contribute to adverse perinatal health outcomes and exacerbate existing racial health disparities in maternal health. One area of particular concern is the negative impact of psychological birth trauma on postpartum mental health and well-being.¹⁵⁷ Researchers have found a significant association between provider pressure to accept labor induction or cesarean surgery and symptoms of post-traumatic stress disorder (PTSD), reflecting the long-lasting harm that healthcare providers can inflict on patients when they use their power and authority to compel patients to accept unwanted medical interventions.¹⁵⁸ The likelihood that a traumatic birth experience will lead to PTSD appears to be higher among patients with high-risk pregnancies.¹⁵⁹ Experts on the psychological dimensions of traumatic childbirth explain that such trauma “has ever widening ripple effects for mothers,” with even just a few minutes of traumatizing treatment acting like “a pebble dropped into a pond,”¹⁶⁰ with ripples that can impact various aspects of postpartum adjustment, including infant bonding, breastfeeding, and the development of postpartum mood disorders short of PTSD, as well as future childbearing decisions.¹⁶¹

More broadly, researchers have highlighted how the “differential ability of people to decline procedures and interventions, and have their pref-

155. Am. College of Obstets. & Gynecols., *Committee Opinion 664: Refusal of Medically Recommended Treatment During Pregnancy*, 127 *OBSTETS. & GYNECOL.* e175, e177 (2016).

156. *Id.* at e178.

157. See Xiaoqing Sun et al., *Psychological Birth Trauma: A Concept Analysis*, *FRONTIERS PSYCHOL.*, 13 Jan. 2023, at 12 (identifying psychological birth trauma as “a more complex and comprehensive concept than previously thought,” which should “be considered as a separate postpartum mental health problem”).

158. See Cheryl Tatano Beck, Robert K. Gable, Carol Sakala & Eugene R. Declercq, *Posttraumatic Stress Disorder in New Mothers: Results From a Two-Stage U.S. National Survey*, 38 *BIRTH: ISSUES IN PERINATAL CARE* 216, 217 (2011).

159. See Pelin Dikmen Yildiz, Susan Ayers & Louise Phillips, *The Prevalence of Post-traumatic Stress Disorder in Pregnancy and After Birth: A Systematic Review and Meta-Analysis*, 208 *J. AFFECTIVE DISORDERS* 634 (2017) (reporting results of meta-analysis that identified a mean of 4% of women in community samples experiencing PTSD after birth trauma, as compared to 18.5% of women in high-risk samples).

160. See Cheryl Tatano Beck, Sue Watson & Robert K. Gable, *Traumatic Childbirth and its Aftermath: Is There Anything Positive?*, 37 *J. PERINAT EDUC.* 175, 175 (2018).

161. *Id.*; see also Kukura, *supra* note 26, at 756–57 (discussing the health consequences of mistreatment during childbirth that causes emotional harms).

erences respected” can lead to more medically unnecessary procedures and an increase in iatrogenic harm,¹⁶² which is harm patients experience as a result of medical care.¹⁶³ Black and Native American pregnant people experience childbirth-related mortality and morbidity at disproportionately high rates and thus would likely bear a disproportionate degree of the harm inflicted by medically unnecessary interventions accepted as the result of provider coercion.¹⁶⁴ Because more pregnancies carried to term after *Dobbs* will be high-risk—due to the inability to terminate pregnancies that threaten the health of the pregnant person, fetus, or both—it may be hard to disentangle iatrogenic harm due to provider coercion from unavoidable injury related to the pregnant person’s health status.¹⁶⁵ This difficulty makes it less likely that physicians will subsequently have to reckon with their role in creating harm by pressuring their patients to accept interventions, let alone be held to account for violating their legal and ethical obligations to patients.

Finally, healthcare provider coercion can have a dehumanizing effect on patients at a vulnerable time—childbirth and postpartum—when birthing people particularly need support, not conflict. Pressuring a pregnant patient to accept medical intervention can negatively impact the patient’s expectations and confidence about birth, leading to longer and more stressful labor.¹⁶⁶ When healthcare providers use messages about maternal unfitness in order to secure acquiescence to treatment—suggesting that the patient is making the wrong decision for her baby or making morbid threats¹⁶⁷—women may begin to perceive themselves as incapable mothers, which diminishes the well-being of both parents and

162. Logan et al., *supra* note 26, at 758.

163. Ramya Sampath, *When is Iatrogenic Harm Negligent?*, 24 *AMA J. ETHICS* E735, E735 (2022) (defining iatrogenesis and noting that “while all harm that results from negligence is iatrogenic, not all iatrogenic injury is negligent”).

164. Hoyert, *supra* note 14 (reporting a Black maternal mortality rate in 2021 of 69.9 deaths per 100,000 live births, which was 2.6 times higher than for White women); Mary Annette Pember, *Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support*, *REWIRE* (July 9, 2018, 11:05 AM), <http://rewire.news/article/2018/07/09/amid-staggering-maternal-infant-mortality-rates-native-communities-revive-traditional-concepts-support> [<https://perma.cc/2JWA-A4RG>] (reporting that Native American women die from childbirth-related causes at 4.5 times the rate of White women); EUGENE DECLERCQ & LAURIE ZEPHYRIN, COMMONWEALTH FUND, SEVERE MATERNAL MORBIDITY IN THE UNITED STATES: A PRIMER 1 (2021), https://www.commonwealthfund.org/sites/default/files/2021-10/Declercq_severe_maternal_morbidity_in_US_primer_db.pdf [<https://perma.cc/Y9TT-BJCH>].

165. Furthermore, because “risk is perceived in terms of physical harm to the mother or baby, discounting psychological harm,” providers—and those judging the appropriateness of intervention after the fact—are biased to overestimate the benefits of pressuring patients to accept treatment and underestimate the harmful effects of employing coercive tactics in patient care. See Healy et al., *supra* note 138, at 112.

166. See Healy et al., *supra* note 138, at 107 (noting that “women’s confidence in their ability to have a normal birth is increasingly diminished . . . as a result of an increased focus on risk assessment and risk management”).

167. See Section III.A *supra*.

children in the postpartum and early childhood periods.¹⁶⁸ In short, when healthcare providers coerce pregnant people to accept medical intervention, they are undermining their patients instead of caring for them.

IV. CONCLUSION

People experiencing high-risk pregnancies often face significant decisions about medical interventions that require balancing risks and benefits for both the pregnant person and the fetus. Research suggests that instead of ensuring such people receive patient-centered counseling enabling them to make informed decisions about their care, providers are more likely to pressure high-risk patients to acquiesce to the provider's preferred approach. Lack of consent in this context raises significant concern about the ability of patients labeled "high-risk" to exercise autonomy and the consequences for their health of being coerced into treatment.¹⁶⁹

The anticipated post-*Dobbs* increase in coerced interventions has broader implications for all birthing people. Specifically, caring for more people with medically complex pregnancies may prompt providers to view childbirth across the board as riskier than it is—a position some obstetricians already seem to embrace with their heavy reliance on medical interventions for low-risk pregnancies and uncomplicated deliveries.¹⁷⁰ Exposure to adverse patient outcomes, especially if there is subsequent litigation, tends to make providers more risk-averse and more likely to take precautionary measures, even when intervention may not be medically indicated or where the evidence is mixed on whether such intervention is associated with an overall reduction in likelihood of poor outcome.¹⁷¹ In light of this tendency, the increase in pregnant people carrying high-risk pregnancies to term and delivering in the post-*Dobbs* era may have spillover effects on the clinical environment for patients with uncomplicated pregnancies whose providers are nevertheless more likely to perceive risk and pressure healthy patients into accepting unnecessary

168. Stoll et al., *supra* note 136, at 11 (noting that "coercing women into accepting care or interventions they do not want can impact women's internal perceptions of self-efficacy and motherhood").

169. See Logan et al., *supra* note 26, at 758 (expressing concern that "those who require more attention and information, such as those with higher-risk conditions who must face complex decisions, report the lowest levels of agency and a lack of person-centered, informed consent interactions in hospitals").

170. Helen M. Bryers & Edwin van Teijlingen, *Risk, Theory, Social and Medical Models: A Critical Analysis of the Concept of Risk in Maternity Care*, 26 *MIDWIFERY* 488, 492 (2010) (arguing that predominance of high-risk patients leads obstetric care providers to perceive birth as riskier); Healy et al., *supra* note 138, at 112 (discussing research that highlights the "assumption of abnormality" in childbirth and the impact that "risk culture and the assumption that birth is abnormal" have on provision of care).

171. See David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves and their Colleagues*, 12 *AM. L. & ECON. REV.* 69, 69 (2010) (identifying increase in cesareans following the initiation of a lawsuit against a colleague); Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 *BERKELEY J. GENDER L. & JUST.* 241, 267–70 (2016) (discussing evidence on risks of cesarean surgery).

medical intervention.¹⁷²

The *Dobbs* decision undermines respect for autonomy in reproductive decision-making by declaring that the right to abortion is no longer considered a fundamental right located in the Fourteenth's Amendment guarantee of liberty. It is imperative that healthcare providers not compound the harms of compelled pregnancy under *Dobbs* by coercing their patients into accepting medical intervention during childbirth.

172. See Healy et al., *supra* note 138, at 108 (discussing how exposure “to increasing amounts of intervention result[s] in higher perceptions of risk regarding women who are in fact low-risk,” also known as “learning the lessons of fear”).

