ECLIPSED: PREGNANT WOMEN IN THE POST-*ROE* ERA

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ABSTRACT

In Dobbs v. Jackson Women's Health Organization*, the United States Supreme Court overturned* Roe v. Wade *and* Planned Parenthood v. Casey *and authorized states to ban abortion and force pregnant women to carry a pregnancy to term. However,* Dobbs *is not just about abortion. By expressly recognizing the state's interest in "respect for and preservation of prenatal life at all stages of development," the Court has swung open the door for states to risk and regulate pregnant women's lives, regardless of whether they want an abortion, need an abortion, or are carrying a pregnancy to term.*

*This Article focuses on pregnancy—wanted or forced—in the post-*Roe *era. It reconstructs how we arrived at this point where the state's interest in protecting fetal life can eclipse a pregnant woman's rights to privacy, equality, and dignity. It then examines the immediate and long-term consequences of* Dobbs *on pregnant women's care and decision-making autonomy. Most immediately, pregnant women are now vulnerable to unnecessary health risks and inadequate pregnancy care in states with newly enacted or newly enforceable laws that ban abortion. Both historically and in the post-*Roe *era, exceptions to abortion bans have proven unworkable. They interfere with pregnant women's ability to obtain standard-of-care medical treatment and create chaos and confusion for doctors who practice in fear of losing their medical license or going to prison if they provide women with abortion care. Long term, pregnant women face increased likelihoods of*

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compelled or coerced medical intervention and circumscribed choices throughout pregnancy—all based on a prevailing assumption that women are exclusively responsible for producing a healthy pregnancy but are not capable of making the right decisions for their pregnancy. Decisions resolving individual patient-doctor conflicts, as well as broadly-applicable laws and recommendations governing pregnancy care, such as midwifery regulations and "zero trimester" recommendations, require healthy skepticism to avoid further stripping pregnant women of their decision-making autonomy. This Article concludes by arguing for a reversal of course and advances an agenda grounded in pregnancy justice that recenters pregnant women to improve maternal and infant outcomes.

TABLE OF CONTENTS

INTRODUCTION

In *Dobbs v. Jackson Women's Health Organization*, the United States Supreme Court overturned *Roe v. Wade* and *Planned Parenthood v. Casey* and eliminated the constitutional right to abortion.[1] In so doing, the Court authorized states to ban abortion and force pregnant women,[2] including minors, to carry a pregnancy to term.[3] The Court distinguished the state's right to prohibit abortion from other constitutionally-protected private conduct because abortion involves the termination of "potential life."[4] By expressly recognizing the state's legitimate interest in "respect for and preservation of prenatal life at all stages of development,"[5] the Court has now swung open the door for states to detrimentally risk and regulate pregnant women's lives,

1. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 292 (2022).

2. People of all gender identities, including transgender men and nonbinary people, can become pregnant and are entitled to equal rights and dignity. Debra DeBruin & Mary Faith Marshall, *Coercive Interventions in Pregnancy: Law and Ethics*, 23 J. HEALTH CARE L. & POL'Y 187, 187 n.1 (2021). People of all gender identities are also harmed by restrictions or prohibitions on abortion and reproductive health care. *See id.* This Article uses the term "pregnant women" because, to date, studies and cases related to pregnancy and pregnancy intervention involve pregnant cisgender women. *See* Ayesha Hassan, Jessica Perini, Amna Khan & Apoorva Iyer, *Pregnancy in a Transgender Male: A Case Report and Review of the Literature*, CASE REPS. ENDOCRINOLOGY, June 2022, at 1, 1–2 ("Our case is important as it highlights how little is known [about pregnant transgender men]."). In addition, most laws regulating reproduction target women. *See infra* Section I.B. Finally, transgender men and nonbinary people face unique pressures that extend beyond the limited scope of this Article. *See* DeBruin & Marshall, *supra*, at 187 n.1.

3. *See Dobbs*, 597 U.S. at 302 ("The Constitution does not prohibit the citizens of each State from regulating or prohibiting abortion."); Elizabeth Kukura, *Pregnancy Risk and Coerced Interventions After* Dobbs, 76 SMU L. REV. 105, 106 (2023) [hereinafter Kukura, *Coerced Interventions*] ("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."); Khiara Bridges, *Deploying Death*, 68 UCLA L. REV. 1510, 1523 (2022) ("If *Roe* is overturned . . . more people will be forced to carry pregnancies to term; more people will be forced to give birth to babies that they did not want to have."); Bryce Covert, *What It's Like to Have an Abortion Denied by Dobbs*, IN THESE TIMES (May 22, 2023), https://inthesetimes.com/article/what-its-like-to-have-an-abortion-denied [https://perma.cc/UX4W-V66Y] (Lationna Halbert wanted an abortion in Mississippi but was unable to obtain one after *Dobbs* and now has a second child); Charlotte Alter, *She Wasn't Able to Get an Abortion. Now She's a Mom. Soon She'll Start 7th Grade*, TIME (Aug. 14, 2023, 6:00 AM), https://time.com/6303701/a-rape-in-mississippi/ [https://perma.cc/2ZQG-XMZU].

4. *Dobbs*, 597 U.S. at 257.

5. *Id.* at 301.

regardless of whether they want an abortion, need an abortion, or are carrying a pregnancy to term.[6]

This Article examines the consequences of *Dobbs* on pregnant women, focusing on their care and decision-making rights during pregnancy. Now, on the one hand, *Dobbs* relates to abortion and pregnant women who want to terminate a pregnancy, and on the other hand, pregnancy care typically relates to pregnant women who want to carry a pregnancy to term. Although abortion exceptionalism and abortion stigma have created a perception that abortion care is separate from women's reproductive health care,[7] as this Article helps demonstrate, abortion and pregnancy care are often inextricably tied together—for pregnant women and in the eyes of the law.[8]

First, as a purely factual matter, women need access to the full range of reproductive health care because many women use the full range over the course of their reproductive lives.[9]

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6. *Compare* Roe v. Wade, 410 U.S. 113, 152–53 (1973) ("The detriment that the State would impose upon the pregnant woman by denying this choice [to have an abortion] altogether is apparent."), *with* Planned Parenthood S. Atl. v. State, 892 S.E.2d 121, 131 (S.C. 2023) (upholding the State's ban on abortion based on the legislature's determination that an unborn child's right to live outweighs a woman's interest in autonomy and privacy).

7. DAVID S. COHEN & CAROLE JOFFE, OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA 8 (2020) (explaining abortion exceptionalism as "the idea that abortion is treated uniquely compared to other medical procedures that are comparable to abortion in complexity and safety.").

8. Elizabeth Sepper, *The Right to Avoid Procreation and the Regulation of Pregnancy: A US Perspective*, *in* THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW 1050, 1068 (David Orentlicher & Tamara K. Hervey eds., 2020) (explaining that criminalizing abortion would allow state actors to "subject pregnant women to surveillance, incarceration, forced surgery, and other deprivations of liberty—that is, to subjugate the interest of the woman to the interest of the fetus").

9. The full range of reproductive health care includes pregnancy, childbirth, and postpartum care; contraceptive care and counseling; gynecological care like a pap test; sexually transmitted infection and HIV testing; abortion; and menopause care. *Access to Contraception*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Jan. 2025), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception [https://perma.cc/4BPL-HGNP]; Leah H. Keller & Adam Sonfield, *More to Be Done: Individuals' Needs for Sexual and Reproductive Health Coverage and Care*, GUTTMACHER POL'Y REV., Feb. 2019, at 1, 9; Matthew Rae, Cynthia Cox & Hanna Dingel, *Health Costs Associated with Pregnancy, Childbirth, and Postpartum Care*, PETERSON-KFF HEALTH SYS. TRACKER (July 13, 2022), https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/ [https://perma.cc/9LTV-6T3T]; Brittni Frederiksen, Usha Ranji, Alina Salganicoff & Michelle Long, *Women's Sexual and Reproductive Health Services: Key Findings from the 2020 KFF*

Women who have had abortions go on to get pregnant and have children.[10] In fact, two-thirds of women who have an abortion and do not already have existing children intend to or go on to have children when they are ready.[11] Likewise, women who have children may have abortions in an effort to prioritize their existing children.[12] In fact, almost 60% of women who had abortions in 2014 had experienced childbirth previously.[13] In addition, although many people think about abortion in connection with unwanted pregnancies, abortion care and wanted pregnancies are connected when a pregnancy becomes health- or life-threatening because of complications, severe fetal abnormality, or pregnancy loss.[14]

Second, without a legal right to abortion, more women will lose access to abortion care and decide to carry a pregnancy to term or be forced to do so by the laws of their state.[15] One year

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Women's Health Survey, KFF (Apr. 21, 2021), https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2020-kff-womens-health-survey/ [https://perma.cc/3THZ-BFB3].

10. *See* DIANA GREENE FOSTER, THE TURNAWAY STUDY 165 (2020) (telling the story of Ariela, who had an abortion and went on to finish college and have a baby when she felt ready).

11. Danielle Campoamor, *Portraits of Abortion: On Mother's Day, Five Women Share How Abortion Shaped Them as Moms*, TODAY (May 6, 2022, 5:15 PM), https://www.today.com/parents/moms/abortion-moms-mothers-day-women-share-abortion-stories-rcna27631 [https://perma.cc/J74Y-QT58].

12. KATIE WATSON, SCARLET A: THE ETHICS, LAW, AND POLITICS OF ORDINARY ABORTION 20 (2018).

13. GUTTMACHER INST., INDUCED ABORTION IN THE UNITED STATES 1 (2019).

14. *See* Maya Manian, *The Ripple Effects of* Dobbs *on Health Care Beyond Wanted Abortion*, 76 SMU L. REV. 77, 86 (2023) ("In the aftermath of *Dobbs*, patients and providers have been publicly sharing their stories of obstacles to care for pregnancy-related complications in states with abortion bans.").

15. *See* Daniel Dench, Mayra Pineda-Torres & Caitlin Myers, *The Effects of the* Dobbs *Decision on Fertility* 15 (IZA Inst. of Lab. Econ., Discussion Paper Series No. 16608, 2023) (finding that in the first six months of 2023, states that banned abortion experienced an increase in births of 2.3% compared to states that protected abortion rights); Brittni Frederiksen, Usha Ranji, Ivette Gomez & Alina Salganicoff, *A National Survey of OBGYNs' Experiences After* Dobbs, KFF (June 21, 2023), https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/ [https://perma.cc/942V-D2PE] (finding half of OBGYNs who practice in states with abortion bans have had patients "who were unable to get an abortion they sought"); Suzanne O. Bell, Elizabeth A. Stuart & Alison Gemmill, *Texas' 2021 Ban on Abortion in Early Pregnancy and Changes in Live Births*, 330 JAMA NETWORK 281, 281 (2023) ("We estimated that the SB8 policy was associated with 9799 additional births in Texas between April and December 2022

after *Dobbs*, twenty-five million women of reproductive age lived in states with abortion bans or laws limiting access to abortion care.[16] Women of color and poor women are being hit hardest by the Court's decision in *Dobbs*; the sharpest decreases in abortion are also in states with the worst inequities with respect to maternal morbidity and mortality, and poverty.[17] After *Dobbs*, these inequities will get worse.[18] Although a primary goal behind state laws banning abortion may be eliminating women's access to legal abortion, these bans have also decreased access to pregnancy care, reproductive health care broadly, and other health care that women in these states need.[19]

. . . ."); Daniel Grossman, Jamila Perritt & Deborah Grady, *The Impending Crisis of Access to Safe Abortion Care in the US*, 182 JAMA NETWORK 793, 793 (2022) ("People needing abortions in states with bans will have few options: seek abortion in other states, self-manage their abortion, or carry the pregnancy to term.").

16. Geoff Mulvihill, Kimberlee Kruesi & Claire Savage, *A Year After Fall of* Roe*, 25 Million Women Live in States with Abortion Bans or Tighter Restrictions*, ASSOCIATED PRESS (June 22, 2023, 12:01 AM), https://apnews.com/article/abortion-dobbs-anniversary-state-laws-51c2a83899f133556e715342abfcface [https://perma.cc/R64V-GGQX].

17. Isaac Maddow-Zimet & Candace Gibson, *Despite Bans, Number of Abortions in the United States Increased in 2023*, GUTTMACHER INST., https://www.guttmacher.org/2024/03/despite-bans-number-abortions-united-states-increased-2023 [https://perma.cc/NCH9-YHS8] (May 10, 2024); Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of* Roe *Is Deepening Existing Divides*, GUTTMACHER INST. (Jan. 17, 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides [https://perma.cc/2SHU-Z34T]; Elizabeth B. Harned & Liza Fuentes, *Abortion Out of Reach: The Exacerbation of Wealth Disparities After* Dobbs v. Jackson Women's Health Organization, GUTTMACHER INST. (Jan. 25, 2023), https://www.guttmacher.org/article/2023/01/abortion-out-reach-exacerbation-wealth-disparities-after-dobbs-v-jackson-womens [https://perma.cc/8X36-GFJ9]; SOC'Y OF FAM. PLAN., #WECOUNT REPORT: APRIL 2022 TO JUNE 2023 3 (2023).

18. *See* Maddow-Zimet & Gibson, *supra* note 17; Amirala S. Pasha, Daniel Breitkopf & Gretchen Glaser, *The Impact of* Dobbs *on US Graduate Medical Education*, 51 J.L. MED. & ETHICS 497, 498, 501 (2023).

19. ELIZABETH WARREN, TAMMY DUCKWORTH, MAZIE HIRONO & TINA SMITH, U.S. SENATE OFF., POST-ROE ABORTION BANS THREATEN WOMEN'S LIVES: HEALTH CARE PROVIDERS SPEAK OUT ON THE DEVASTATING HARM POSED BY ABORTION BANS AND RESTRICTIONS 3 (2022) [hereinafter WARREN ET AL., ABORTION BANS THREATEN LIVES]; MARIA CANTWELL, CHARLES E. SCHUMER, LAPHONZA BUTLER, MAZIE HIRONO, TAMMY DUCKWORTH, DEBBIE STABENOW, AMY KLOBUCHAR, TAMMY BALDWIN, ELIZABETH WARREN, TINA SMITH, KIRSTEN GILLIBRAND, CATHERINE CORTEZ MASTO, PATTY MURRAY, JEANNE SHAHEEN, JACKY ROSEN & MAGGIE HASSAN, U.S. SENATE OFF., TWO YEARS POST-DOBBS: THE NATIONWIDE IMPACTS OF ABORTION BANS 4–5 (2024) [hereinafter CANTWELL ET AL., TWO YEARS POST-DOBBS].

Finally, abortion and pregnancy care are intertwined in peculiar ways in the eyes of the law. For example, although many laws banning abortion carve out exceptions for limited circumstances, such as when a pregnant woman's life is in danger, since *Dobbs*, these legal exceptions have proven woefully inadequate to ensure that pregnant women receive access to timely care.[20] In fact, five prominent medical organizations, including the American Medical Association, reported to federal lawmakers that state laws banning abortion have threatened the lives of pregnant women experiencing miscarriages, ectopic pregnancies, and other pregnancy complications and will result in more pregnancy-related deaths.[21]

In addition, although state regulation of women's reproductive decision-making has been most glaring in connection with abortion, state actors have also regulated women's reproductive decision-making in connection with pregnancy care.[22] To be clear, women who seek abortion care have interests that diverge from fetal interests, and women who seek to carry a pregnancy to term have mutual or shared interests with the fetus and strive to make the best decisions for their health and the fetus' health.[23] Some courts have nevertheless applied abortion law, like *Roe* and *Casey*'s viability line, to decide whether and when the state can intervene in a woman's pregnancy care.[24] In addition, similar to states' hyper-regulation of abortion providers is

20. WARREN ET AL., ABORTION BANS THREATEN LIVES, *supra* note 19, at 3, 6–7, 9–10; CANTWELL ET AL., TWO YEARS POST-DOBBS, *supra* note 19, at 5; Shefali Luthra, *Abortion Bans Are Barring People from Life-Saving Pregnancy Care, Medical Groups Warn*, THE 19TH (Nov. 1, 2022, 6:00 AM), https://19thnews.org/2022/11/abortion-bans-restrict-critical-pregnancy-care-senate-report/ [https://perma.cc/K35B-GCDA].

21. *See infra* Section II.A; WARREN ET AL., ABORTION BANS THREATEN LIVES, *supra* note 19, at 4; Luthra, *supra* note 20.

22. *See infra* Part III.

23. Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 794–95 (2018) [hereinafter Kukura, *Obstetric Violence*].

24. Sepper, *supra* note 8, at 1066; Kukura, *Obstetric Violence*, *supra* note 23, at 794; Lynn M. Paltrow, Roe v Wade *and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration*, 103 AM. J. PUB. HEALTH 17, 18 (2013) ("*Roe v Wade* . . . has been 'sensibly relied upon to counter' attempts to interfere with a woman's decision to become pregnant or to carry her pregnancy to term.").

states' hyper-regulation of midwives; these regulations adversely affect cost, access, and quality of care, but do nothing to improve patient safety.[25] Compounding these state laws and regulations are medical and public health pregnancy recommendations that effectively enlist doctors for enforcement purposes.[26] The Court's decision in *Dobbs* creates instability and uncertainty in these areas of the law insofar as they rely on pre-*Dobbs* abortion rights jurisprudence or will rely on *Dobbs* to circumscribe pregnant women's decision-making autonomy.

Part I of this Article offers an overview of pregnancy and the ways in which the government has regulated pregnancy decision-making and care, especially the courts. Historically, under the law, a pregnant woman had autonomy over her pregnancy experience.[27] More recently, however, the law has treated the pregnant woman and fetus as adverse parties or as if the pregnant woman and fetus have mutually exclusive interests. The Court's decision in *Dobbs* entrenches this adversarial view and clears the way for a new era in which the state's interest in fetal life can take precedence over a pregnant woman's decision-making about her care throughout pregnancy.[28]

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25. *The Legal Infrastructure of Childbirth*, 134 HARV. L. REV. 2209, 2226–28 (2021) (discussing similarities between targeted regulations of abortion providers ("TRAP" laws) and targeted regulation of midwifery practice ("TROMP" laws)).

26. *Id.* at 2210 ("[A] runaway tort system encourages physicians to prioritize the fetus at all costs, giving them wide latitude to impose a distorted standard of care on pregnant people, while, in contrast, restrictive midwifery regulation denies various reproductive options to pregnant people—mimicking the hyper-regulatory oversight of abortion.").

27. *See infra* Section I.B. Although the law in the 1900s treated a woman and fetus as inseparable until after birth, offering pregnant women autonomy relative to the fetus, broadly speaking, pregnancy autonomy under the law is more complex. *See id.* As Professor Michele Goodwin has explained,

> [T]here was little debate or confusion in the Antebellum period about the existence of the involuntary sexual and physical labors imposed on Black women and girls, even if historians ignored writing about those matters from the point of view of Black women and girls. Forced reproduction and involuntary reproductive servitude were well-settled concepts and practices woven into the legal and social fabric of slavery.

Michele Goodwin, *Involuntary Reproductive Servitude: Forced Pregnancy, Abortion, and the Thirteenth Amendment*, 2022 U. CHI. LEGAL F. 191, 204 (2023).

28. *See, e.g.*, Planned Parenthood S. Atl. v. State, 892 S.E.2d 121, 131 (S.C. 2023) (upholding South Carolina's ban on abortion and deferring to legislature's policy determination that "a

Part II of this Article examines the immediate consequences of *Dobbs* on pregnant women and their care. Specifically, as soon as the Court ended the constitutional right to abortion and states banned that care, pregnant women who suffered health complications, received severe fetal abnormality diagnoses, or experienced pregnancy loss began to encounter health care providers who refused to treat them with necessary abortion care.[29] By design, state laws banning abortion have created chaos and confusion for pregnant women and their doctors, who increasingly practice in fear of losing their medical license or going to prison if they provide emergency and life-saving abortion care.[30] Moreover, as federal and state litigation over these exceptions shows, legal challenges to these laws are inefficient and have provided virtually no relief.[31]

Part III of this Article predicts some of the long-term consequences of *Dobbs* for pregnant women and pregnancy care. Specifically, the end of the constitutional right to abortion means

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woman's interest in autonomy and privacy does not outweigh the interest of the unborn child to live").

29. DANIEL GROSSMAN, CAROLE JOFFE, SHELLY KALLER, KATRINA KIMPORT, ELIZABETH KINSEY, KLAIRA LERMA, NATALIE MORRIS & KARI WHITE, CARE POST-ROE: DOCUMENTING CASES OF POOR QUALITY CARE SINCE THE DOBBS DECISION 5, 8, 10, 14, 16 (2023) (preliminary findings). In a nationally-publicized case, Brittany Watts was twenty-two weeks pregnant with a nonviable pregnancy. Kim Bellware & Anumita Kaur, *Grand Jury Declines to Indict Ohio Woman Who Miscarried of Abusing a Corpse*, WASH. POST, https://www.washingtonpost.com/nation/2024/01/11/brittany-watts-grand-jury/ [https://perma.cc/SY9T-7VNR] (Jan. 11, 2024). After several days, Ohio hospital officials sent her home, where she suffered a miscarriage and delivered a fifteen-ounce fetus. *Id.* She returned to the hospital, and a nurse reported her to police. *Id.* Law enforcement authorities arrested her, and despite legal and medical professionals encouraging Trumball County prosecutor Dennis Watkins not to bring a criminal case against her, he pursued one for "abuse of a corpse." *Id.* A grand jury refused to indict her. *Id.*

30. Laurie Sobel, Mabel Felix & Alina Salganicoff, *Who Decides When a Patient Qualifies for an Abortion Ban Exception? Doctors vs. the Courts*, KFF (Dec. 14, 2023), https://www.kff.org/policy-watch/who-decides-when-patient-qualifies-for-abortion-ban-exception/ [https://perma.cc/9G8N-Z9L8]; Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF, https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/55BZ-N8HB] (June 6, 2024).

31. *See, e.g.*, Moyle v. United States, 603 U.S. 324, 325 (2024) (dismissing writs of certiorari as improvidently granted); Texas v. Zurawski, 690 S.W.3d 644, 653–54 (Tex. 2024) (holding the exceptions under the Texas abortion ban were not impermissibly narrow under the Texas Constitution).

that, over time, states may increasingly exert control over pregnant women's lives and their care. Pregnant women may find themselves navigating a new-fangled web of compelled medical intervention and circumscribed choices in the form of broadly-applicable laws and intrusive lifestyle recommendations—all based on a prevailing assumption that women are exclusively responsible for producing a healthy pregnancy but are not capable of making the right decisions for their pregnancy.

Finally, Part IV of this Article prescribes an alternative way forward—one grounded in pregnancy justice—that recenters pregnant women and prioritizes their autonomy to improve pregnancy health and maternal and infant outcomes. This section proposes a cultural shift away from the adversarial view of a pregnant woman and fetus and toward a woman-centered view of pregnancy and pregnancy care. This section also proposes public policy recommendations to improve pregnancy health outcomes, including policies that increase access to legal abortion, broaden the availability of midwives, decrease domestic violence and abuse, and make inroads in alleviating poverty. There is immense value in providing pregnant women with information and care that is appropriate for pregnancy health and serves the mutual needs of the pregnant woman and fetus, but that information provision and care should prioritize women's health and autonomy and not further curtail their privacy, equality, and dignity.

I. PREGNANCY AND PREGNANT WOMEN'S DECISION-MAKING AUTONOMY DURING CARE

In the United States, pregnancy is a life event that is deeply personal as well as biological, social, and political. Over the past five decades, the state's increasing involvement in pregnancy has blurred these categorical lines and shaped the law and

corresponding legal narrative surrounding pregnancy.[32] This section provides a brief overview of pregnancy and examines the ways in which the law has evolved with respect to pregnancy, pregnancy care, and the relationship between a pregnant woman and fetus. Historically, women had the most decision-making autonomy during pregnancy. More recently, despite having made considerable social, economic, and political progress in American society, women have experienced less decision-making autonomy during pregnancy. The Court's decision to overturn *Roe* and *Casey*, which protected pregnant women's decision-making rights or at least sought to balance women's rights against state interests and fetal rights, commences a new chapter: states can now strip pregnant women of their decision-making autonomy based on states' purported interest in potential life.

A. Pregnancy Is a Life Event that Is Deeply Personal as well as Biological, Social, and Political

Pregnant women's voices are critical to understanding pregnancy and, by extension, the law that regulates it. However, pregnancy discourse has not always included their subjective experience, which has resulted in society framing and understanding the pregnancy experience in ways that are oftentimes incomplete, oversimplified, and reduced.[33] First, pregnancy is deeply personal. Women experience it in varied and complex ways and often describe it as an existentially altering experience.[34] Pregnant women may welcome their pregnancy or resent it; they may love their unborn child or fear it; they may

32. MIRANDA R. WAGGONER, THE ZERO TRIMESTER: PRE-PREGNANCY CARE AND THE POLITICS OF REPRODUCTIVE RISK 23 (2017) ("Sociologists of medicine and science have long observed that what has become conventional medical and health wisdom is intricately tied up with what is considered conventional social wisdom. That is, social, cultural, and political currents shape and are shaped by scientific and medical knowledge.").

33. Rona Kaufman Kitchen, *Holistic Pregnancy: Rejecting the Theory of the Adversarial Mother*, 26 HASTINGS WOMEN'S L.J. 207, 236–37 (2015).

34. *Id.* at 238; *see also* Greer Donley & Jill Wieber Lens, *Abortion, Pregnancy Loss, & Subjective Fetal Personhood*, 75 VAND. L. REV. 1649, 1662–63, 1672 (2022) (explaining that a woman's attachment to the fetus is based on a range of factors, including wantedness).

eagerly await motherhood but also yearn for their individuality; they may experience pregnancy as duality or oneness or both (sometimes simultaneously); they may feel connected to the life they are bringing into the world but also feel invaded by it.[35] When a pregnant woman obtains health care, that experience may exacerbate these conflicts if she feels neglected or as though doctors are treating the pregnancy or the fetus, but not her, as a whole person.[36] Pregnant women may also experience obstetric violence or abuse, coercion, and disrespect at the hands of a health care provider.[37]

Of course, pregnant women do not experience pregnancy alone for biological, social, and political reasons, and understanding the life event through these lenses is helpful in understanding the ways in which the law has evolved with respect to it. First, pregnancy is a biological event that begins at fertilization or when an egg and sperm meet and form a single cell.[38] That single cell divides into a cluster of multiple cells, which then implants into the lining of the woman's uterus.[39] For two months after implantation, it is referred to as an embryo.[40] Thereafter, it is referred to as a fetus.[41] Full-term pregnancy lasts around forty weeks.[42] At the same time the fetus is developing,

35. Kitchen, *supra* note 33, at 238, 241.

36. *Id.* at 240.

37. Yousra A. Mohamoud, Elizabeth Cassidy, Erika Fuchs, Lindsay S. Womack, Lisa Romero, Lauren Kipling, Reena Oza-Frank, Katharyn Baca, Romeo R. Galang, Andrea Stewart, Sarah Carrigan, Jennifer Mullen, Ashley Busacker, Brittany Behm, Lisa M. Hollier, Charlan Kroelinger, Trisha Mueller, Wanda D. Barfield & Shanna Cox, *Vital Signs: Maternity Care Experiences—United States, April 2023*, 72 MORBIDITY & MORTALITY WKLY. REP. 961, 962 (2023) (finding one in five women surveyed reported they were mistreated while receiving maternity care; mistreatment included discrimination, verbal abuse, and physical privacy violations). *See generally* Kukura, *Obstetric Violence*, *supra* note 23, at 730 (listing forced surgery, unconsented medical procedures, sexual violations, and physical restraint as extreme forms of mistreatment women face when giving birth).

38. *How Your Fetus Grows During Pregnancy*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Jan. 2024), https://www.acog.org/womens-health/faqs/how-your-fetus-grows-during-pregnancy [https://perma.cc/SZ7J-LVHP].

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

a woman's body is changing, including her abdomen, breasts, and legs and feet; her body systems are also changing, including her endocrine system, cardiovascular system, respiratory system, musculoskeletal system, urinary system, integumentary system (hair, skin, and nails), body temperature, and body weight.[43] During pregnancy, women can suffer a vast range of physical side effects that can lead to discomfort, pain, and disability, including nausea and vomiting, gestational diabetes, pregnancy-induced hypertension, and preeclampsia.[44] Childbirth can also demand a multi-hour vaginal delivery or a caesarian section.[45] In the worst cases, pregnancy and childbirth can result in a woman's death.[46]

Pregnancy is not just a biological event; it is also a social event. Societal forces influence when women conceive; whether women have access to contraception, abortion, and quality reproductive health care and whether their use of these various forms of family planning is acceptable; and whether pregnant women have support during pregnancy and after childbirth.[47] In general, American society views pregnancy as "a wonderful, life-affirming, overwhelmingly good event in the life of the woman (and her family, nation, and, ultimately, species)."[48] Governmental, religious, and other powerful institutions support this positive construction of pregnancy.[49] Indeed, motherhood is often seen as central to womanhood, even though

43. *How Your Body Changes During Pregnancy*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/healthy-pregnancy/changes-in-your-body/body-changes-during-pregnancy/ [https://perma.cc/4N98-CCBY] (last visited Apr. 15, 2025).

44. Rachel A. Camp, *Coercing Pregnancy*, 21 WM. & MARY J. WOMEN & L. 275, 304 (2015); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 373 (1992).

45. Camp, *supra* note 44, at 304.

46. DONNA L. HOYERT, MATERNAL MORTALITY RATES IN THE UNITED STATES, 2022 1 (2024).

47. Siegel, *supra* note 44, at 267, 272.

48. Khiara M. Bridges, *When Pregnancy Is an Injury: Rape, Law, and Culture*, 65 STAN. L. REV. 457, 461–62 (2013) [hereinafter Bridges, *When Pregnancy Is an Injury*] (claiming, in discussing the harms of statutory rape, that the unequal burden of childcare and pregnancy falling on women and girls is the consequence of social mores, not any biological fact).

49. *Id.* at 490.

society puts women at a disadvantage because of pregnancy and motherhood.[50]

Specifically, as soon as a woman becomes pregnant, society subjects her to certain assumptions and judgments related to what constitutes a "good" mother, and if she fails to demonstrate absolute devotion to the fetus, she will fall short of society's expectations of mothers and face possible legal intervention.[51] The "detailed prescriptive norms" pregnant women must negotiate on a daily basis include what they eat and drink, how they exercise and obtain health care, whether they travel and engage in leisure activities, and what work they engage in at their jobs and at home.[52] In addition, even though a pregnant woman's ambivalence towards motherhood is normal and healthy, society has used it as a weapon to punish her in some instances.[53] A pregnant woman's position in society stands in stark contrast to soon-to-be fathers.[54] In fact, in the past few decades, society has held pregnant women responsible for fetal health and well-being while ignoring the enormous roles

50. WAGGONER, *supra* note 32, at 106; KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS 198, 200–01 (2017) [hereinafter BRIDGES, THE POVERTY OF PRIVACY RIGHTS].

51. LINDA C. FENTIMAN, BLAMING MOTHERS: AMERICAN LAW AND THE RISKS TO CHILDREN'S HEALTH 9 (2017); Camp, *supra* note 44, at 309. Gendered norms make it challenging to see even when pregnant women experience physical injuries or trauma. Kukura, *Obstetric Violence*, *supra* note 23, at 776.

52. Siegel, *supra* note 44, at 373–74.

53. Elizabeth Kukura, *Punishing Maternal Ambivalence*, 90 FORDHAM L. REV. 2909, 2915 (2022) [hereinafter Kukura, *Punishing Maternal Ambivalence*]. One can expect pregnant women's mental health needs will increase after *Dobbs*. Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of* Roe v. Wade, 386 NEW ENG. J. MED. 2061, 2063 (2022) ("The perinatal mental health needs of pregnant patients who are continuing undesired pregnancies, including those resulting from sexual assault, will undoubtedly intensify as well, further stressing an overtaxed mental health care system.").

54. WAGGONER, *supra* note 32, at 141–44; FENTIMAN, *supra* note 51, at 9, 57–58; Siegel, *supra* note 44, at 343 ("[M]en may abandon children they 'father,' failing to participate in their care or economic support in a fashion that compromises a child's welfare just as surely as any act of maternal neglect, yet their conduct does not elicit communal retribution of the sort faced by pregnant women judged neglectful today.").

played by "poverty, genetics, environmental toxins, fathers, government, and private institutions."[55]

Finally, pregnancy is a political event. Abortion and a woman's decision about whether to carry a pregnancy to term has been one of the most contested political issues in the United States for decades.[56] More broadly, maternal and child health are indicators of the nation's overall health and the strength of its health care institutions, so it is not surprising that pregnancy and reproduction are part of political debates related to welfare, immigration, policing, schools, and other major questions in society.[57] With any pregnancy, political factors influence a pregnant woman's care, not just medical considerations.[58] For example, before *Roe v. Wade*, political actors and social regulators passed state and federal laws outlining the number of hours a pregnant woman could work based on her pregnancy or her future pregnancy status.[59] Nowadays, some health care providers take on dual roles as a pregnant woman's caretaker and obedience officer, monitoring her compliance with state statutes, regulations, and recommendations that often purport to promote

55. FENTIMAN, *supra* note 51, at 3; WAGGONER, *supra* note 32, at 29 ("[M]aternal responsibility is defined for women writ large."); SHEENA MEREDITH, POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT 207 (2005) ("The concentration on women's [behavior] and choices in pregnancy, and the concerted attempts to elevate '[fetal] rights' often for other purposes, stand in marked and ironic contrast to the inattention and lack of support or resources given to mothers and young children.").

56. *See generally* MARY ZIEGLER, ABORTION AND THE LAW IN AMERICA: ROE V. WADE TO THE PRESENT (2020) (tracking the history of the abortion debate and the Supreme Court's influence on that debate).

57. WAGGONER, *supra* note 32, at 29; LAURA BRIGGS, HOW ALL POLITICS BECAME REPRODUCTIVE POLITICS 2–3 (2017).

58. MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 82 (2020); BRIDGES, THE POVERTY OF PRIVACY RIGHTS, *supra* note 50, at 5 ("And if we understand a woman's decision about whether or not to become a mother to be a private matter, then most states' Medicaid programs violate poor women's privacy in that they implicate themselves in this decision by using government largesse to direct poor women toward or away from motherhood.").

59. WAGGONER, *supra* note 32, at 106 ("During the first two decades of the twentieth century, numerous labor protections and social regulations were legislated by states and by Congress to 'help adult American women as mothers or as *potential mothers*.'" (citations omitted)).

fetal well-being but actually achieve very little toward that end.[60]

The politics of pregnancy is most pervasive for women experiencing poverty. For example, states have adopted family cap or child exclusion policies in their Temporary Assistance for Needy Families programs to limit how many children beneficiaries have.[61] These policies freeze a family's grant, regardless of any increases in the family's size, supposedly to incentivize beneficiaries to seek employment.[62] These political choices, however, ignore that unemployment has a variety of causes and that these policies are ineffective at reducing the number of children that welfare beneficiaries have.[63] Moreover, at the same time that states adopted family cap or child exclusion policies, they restricted abortion funding to encourage or compel women to give birth.[64] Under *Roe* and *Casey*, women had the constitutional right to decide whether to obtain an abortion, but states and the federal government refused to fund abortion care services for poor women, and the Supreme Court supported these political decisions.[65] To be sure, policies that implemented family caps and restricted abortion funding may seem contradictory, but as Professor Khiara Bridges explains, the policies are perfectly consistent if the state's goal is to control poor women's reproductive decision-making.[66]

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60. GOODWIN, *supra* note 58, at 82; Sepper, *supra* note 8, at 1064–65; Naomi K. Seiler, *Alcohol and Pregnancy: CDC's Health Advice and the Legal Rights of Pregnant Women*, 131 PUB. HEALTH REPS. 623, 625 (2016) ("[M]andatory reporting requirements can effectively bootstrap providers into the machinery of legal enforcement.").

61. BRIDGES, THE POVERTY OF PRIVACY RIGHTS, *supra* note 50, at 187.

62. *Id.* at 187–88.

63. *Id.* at 188–89.

64. *Id.* at 181–90.

65. *Id.* at 181–85. *See generally* Harris v. McRae, 448 U.S. 297 (1980) (determining that states participating in Medicaid did not need to fund medically necessary abortions under Title XIX of the Social Security Act); Maher v. Roe, 432 U.S. 464 (1977) (upholding the Connecticut law because it did not create obstacles for women to get abortions or "impinge upon the fundamental right recognized in *Roe*"); Poelker v. Doe, 432 U.S. 519 (1977) (finding no constitutional violation by the city-owned hospital's refusal to perform a nontherapeutic abortion on an indigent female).

66. BRIDGES, THE POVERTY OF PRIVACY RIGHTS, *supra* note 50, at 193–94.

B. The Law and Decision-Making Autonomy During Pregnancy Care

The law as it relates to pregnancy care has often tracked the ways in which society has understood pregnancy, but that understanding has been and remains limited even with advances in medical technology.[67] As an initial matter, in the United States, pregnant women are rarely allowed to participate in research both because of limits on research of human subjects and because the National Institutes of Health did not require a balance between male and female subjects until 2014.[68] In addition, although medical research on fetal development has increased significantly, fetal risk research has produced inconsistent and inconclusive results, and there are still no clear causes for many common adverse pregnancy outcomes, including stillbirths, miscarriages, and preterm births.[69] Nevertheless, pregnant women are experiencing rising medical and legal intervention and increased pressure to avoid risks during pregnancy at the expense of their decision-making autonomy.[70]

Historically, the law granted pregnant women decision-making autonomy with respect to the fetus. For example, in early tort cases in the 1900s, courts conceptualized pregnancy in the law in a way that recognized the maternal-fetal connection in the same way that physicians and midwives treated pregnant women and the fetus—as inseparable until birth.[71]

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67. FENTIMAN, *supra* note 51, at 73–75 (discussing the role of medical research on fetal health, modern visual imagery of the fetus, including 3D and 4D ultrasounds, and media portrayals of the fetus in mainstream media); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 471–72 (2000) ("In large part, the leap from acknowledging the fetus's presence to limiting the pregnant woman's autonomy is a reflection of the medical community's response to technological advances such as ultrasound, which permits obstetricians to visualize the fetus within the mother's uterus.").

68. FENTIMAN, *supra* note 51, at 76.

69. *Id. Dobbs* may create additional barriers to medical research related to pregnant women because of the heightened legal risks related to fetal life. Richard M. Weinmeyer, Seema K. Shah & Michelle L. McGowan, *Ethical and Legal Obligations for Research Involving Pregnant Persons in a Post-*Dobbs *Context*, 51 J.L. MED. & ETHICS 504, 504 (2023).

70. FENTIMAN, *supra* note 51, at 71.

71. *Id.* at 74; Kitchen, *supra* note 33, at 212.

Both tradition and common law viewed the fetus as "part and parcel" of the pregnant woman.[72] Under common law, the "born-alive rule" prevailed, and nobody could be held criminally or civilly responsible for harm until after birth.[73] Addressing a case involving injuries to a fetus in utero, Justice Oliver Wendell Holmes Jr., while sitting on the Massachusetts high court, concluded that a fetus was not a person under the common law "born-alive rule," and a lawsuit could not be brought on behalf of it.[74] Rather, "the unborn child was part of the mother at the time of the injury."[75] Courts recognized personhood at birth, and until the mother and child were separated at birth, courts declined to recognize causes of action for injuries to the fetus.[76] The law was consistent with the "prevailing medical wisdom" that ensuring pregnant women were healthy was the best way to ensure that deliveries were healthy.[77]

By the late 1950s, the emphasis shifted, and courts conceptualized pregnancy in the law in a way that recognized a pregnant woman and fetus had separate existence.[78] For example, a New York court concluded that a child born alive could maintain a cause of action if the child sustained injuries at any time during pregnancy.[79] The Oregon Supreme Court took a narrower view and concluded that a lawsuit could be brought on behalf of a fetus for injuries if the injuries took place after viability.[80] Recognition of the fetus as separate from the pregnant woman was consistent with the medical community's approach to pregnancy at that time.[81] It began treating the pregnant woman and the fetus as two patients.[82] Researchers began

72. Siegel, *supra* note 44, at 290.
73. FENTIMAN, *supra* note 51, at 74.
74. *Id.*; Kitchen, *supra* note 33, at 212.
75. FENTIMAN, *supra* note 51, at 74; Kitchen, *supra* note 33, at 212.
76. FENTIMAN, *supra* note 51, at 74; Kitchen, *supra* note 33, at 213.
77. FENTIMAN, *supra* note 51, at 75.
78. *Id.*; Kitchen, *supra* note 33, at 214.
79. Kitchen, *supra* note 33, at 214.
80. *Id.*
81. FENTIMAN, *supra* note 51, at 74–75.
82. *Id.* at 75.

studying fetal oxygen deprivation and created electronic fetal monitoring for this purpose, leading to dramatic increases in cesarean sections despite the imprecise technology.[83] Recognition of the fetus as separate from the pregnant woman in law was also consistent with the view that human beings had a right to be born unimpaired because of the negligent act of another.[84]

In 1973, the emphasis shifted once more when the Supreme Court decided *Roe v. Wade* and conceptualized pregnancy in the law in a way that established adversarial interests between the pregnant woman and fetus.[85] With the trimester framework, the Court recognized that the state's interest in regulating abortion became compelling at different stages of pregnancy depending on whether it was regulating abortion in the interest of maternal health or in the interest of the potential human life.[86] Although the Court in *Roe* recognized the pregnant woman and fetus as separate, unlike prior tort cases, the Court recognized the woman and fetus as having adversarial interests, redefining the maternal-fetal connection, and appointed the state to represent fetal interests.[87] More recently, lawmakers and prosecutors have begun to hold pregnant women accountable for harm or threat of harm to the fetus, and American women have found themselves under surveillance for their actions or inactions while pregnant.[88]

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83. *Id.*

84. Kitchen, *supra* note 33, at 214–15.

85. *Id.* at 216–17. *See also* Julia Epstein, *The Pregnant Imagination, Fetal Rights, and Women's Bodies: A Historical Inquiry*, 7 YALE J.L. & HUMANS. 139, 140 (1995) ("Focus on the fetus as an entity that is available to medical and legal professionals for pronouncement and intervention, and that can be discussed separately from the womb that contains it, is very much a modern phenomenon.").

86. Roe v. Wade, 410 U.S. 113, 162–66 (1973); Kitchen, *supra* note 33, at 216–17.

87. Kitchen, *supra* note 33, at 217. While the *Roe* holding itself conceptualized pregnancy as an adversarial event, the Court's dicta show it may not have entirely bought into that idea. *Id.* at 224–27. The view of pregnant women and fetal interests as adversarial was consistent with the medical profession's advocacy against abortion in the first half of the twentieth century. *See* Siegel, *supra* note 44, at 288.

88. FENTIMAN, *supra* note 51, at 71 ("Physicians, nurses, and other health care providers have often 'referred' their patients to law enforcement, resulting in legal interventions that include court-ordered medical treatment, involuntary civil commitment, tort liability, and even criminal prosecution.").

That brings us to the present day. The Court in *Dobbs* eliminated the constitutional right to abortion and rejected the viability line and undue burden standard from *Roe* and *Casey*.[89] The Court explained that rational basis review would apply to future challenges to abortion laws, offering a "strong presumption of validity" to such laws, and upheld Mississippi's ban on abortion after fifteen weeks of pregnancy.[90] The Court approved of that state's asserted interest in "protecting the life of the unborn" and made clear that state legitimate interests include "respect for and preservation of prenatal life at all stages of development."[91] In doing so without "any serious discussion" of women,[92] the Court entrenched an adversarial view of the maternal-fetal relationship and commenced a new era where, by law, a pregnant woman's decision-making rights and care no longer need to be balanced against state interests and fetal rights and well-being—they can be eclipsed entirely.[93]

II. THE IMMEDIATE CONSEQUENCES OF *DOBBS* ON PREGNANT WOMEN AND THEIR DECISION-MAKING AUTONOMY AND CARE: EXCEPTIONS TO ABORTION BANS ARE UNWORKABLE

Since *Dobbs*, twelve states have banned abortion.[94] Although these laws often contain narrow exceptions for a woman's life or health, they have proven underinclusive, unclear, and too vague for medical providers to apply in the fast-paced and often tragic real-life circumstances they face.[95] According to the

89. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 231 (2022).

90. *Id.* at 301.

91. *Id.*

92. *Id.* at 405 (Breyer, Sotomayor & Kagan, JJ., dissenting).

93. Siegel, *supra* note 44, at 333 ("When the fetus is considered an object of regulatory concern distinct and apart from the woman bearing it, it becomes possible to reason about regulating women's conduct without seeming to reason about women at all.").

94. *Abortion in the United States Dashboard*, KFF, https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/ [https://perma.cc/K4WK-Q3CS] (last visited Apr. 15, 2025).

95. Frederiksen et al., *supra* note 15 (finding that 40% of office-based OBGYNs in states with abortion bans "personally felt constraints on their ability to provide care for miscarriages and

president of the American Medical Association, cases of pregnant women not receiving standard-of-care medical treatment happen "every day, all the time" in states with laws banning abortion.[96] This section brings to light just a few of the many cases in which pregnant women suffering health- or life-threatening complications did not receive necessary pregnancy care because of state laws banning abortion. This section also makes clear that cases involving pregnant women not receiving timely and adequate care will persist until there is a comprehensive and enduring shift in the legal landscape that reprioritizes pregnant women and their care rather than leaving them susceptible to unworkable exceptions in law or in legal limbo as courts grapple with whether their lives are entitled to protection under law.

A. Pregnant Women with Health- and Life-Threatening Complications Do Not Receive Adequate Pregnancy Care in States with Abortion Bans

Exceptions to the state laws banning abortion have proven unworkable in cases in which pregnant women experience loss, including early miscarriages and ectopic pregnancies.[97] For

other pregnancy-related medical emergencies since the *Dobbs* decision"); Harris, *supra* note 53, at 2061 ("[I]t's unclear what, precisely, 'life saving' means. What does the risk of death have to be, and how imminent must it be? Might abortion be permissible in a patient with pulmonary hypertension, for whom we cite a 30-to-50% chance of dying with ongoing pregnancy? Or must it be 100%?").

96. Kate Zernike, *Medical Impact of* Roe *Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, N.Y. TIMES (Sept. 10, 2022), https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html [https://perma.cc/FRX8-ZSZ2]; Jessica Valenti, *I Write About Post-*Roe *America Every Day. It's Worse Than You Think*, N.Y. TIMES (Nov. 5, 2022), https://www.nytimes.com/2022/11/05/opinion/election-abortion-roe-women.html [https://perma.cc/224S-YAVB] ("For every one story shared, there are hundreds or thousands more that we will never know about."); Frederiksen et al., *supra* note 15 ("Most OBGYNs [surveyed] (68%) say the ruling has worsened their ability to manage pregnancy-related emergencies. Large shares also believe that the *Dobbs* decision has worsened pregnancy-related mortality (64%), racial and ethnic inequities in maternal health (70%) and the ability to attract new OBGYNs to the field (55%).").

97. Up to 25% of recognized pregnancies end in a miscarriage. *Symptoms & Signs of Miscarriage*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/getting-pregnant/pregnancy-loss/signs-of-miscarriage/ [https://perma.cc/RKJ8-74SS] (last visited Apr. 15, 2025). For women who suffer a first-trimester miscarriage, they may have to undergo a dilation and curettage

example, the Court's decision in *Dobbs* revived what many thought was Wisconsin's 1849 pre-*Roe* ban on abortion.[98] Although that law contains an exception for a "therapeutic abortion" that is necessary "to save the life of the mother," it does not explicitly except pregnancy loss and underestimates the harm—short of death—that pregnancy complications can cause.[99] Dr. Carley Zeal found herself treating a pregnant woman suffering a miscarriage because a hospital refused to provide her with care.[100] The hospital told her "they couldn't do a D&C because of the laws."[101] The hospital also refused to

("D&C") to prevent infection or heavy bleeding. *D&C Procedure After a Miscarriage*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/healthy-pregnancy/pregnancy-complications/d-and-c-procedure-after-miscarriage/ [https://perma.cc/6LSU-4MTU] (last visited Apr. 15, 2025); *Dilation and Curettage (D&C)*, MAYO CLINIC (Nov. 7, 2023), https://www.mayoclinic.org/tests-procedures/dilation-and-curettage/about/pac-20384910 [https://perma.cc/WE3T-63ZK]. The D&C procedure is also used for abortion care. *D&C Procedure After a Miscarriage*, *supra*. About half of women who miscarry do not need a D&C, but after ten weeks of pregnancy, women may not be able to complete the miscarriage on their own. *Id.* Some women may also elect for the D&C procedure because of the "emotional toll of waiting to miscarry" on their own. *Id.* Doctors adhering to the national standard of care allow women to let the miscarriage happen on its own (expectant management) or provide D&C care. *Id.* Miscarriages are a common experience; in fact, the rate of miscarriages is probably higher because they occur early in pregnancy and sometimes before one knows they are pregnant. *Miscarriage*, MAYO CLINIC (Sept. 8, 2023), https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298 [https://perma.cc/KLX7-3HNK] ("Miscarriage is a somewhat common experience—but that doesn't make it any easier.").

98. *See* WIS. STAT. § 940.04 (2024); Kaul v. Urmanski, No. 22 CV 1594, slip op. at 1 (Dane Cnty. Cir. Ct. Dec. 5, 2023), https://www.wispolitics.com/wp-content/uploads/2023/12/231205Ruling.pdf (holding the 1849 law does not apply to consensual abortions); Hope Kirwan & Brady Carlson, *Wisconsin's Abortion Law Was on the Books for over a Century. But It Rarely Led to Prosecutions*, WIS. PUB. RADIO (Aug. 8, 2023), https://www.wpr.org/wisconsin-1849-abortion-ban-history-prosecutions [https://perma.cc/2W6U-4NHC].

99. § 940.04(5); *see* Jessica Winter, *What the 'Life of the Mother' Might Mean in a Post*-Roe *America*, NEW YORKER (May 12, 2022), https://www.newyorker.com/science/annals-of-medicine/what-the-life-of-the-mother-might-mean-in-a-post-roe-america [https://perma.cc/HD66-GF9Q] (demonstrating that delays in miscarriage management have resulted in acceleration of death that might not fall under a medical emergency exception).

100. Frances Stead Sellers & Fenit Nirappil, *Confusion Post*-Roe *Spurs Delays, Denials for Some Lifesaving Pregnancy Care*, WASH. POST (July 16, 2022), https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care/ [https://perma.cc/4C7N-KNR8]; Pam Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, N.Y. TIMES (July 17, 2022), https://www.nytimes.com/2022/07/17/health/abortion-miscarriage-treatment.html [https://perma.cc/4S9R-FUTB].

101. Belluck, *supra* note 100.

provide her with abortion medication to complete the miscarriage and instead told her to find an obstetrician-gynecologist to help her.[102] The woman was still suffering from the miscarriage a week and a half later, so Dr. Zeal treated her with abortion medication.[103] Dr. Zeal noted that confusion around Wisconsin's law delayed the woman's care and increased her risk of hemorrhage or infection.[104] Even in straightforward cases, the Wisconsin law hurt patients and had providers in fear.[105]

Dr. Elana Wistrom explained that the same Wisconsin law forced her to delay giving critical care to a woman suffering from a ruptured ectopic pregnancy.[106] Under the law's exception, therapeutic abortion is permissible when it "is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother."[107] Dr. Wistrom was not sure whether the law required her to obtain two additional doctors to agree that the woman's life was in danger.[108] Out of caution, Dr. Wistrom turned to an emergency room physician who had also treated the woman and the radiologist who had viewed the woman's ultrasound showing the rupture for documentation before providing her care.[109] Dr. Wistrom knew how to treat the woman, but she delayed providing that care for more than an hour because of confusion about what the law required.[110]

Although a Wisconsin lower court declared that the 1849 law "does not apply to consensual abortions," the Sheboygan County District Attorney and state's Attorney General petitioned the Wisconsin Supreme Court to bypass the appellate

102. *Id.*
103. Stead Sellers & Nirappil, *supra* note 100.
104. *Id.*
105. *See, e.g.*, Stead Sellers & Nirappil, *supra* note 100; Belluck, *supra* note 100.
106. Stead Sellers & Nirappil, *supra* note 100.
107. WIS. STAT. § 940.04(5)(b) (2024).
108. Stead Sellers & Nirappil, *supra* note 100.
109. *Id.*
110. *Id.*

court and rule on whether the state can enforce the statute.[111] The Wisconsin Supreme Court granted their request, and at the time of publication, the high court was reviewing the 175-year-old law.[112]

Exceptions to state abortion bans have also proven unworkable in cases in which pregnant women learn of fetal anomalies.[113] For example, Louisiana was one of the first states to criminalize abortion after *Dobbs*—doctors and others convicted of violating the law can face up to fifteen years in prison.[114] The law contains an exception for a pregnancy that involves "an unborn child who is deemed to be medically futile," meaning "in reasonable medical judgment as certified by two physicians, the unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth."[115]

The exception proved too vague for doctors treating Ms. Nancy Davis. Ms. Davis was pregnant with a desired pregnancy, but she learned the fetus suffered from acrania, a rare condition that does not allow the fetus' skull to develop.[116]

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111. Kaul v. Urmanski, No. 22 CV 1594, slip op. at 1 (Dane Cnty. Cir. Ct. Dec. 5, 2023), https://www.wispolitics.com/wp-content/uploads/2023/12/231205Ruling.pdf (holding that Wisconsin's 1849 law only applies to feticide); Plaintiffs-Respondents' Supplemental Petition in Support of Request to Bypass the Court of Appeals at 7, Kaul v. Urmanski, No. 2023AP2362 (Wis. Feb. 27, 2024), https://www.doj.state.wi.us/sites/default/files/news-media/2.27.24_Plaintiffs-Respondents_Supplemental_Petition_in_Support_Request_to_Bypass_Court_of_Appeals.pdf.

112. Planned Parenthood of Wis. v. Urmanski, No. 2024AP330, at *2 (Wis. July 2, 2024), https://www.wicourts.gov/sc/order/DisplayDocImage.pdf?docId=822534 (order granting leave to commence original action).

113. *See, e.g.*, Ava Sasani & Emily Cochrane, *'I'm Carrying This Baby Just to Bury It': The Struggle to Decode Abortion Laws*, N.Y. TIMES (Aug. 19, 2022), https://www.nytimes.com/2022/08/19/us/politics/louisiana-abortion-law.html [https://perma.cc/F87R-6WHP] ("[I]nterpreting [abortion bans' exceptions] properly is an emerging issue for doctors and hospitals, who fear hefty fines and prison sentences if they get it wrong.").

114. *See* Piper Hutchinson, *Louisiana House Approves Harsher Criminal Penalties for Abortion Providers*, LA. ILLUMINATOR (June 2, 2022, 8:21 PM), https://lailluminator.com/2022/06/02/louisiana-criminal-penalties-for-abortion/ [https://perma.cc/YU4U-LR6Z]; *see also* LA. STAT. ANN. §§ 14:87.7–87.8(B), 40:1061.1.3 (2024) (stating that the abortion ban shall take effect if the Supreme Court overturns *Roe v. Wade* and increasing the sentences for those charged with providing "late term abortion" to "no[] more than fifteen years").

115. § 14:87.1(1)(b)(vi), (19)(a).

116. Sasani & Cochrane, *supra* note 113.

Babies with acrania are typically born still, and while some may live up to hours or even weeks, their chance of survival is zero because amniotic fluid surrounding the fetus damages the brain.[117] Doctors provided Ms. Davis with a referral to an abortion care provider in Baton Rouge, but in the ensuing days, the Court decided *Dobbs*, and that facility shut down.[118] She returned to the hospital for care, but the hospital could not determine whether her specific diagnosis fell within the "medically futile" exception and could not ensure that any doctors willing to provide Ms. Davis with abortion care would be safe from prosecution.[119] Ultimately, Ms. Davis traveled out of state for the care.[120]

Doctors in Louisiana vehemently opposed the state's abortion law and sounded alarm bells about the uncertainty and confusion surrounding its narrow exceptions.[121] They expressed fear about whether they might be charged and convicted for treating their patients for pregnancy complications or miscarriages.[122] They also made clear that confusion around the law creates barriers to doctors providing care and patients receiving care, and therefore, the law is detrimental to a pregnant

117. *Id.*

118. *Id.*

119. *Id*.

120. *Id.* To be sure, cases like Ms. Davis's happened before *Dobbs* because of state laws that prohibit abortion after viability without exceptions for fetal abnormalities, some of which are not detected until later in pregnancy. *See, e.g.*, Brenna Rose, *Outlawing Abortion in Oklahoma: Woman Forced out of State to Abort Unviable Fetus*, KTUL, https://ktul.com/news/local/outlawing-abortion-in-oklahoma-okc-woman-forced-out-of-state-to-abort-unviable-fetus [https://perma.cc/P7YR-7R64] (Jan. 31, 2023, 7:46 PM). In this regard, *Dobbs* does not create a new problem but rather exacerbates an existing problem for pregnant women already facing limited options for abortion care later in pregnancy because of state laws. *See, e.g.*, Ariane Lange, *She Had an Abortion at 31 Weeks. Why Did California Turn Her Away?*, SACRAMENTO BEE, https://www.sacbee.com/news/california/article262095082.html [https://perma.cc/3AHC-7NEH] (June 28, 2022, 4:29 PM).

121. *See, e.g.*, Affidavit of Jennifer L. Avegno, M.D. et al. in Support of Plaintiffs' Motion for Preliminary Injunction at 3–4, June Med. Servs. v. Landry, No. 2022-05633 (La. Civ. Dist. Ct. for the Parish of Orleans) (affidavits from Louisiana doctors explaining that the threat of prosecution would interfere with their judgment and delay reproductive health care).

122. *Id.* at 2 (expressing concern that "physicians and staff could face extensive jail time and hundreds of thousands of dollars in fines if they make the wrong decision or are later deemed to have interpreted the law incorrectly").

woman's health and life and would cause grave and devastating consequences for reproductive health care patients.[123] Doctors in the state expressed concern that maternal mortality in Louisiana, which already has one of the highest rates in the country, would only get worse because of confusion and decreased access to care.[124] Despite these widespread concerns, a court has allowed the state law to go into effect.[125]

Finally, exceptions to state abortion bans have proven unworkable in cases in which pregnant women themselves experience health- or life-threatening complications. Ohio banned abortion shortly after *Dobbs*, and the law had dire consequences for Ms. Tara George.[126] Ohio's "heartbeat" law effectively banned abortion after six weeks of pregnancy—before many women even know that they are pregnant.[127] The law contained exceptions "to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman."[128]

The exception proved woefully inadequate for doctors treating Ms. George. Ms. George and her husband were expecting their first child, but at twenty weeks of pregnancy, they learned the fetus would likely not survive outside of the womb.[129] The

123. *Id.* at 2 ("Any perceived lack of access, or confusion over medical care allowable under law, by patients or providers creates barriers for patients to seek out and receive care.").

124. *Id.* at 3.

125. *After* Roe *Fell: Abortion Laws by State*, CTR. FOR REPROD. RTS., https://reproductiverights.org/maps/abortion-laws-by-state/?state=LA [https://perma.cc/6SPK-8U4P] (last visited Apr. 15, 2025). *See generally* Lift Louisiana, Physicians for Human Rights, Reproductive Health Impact & the Center for Reproductive Rights, *Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians*, PHYSICIANS FOR HUM. RTS. (Mar. 19, 2024), https://phr.org/our-work/resources/louisiana-abortion-bans/ [https://perma.cc/G44X-M3MA] (summarizing results of interviews finding harmful consequences of Louisiana's criminal abortion ban).

126. Abigail Abrams, *'Never-Ending Nightmare.' An Ohio Woman Was Forced to Travel out of State for an Abortion,* TIME (Aug. 29, 2022, 7:00 AM), https://time.com/6208860/ohio-woman-forced-travel-abortion/ [https://perma.cc/58XX-XTPZ].

127. OHIO REV. CODE ANN. § 2919.195 (West 2024); *see* Jane Chertoff, *How Early Can You Hear Baby's Heartbeat on Ultrasound and by Ear?*, HEALTHLINE (Sept. 26, 2018), healthline.com/health/pregnancy/when-can-you-hear-babys-heartbeat [https://perma.cc/7VVM-H9LD].

128. § 2919.195.

129. Abrams, *supra* note 126.

fetus had developed lower urinary tract obstruction, which prevents lung development and would make it impossible for the baby to breathe on its own after birth.[130] In addition, the fetus had not properly developed a heart valve and would require surgery immediately after birth and eventually a heart transplant.[131] These fetal abnormalities put Ms. George's own health at risk because she suffers from a blood clotting condition.[132] Dr. Mae Winchester, a maternal-fetal medicine specialist, told her that if she tried to carry the pregnancy to term, she could become dangerously ill or develop a life-threatening blood clot.[133] Although they thought they could obtain permission to have the abortion at an Ohio hospital, the hospital concluded the circumstances did not fall under the state law's exception.[134]

Dr. Winchester and the Georges arranged for the Georges to travel to Michigan for abortion care, but in the ensuing days, a Michigan court ruled that prosecutors could enforce that state's pre-*Roe* abortion ban, so the hospital had stopped performing all abortions.[135] Dr. Winchester offered to reach out to a Pennsylvania hospital, but the hospital told them that it would not be able to schedule Ms. George for another week.[136] An hour after that call, the Michigan hospital called Ms. George and informed her that a court had temporarily stopped enforcement of the state's ban, so they could see her right away.[137] She was able to obtain the abortion in Michigan.[138] Dr. Winchester said, "I know what the medical answer is, [b]ut the legal part is what I've never had to deal with here before."[139] Throughout the ordeal, Dr. Winchester had to counsel the Georges about Ohio law

130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*

and get in touch with hospitals in Michigan and Pennsylvania because abortion was legal in those states.[140] Dr. Winchester also had to counsel the Georges to consider traveling to Illinois or Maryland if she could not get the care she needed in Michigan or Pennsylvania.[141] Voters in Ohio have since approved a constitutional amendment to protect abortion care in that state.[142]

In sum, abortion care is standard pregnancy care that doctors use to address complications that inevitably arise during some women's pregnancies. Although state laws banning abortion often contain narrow exceptions, purportedly for these kinds of circumstances, the legal exceptions have proven unworkable. Indeed, the law may confer an abortion right in theory, but as these post-*Roe* cases demonstrate, there is no guarantee that a pregnant woman will be able to obtain the care in practice.

B. Cases of Pregnant Women Not Receiving Adequate Care Will Persist Until There Is a Comprehensive and Enduring Shift in the Law that Reprioritizes Them

Although exceptions for abortion bans have widespread public support even in states that ban abortion,[143] the exceptions are unworkable, and cases of pregnant women not receiving adequate care will persist until there is a comprehensive and enduring shift in the legal landscape that reprioritizes them. As an initial matter, cases involving pregnant women not receiving timely, necessary, and consistent care after *Dobbs* was foreseeable. Historically, exceptions to abortion bans have proven unworkable. For example, in the late nineteenth and early twentieth century, abortion was largely illegal in the United States,

140. *Id.*

141. *Id.*

142. OHIO CONST. art. I, § 22.

143. Mary Ziegler, *Why Exceptions for the Life of the Mother Have Disappeared*, THE ATLANTIC, https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582/ [https://perma.cc/4GEG-7F7F] (Aug. 2, 2022) (finding 73% of Americans support exceptions for a woman's life and health).

and the medical profession or individual providers decided whether abortion care was necessary for a woman for purposes of the exceptions under the law.[144] Even when the law granted doctors wide discretion, the exceptions still proved unworkable.[145]

For example, Illinois's abortion law had an exception for "any person who procure[d] or attempt[ed] to produce the miscarriage of any pregnant woman for *bona fide* medical or surgical purposes."[146] Medical texts guided physicians and taught them how to perform therapeutic abortions.[147] No one wanted pregnant women to die because a doctor failed to perform an abortion.[148] Nevertheless, doctors disagreed about abortion because their texts did not define when they should perform abortions.[149] Even the most vehement antiabortion doctors maintained that a woman's life was primary over the fetus, but "the line between legal and illegal was always vague."[150]

In the 1940s, there was an aggressive campaign to suppress abortion and enforce criminal abortion bans in the United States; that era saw police raids and hospital policies restricting even therapeutic abortions.[151] These raids and policies effectively narrowed the definition of legal abortion and created a system where racial privilege allowed white women with private health insurance to obtain therapeutic abortions while poor women and women of color endured the ill effects of illegal abortion.[152] By the 1960s, a woman's risk of dying after an

144. LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973 61 (1997).

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.* at 62.

149. *Id.* at 61–62.

150. *Id.* at 62.

151. *Id.* at 60–62.

152. *Id.* at 193, 211–13.

abortion was closely tied to her race and class.[153] Women of color were four times more likely to die than white women.[154]

By the mid-1950s and 1960s, efforts to reform abortion law were aimed at freeing physicians from the restraints imposed by law and hospital committees.[155] To that end, the American Law Institute ("ALI") proposed a model law that expanded the legal exception for therapeutic abortion to cover physical and mental health reasons, fetal defects, or when the pregnancy resulted from rape or incest.[156] ALI participants had hoped the model law would address the indefiniteness of the existing law and help alleviate the anxiety physicians and attorneys felt about therapeutic abortions, making the care more available.[157]

By 1970, a dozen states had passed abortion laws based on the ALI model,[158] but those exceptions proved unworkable, too. California had passed a law based on the ALI model but repealed it a year later because it made providing therapeutic abortions inflexible.[159] The "reform" did not provide doctors with more freedom to perform therapeutic abortions but instead tied them to the committee system.[160] Before the reform, the law allowed hospital committees to authorize doctors to perform therapeutic abortions, but the reform law delineated reasons and left no room for interpretation or discretion in response to individual women's cases.[161]

Whether an abortion constituted a "therapeutic abortion" under law also depended on who was playing gatekeeper, which led to inconsistent access to care.[162] For example, at one Chicago hospital, a social worker had the power to make the

153. *Id.* at 211.
154. *Id.*
155. *Id.* at 220.
156. *Id.* at 220–21.
157. *Id.* at 221.
158. *Id.* at 222.
159. *Id.* at 233.
160. *Id.*
161. *Id.*
162. *Id.* at 240.

initial decision as to whether a woman's need for an abortion was "therapeutic."[163] Over a year and a half, she rejected two-thirds of the women who sought care.[164] More broadly, in 1970, eight hospitals in Chicago "had provided over five hundred therapeutic abortions."[165] This figure stands in stark contrast to the three thousand annual abortions "Jane" provided and the five thousand women Cook County Hospital treated for abortion complications.[166] An estimated fifty thousand illegal abortions took place every year in that county.[167] Hospitals throughout Chicago had different policies.[168] Not surprisingly, committees at nine hospitals reached different conclusions when they reviewed ten hypothetical requests.[169] In a case of rubella, which presented possible fetal defects, or a case of rape, six of the nine hospitals would allow a woman to have an abortion.[170] In a case where a woman had multiple children, tuberculosis, and financial constraints, typifying a woman experiencing poverty, one hospital would have denied her the care.[171]

In 1973, the Supreme Court decided *Roe v. Wade* and its companion case *Doe v. Bolton*, legalizing abortion and eliminating much of the wrangling over the exceptions for abortion for almost five decades.[172] In *Roe*, the Court declared Texas' criminal law prohibiting virtually all abortions unconstitutional.[173] In *Doe*, the Court decided Georgia's hospital therapeutic abortion committee process, which was institutionalized with abortion reform laws, was also unconstitutional.[174]

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163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*; *see* LAURA KAPLAN, THE STORY OF JANE: THE LEGENDARY UNDERGROUND FEMINIST ABORTION SERVICE 68 (1997).

167. REAGAN, *supra* note 144, at 240.

168. *See id.*

169. *Id.*

170. *Id.*

171. *Id.* at 240–41.

172. Roe v. Wade, 410 U.S. 113, 166 (1973); Doe v. Bolton, 410 U.S. 179, 201 (1973).

173. *Roe*, 410 U.S. at 166.

174. *Doe*, 410 U.S. at 200.

Although *Roe* and *Doe* put doctors and women in control of the abortion decision and ended illegal abortion,[175] poor women faced public funding restrictions, which prohibited the use of Medicaid funding for abortion care under the Hyde Amendment, except in cases where a woman's life was in danger or in cases of rape or incest.[176] These exceptions proved unworkable and inconsistent in their application, too. For example, South Dakota admitted it would not provide funding for abortion in cases of rape or incest.[177] In addition, more than a dozen states refused to cover Mifeprex for medication abortion.[178] States also imposed different requirements with respect to the conditions that patients had to meet before being eligible for Medicaid payment: some required provider certification that the abortion fell under one of the exceptions; others required counseling certification; some required additional documentation or prior authorization from the state Medicaid agency.[179]

After the Court's decision in *Dobbs*, depending on the state, pregnant women's access to care is controlled by the interpretation (or misinterpretation) of legal exceptions to abortion bans, despite the medical establishment making clear to the Court that overturning *Roe* and *Casey* would endanger women's health and lives.[180] As alluded to above, in the post-*Roe* era, there are four types of exceptions to abortion bans: "to prevent the death of the pregnant person, to preserve the health of the pregnant person, when the pregnancy is the result of rape or incest, and where the embryo or fetus has lethal anomalies incompatible with life."[181] A handful of states also exempt certain

175. *See* REAGAN, *supra* note 144, at 244–45.

176. *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-159, MEDICAID: CMS ACTION NEEDED TO ENSURE COMPLIANCE WITH ABORTION COVERAGE REQUIREMENTS 1 n.2 (2019).

177. *Id.* at 15.

178. *Id.* at 15–16.

179. *Id.* at 18–20.

180. *Why* Roe v. Wade *Must Be Defended*, 399 THE LANCET 1845, 1845 (2022).

181. Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF, https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/66DC-L3AK] (June 6, 2024).

types of pregnancy complications like ectopic pregnancies or the premature rupture of membranes.[182]

Unlike some of the pre-*Roe* exceptions to abortion bans, post-*Roe* exceptions to abortion bans are narrow by design, reflecting the antiabortion movement's belief that women never need an abortion.[183] For example, Tennessee, which prohibits abortion at all stages of pregnancy, only reluctantly enacted narrow exceptions to its abortion ban after medical experts warned lawmakers that the state's laws did not protect doctors or pregnant patients.[184] The exceptions include "to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman, [for] ectopic or molar pregnanc[ies], or to remove a dead fetus."[185] The original bill would have exempted "medically futile pregnancies" and lethal fetal anomalies and would have allowed providers to use "good-faith judgment," which would have granted them more flexibility than the "reasonable medical judgment" standard in the law.[186] However, the state's antiabortion lobby threatened lawmakers with political retribution if they supported those provisions.[187]

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182. *See, e.g.*, TEX. CIV. PRAC. & REM. CODE. ANN. § 74.552(a) (West 2023) (explicitly listing ectopic pregnancy and rupture of membrane as affirmative defenses for providers).

183. Kukura, *Coerced Interventions*, *supra* note 3, at 114, 118 ("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."); Ziegler, *supra* note 143; Michele Goodwin & Mary Ziegler, *Whatever Happened to the Exceptions for Rape and Incest?*, THE ATLANTIC (Nov. 29, 2021), https://www.theatlantic.com/ideas/archive/2021/11/abortion-law-exceptions-rape-and-incest/620812/ [https://perma.cc/A5JT-R59M].

184. Anita Wadhwani, *Gov. Bill Lee Signs Law Carving out Narrow Exceptions to Tennessee Abortion Ban*, TENN. LOOKOUT (Apr. 28, 2003, 3:26 PM), https://tennesseelookout.com/2023/04/28/gov-bill-lee-signs-law-carving-out-narrow-exceptions-to-tennessee-abortion-ban/ [https://perma.cc/XE4N-8WTZ].

185. TENN. CODE ANN. § 39-15-213 (West 2024).

186. *Id.*; Wadhwani, *supra* note 184.

187. Wadhwani, *supra* note 184. In Tennessee as well as Idaho and North Dakota, lawmakers wrote the exceptions to place the burden on the provider to prove a patient's circumstances fell within the exception rather than requiring the state to prove the patient's circumstances did not fall within the exception, increasing provider anxiety about running afoul the law. Kukura, *Coerced Interventions*, *supra* note 3, at 113.

The United States can expect cases of pregnant women not receiving adequate care to persist—prohibiting abortion care results in unnecessary delays in overall care and poorer health outcomes for pregnant women, including maternal mortality.[188] For example, in 2007, fifteen years before *Dobbs*, the Supreme Court upheld the federal Partial-Birth Abortion Ban Act of 2003 in *Gonzales v. Carhart*.[189] That federal law prohibits the intact dilation and extraction ("D&X") procedure that was used for certain second-trimester abortions.[190] The American College of Obstetricians and Gynecologists accurately predicted the decision would "chill doctors from providing a wide range of procedures used to perform induced abortions or to treat cases of miscarriage and w[ould] gravely endanger the health of women in this country."[191]

After the law took effect, a Massachusetts study showed a range of changes to medical practice that were based not on new scientific evidence but on legal and policy mandates.[192] For example, in addition to the D&X procedure, one hospital stopped performing any dilation and evacuation ("D&E")

188. Harris, *supra* note 53, at 2063 ("Maternal mortality will increase because abortion is far safer than childbirth."); AMANDA JEAN STEVENSON, LESLIE ROOT & JANE MENKEN, THE MATERNAL MORTALITY CONSEQUENCES OF LOSING ABORTION 1, 6 (2022) (estimating that a total ban on abortion in the United States would increase maternal mortality by 24% or from 861 to 1071); Barbara Wilkinson, Chiamaka Onwuzurike & Deborah Bartz, *Restrictive State Abortion Bans—A Reproductive Injustice*, 386 NEW ENG. J. MED. 1197, 1198 (2022) ("In the United States, mortality associated with childbirth is 14 times as high as the rate associated with legal abortion."); Amy N. Addante, David L. Eisenberg, Mark C. Valentine, Jennifer Leonard, Karen E. Joynt Maddox & Mark H. Hoofnagle, *The Association Between State-Level Abortion Restrictions and Maternal Mortality in the United States, 1995-2017*, 104 CONTRACEPTION 496, 500 (2021) ("We found an association between restricted abortion restrictions and increased maternal mortality, particularly for black and Native American women."); Patricia Bayer Richard, *Alternative Abortion Policies: What Are Health Consequences?*, 70 SOC. SCI. Q. 941, 944 (1989) ("Under an abortion policy of complete prohibition, women with unwanted pregnancies could choose only between carrying the pregnancy to term and an illegal abortion. Both alternatives increase maternal deaths since legal abortion is safer than either childbearing or illegal abortion.").

189. 550 U.S. 124, 132–33 (2007).

190. *See id.* at 135–37.

191. Lisa Haddad, Susan Yanow, Laurent Delli-Bovi, Kate Cosby & Tracy A. Weitz, *Changes in Abortion Provider Practices in Response to the Partial-Birth Abortion Ban Act of 2003*, 79 CONTRACEPTION 379, 379 (2009).

192. *Id.* at 382–83 ("[C]hanges appear to be driven by efforts to adhere to concerns about legal repercussions rather than scientific evidence or improvements in patient safety.").

procedures, the most common procedure for second-trimester abortions, except where necessary based on "maternal or fetal indications;" another hospital decreased the number of second-trimester abortions markedly due to a new requirement that a maternal-fetal medicine specialist administer digoxin, which led to "scheduling and coordinating difficulties."[193] Many patients received referrals to obtain care elsewhere, which caused delays in their care.[194] Three other hospitals suspended second-trimester abortion care to seek legal assistance to comply with the law, which interrupted care for two to three months.[195] Three hospitals increased the amounts they charged for second-trimester abortions.[196] In short, the federal ban resulted in disruption to care and changes in care based on possible legal repercussions rather than pregnant women's care and safety.[197]

Texas has also been an ongoing example of how prohibiting abortion, even with exceptions to the law, results in unnecessary delays in care and poorer health outcomes for pregnant women. In 2021, again, before *Dobbs*, Texas passed Senate Bill 8 ("S.B. 8"), also known as the Texas Heartbeat Act, and effectively eliminated access to abortion after six weeks of pregnancy.[198] S.B. 8 prohibits abortion if the doctor detects fetal cardiac activity, and doctors who violate the law or those who aid and abet an abortion may be subject to civil liability of at least $10,000.[199] S.B. 8 contains a narrow exception for a "medical emergency."[200] Although abortion care providers challenged

193. *Id.* at 381.

194. *Id.* at 382.

195. *Id.*

196. *Id.*

197. *Id.* at 383.

198. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 171.204–12 (West 2021); Chertoff, *supra* note 127 (explaining that a fetal heartbeat can be detected as early as five and a half to six weeks after conception).

199. §§ 171.204, 171.208.

200. §§ 171.205, 171.002(3) (defining medical emergency).

the law, the Supreme Court let it stand in *Whole Woman's Health v. Jackson*.[201]

Because S.B. 8 went into effect in September 2021, researchers have been able to study the consequences that law has had on pregnant women experiencing health- and life-threatening complications.[202] One recent study and follow-up examined the law's effect on pregnant women at two Level IV designated maternal care hospitals who arrived experiencing pre-viable pregnancy losses.[203] These patients had a medical need for delivery because of premature rupture of membranes, severe preeclampsia, and/or vaginal bleeding, but their electronic health records showed fetal cardiac motion.[204] Of the twenty-eight patients, on average, women in Texas waited nine days between when they showed up at the hospital with complications and when doctors determined they had developed

201. 595 U.S. 30, 51 (2021) (rejecting petitioners' theories for relief against state-court judges, state-court clerks, Attorney General Paxton, and only named private-individual defendant; however, case could proceed past the motion to dismiss phase with respect to the "defendants with specific disciplinary authority over medical licensees, including the petitioners").

202. *See, e.g.*, Anjali Nambiar, Shivani Patel, Patricia Santiago-Munoz, Catherine Y. Spong & David B. Nelson, Research Letter, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 2022 AM. J. OBSTETRICS & GYNECOLOGY 648, 648 (2022); Courtney C. Baker, Emma Smith, Mitchell D. Creinin, Ghazaleh Moayedi & Melissa J. Chen, *Texas Senate Bill 8 and Abortion Experiences in Patients with Fetal Diagnoses*, 141 OBSTETRICS & GYNECOLOGY 602, 606 (2023) (concluding S.B. 8 style laws "erode the patient-physician relationship, evoke fear and safety concerns, and create a significant burden on patients to understand pregnancy options and navigate the process of abortion alone"); Allie Morris, *Parkland, UTSW Study: Texas Abortion Law Doubled Risk of Health Issues for Pregnant Women*, DALL. MORNING NEWS (July 22, 2022, 7:31 PM) https://www.dallasnews.com/news/politics/2022/07/22/parkland-utsw-study-texas-abortion-law-doubled-risk-of-health-issues-for-pregnant-women/ [https://perma.cc/EN4G-V5S9]; 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/CAN2-2F8W].

203. The study was designed around William P. Clements Jr. University Hospital and Parkland Hospital. Nambiar et al., *supra* note 202, at 648. Both hospitals see approximately fourteen thousand deliveries per year. *Id. See generally* Morris, *supra* note 202 (describing the study, which "offers the most comprehensive look at how the state's controversial abortion restrictions are playing out inside hospitals and upending care for pregnant people who develop complications").

204. Nambiar et al., *supra* note 202, at 648; Morris, *supra* note 202.

sufficient complications to constitute an immediate threat to their lives, allowing doctors to provide them the necessary care.[205]

When these patients received care, they experienced almost double the rate of maternal morbidity compared to pregnant women who had immediate care in states without similar laws (57% to 33%).[206] For about a third of the women, their complications resulted in their admission to the intensive-care unit, surgery, or a subsequent hospital admission.[207] One of the patients needed a hysterectomy, so she will never be able to carry a pregnancy to term.[208] Of the twenty-eight patients, twenty-seven lost the fetus in utero or the infant died not long after delivery.[209] One infant survived but suffered extreme prematurity and complications, "including bleeding in the brain, brain swelling, damage to intestines, chronic lung disease[,] and liver dysfunction."[210] One maternal and fetal medicine specialist in the state opined, "People have to be on death's door to qualify for maternal exemptions to SB8."[211]

In contrast, in New York, where abortion remains legal, a patient similar to those at risk in the Texas study was twenty weeks pregnant when her water broke in the grocery store.[212] Her doctor, a high-risk pregnancy expert, spoke with her and her husband and brought in neonatology ICU experts to further counsel them about their options, including termination of the pregnancy, which is part of the standard of care.[213] The patient

205. Nambiar et al., *supra* note 202, at 649; Morris, *supra* note 202.

206. Nambiar et al., *supra* note 202, at 649; Morris, *supra* note 202.

207. Chavi Eve Karkowsky, *Without Abortion, Doctors in Texas Are Forced to Witness Horrible Outcomes*, SLATE (Nov. 28, 2022, 11:45 AM), https://slate.com/technology/2022/11/abortion-texas-roe-v-wade-data-maternal-morbidity.html?via=rss_flipboard [https://perma.cc/7PQ7-CPZE].

208. *Id.*

209. *Id.*

210. *Id.*

211. Whitney Arey, Klaira Lerma, Anitra Beasley, Lorie Harper, Ghazaleh Moayedi & Kari White, *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, 387 NEW ENG. J. MED. 388, 389 (2022).

212. Karkowsky, *supra* note 207.

213. *Id.*

decided she could not continue the pregnancy with a baby unlikely to survive and chose to induce labor immediately.[214] By the following morning, she had completed the induction.[215] She did not bleed much and never developed an infection.[216] With follow-up instructions, the hospital discharged her to be with her husband and three young children.[217] Although grieving, she was healthy just twenty-four hours after her water broke in a grocery store.[218]

As in other states, doctors in Texas rang alarm bells about the uncertainty and confusion surrounding the exceptions to S.B. 8. Recognizing that the Texas law interferes with doctors' ability to recommend and perform treatment for other pregnancy complications, the Texas Medical Association asked the Texas Medical Board, the state regulatory agency that oversees the practice of medicine, to stop this sort of interference with the practice of medicine, highlighting how it puts patients at risk, erodes the trust between physicians and patients, and could lead to pregnant women choosing not to get care because they are fearful.[219] Dr. Alireza A. Shamshirsaz, an obstetrician and fetal surgeon who used to practice in Texas, explained, "It's like you bring lots of people to the top of a high rise and push them to the edge and then catch them before they fall."[220] He continued, "It's a very dangerous way of practicing. All of us know some of them will die."[221]

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214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.*

219. Reese Oxner & María Méndez, *Texas Hospitals Are Putting Pregnant Patients at Risk by Denying Care out of Fear of Abortion Laws, Medical Group Says*, TEX. TRIB. (July 15, 2022, 1:00 PM), https://www.texastribune.org/2022/07/15/texas-hospitals-abortion-laws/ [https://perma.cc/WK6Q-ZZ3J]; Belluck, *supra* note 100; Arey et al., *supra* note 211, at 389 (finding patients express feeling hurt and confused when doctors tell them they cannot receive care in Texas because of S.B. 8).

220. Goodman & Ghorayshi, *supra* note 202.

221. *Id.*

In response to the ongoing cases involving pregnancy complications in Texas, in August 2023, the state passed a narrow law to exempt premature rupture of membranes as well as ectopic pregnancies from its abortion laws.[222] To be sure, Texas' new law may help the state reverse course with respect to these common pregnancy complications, but the law does not address the full scope of medical complications that doctors use abortion care to treat, including early miscarriages, fetal anomalies, and pregnant women's other health- or life-threatening complications.[223]

C. Litigation over Abortion Ban Exceptions Is Slow and Has Proven Unsuccessful

Although abortion rights supporters have sought relief from the courts, litigation over the interpretation of abortion ban exceptions has proven slow and produced virtually no success. As an initial matter, in *Dobbs*, the Supreme Court was not concerned by the narrowness of abortion ban exceptions or the risks that they pose to pregnant women.[224] Mississippi's fifteen-week abortion ban at issue in *Dobbs* had exceptions for a "medical emergency" or "severe fetal abnormality."[225] The statute defined "medical emergency" as when "an abortion is necessary to preserve the life of the pregnant woman" or when continuing the pregnancy would create a "serious risk of substantial and irreversible impairment of a major bodily function."[226]

The American College of Obstetricians and Gynecologists, the American Medical Association, and other medical professional associations explained in their amicus brief to the Court

222. *See* TEX. CIV. PRAC. & REM. CODE. ANN. § 74.552 (West 2023).

223. Selena Simmons-Duffin, *To Expand Abortion Access in Texas, a Lawmaker Gets Creative*, NPR (Aug. 22, 2023, 5:00 AM), https://www.npr.org/sections/health-shots/2023/08/22/1195115865/texas-abortion-bans-softened-quietly [https://perma.cc/UEC7-PBWN].

224. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 360–61 (Breyer, Sotomayor & Kagan, JJ., dissenting).

225. MISS. CODE ANN. § 41-41-191(4) (West 2024).

226. *Id.* § 41-41-191(3)(j).

that Mississippi's "medical emergency" exception was so narrow that it would prohibit abortion care for women who faced serious medical complications that posed grave risks to their health, including those related to diabetes, pulmonary hypertension, lupus, and heart disease.[227] In their expert medical opinion, forcing women to wait until their medical conditions escalated to meet the language of the exception was untenable; allowing these conditions and others to progress could lead to additional health risks.[228] Under the Mississippi law, they made clear, doctors would have to choose between providing appropriate medical care and following the law.[229] Nevertheless, the Court upheld the state's law without any analysis of the exceptions.[230]

Since *Dobbs*, abortion rights advocates and opponents have been involved in litigation over emergency abortion care. At the federal level, federal courts are split on whether the Emergency Medical Treatment and Labor Act ("EMTALA") requires doctors to provide abortion care when doing so would violate state law.[231] Under EMTALA, every person who goes to a hospital emergency room is entitled to stabilizing treatment or a transfer to another facility that can provide the stabilizing treatment if

227. Brief of Amici Curiae American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Public Health Physicians, et al. in Support of Respondents at 23–24, Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (No. 19-1392). Mississippi's exceptions also would not cover women who had prior life-threatening complications seeking an abortion to avoid similar complications. *Id.* Nor would they except mental health issues that could also put a woman's life or health in danger if she did not get an abortion. *Id.*

228. *Id.* at 25.

229. *See id.* at 23–24.

230. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 232 (2022).

231. *Compare* United States v. Idaho, 623 F. Supp. 3d 1096, 1111 (D. Idaho 2022) (holding that Idaho's abortion law directly conflicts with EMTALA's requirements and is therefore preempted under the Supremacy Clause), *with* Texas v. Becerra, 623 F. Supp. 3d 696, 714, 739 (N.D. Tex. 2022) (affirming a permanent injunction preventing the United States from enforcing EMTALA's requirements concerning stabilizing emergency abortion prohibited by Texas law).

the person is suffering from an emergency medical condition.[232] After the Court decided *Dobbs*, the Biden Administration issued guidance making clear that if a state law prohibits abortion without exceptions for the life and health of the pregnant woman, or has an exception that is narrower than EMTALA's emergency medical condition definition, EMTALA preempts that state law.[233]

In *Moyle v. United States*, the Supreme Court had an opportunity to resolve the split and decide whether EMTALA preempts state law, but it dismissed the writs of certiorari in that case as improvidently granted.[234] In response to the Court's decision to dismiss *Moyle* after full briefing and oral argument, Justice Jackson wrote:

> Today's decision is not a victory for pregnant patients in Idaho. It is delay. While this Court dawdles and the country waits, pregnant people experiencing emergency medical conditions remain in a precarious position, as their doctors are kept in the dark about what the law requires. This Court had a chance to bring clarity and certainty to this tragic situation, and we have squandered it. And for as long as we refuse to declare what the law requires, pregnant patients in Idaho, Texas, and elsewhere will be paying the price. Because we owe them—and the Nation—an answer to the straightforward pre-emption question presented in these cases, I respectfully dissent.[235]

232. 42 U.S.C. § 1395dd(b)(1); *see* Patricia J. Zettler, Annamarie Beckmeyer, Beatrice L. Brown & Ameet Sarpatwari, *Mifepristone, Preemption, and Public Health Federalism*, J.L. & BIOSCIS., July–Dec. 2022, at 1, 4 ("[T]here are compelling legal arguments that support courts concluding many state laws limiting or banning access to mifepristone are preempted by FDA regulation.").

233. Memorandum from the Dep't of Health & Hum. Servs. to State Surv. Agency Dirs., Ref: QSO-22-22-Hospitals 1 (Aug. 25, 2022).

234. Moyle v. United States, 603 U.S. 324, 325 (2024).

235. *Id.* at 345 (Jackson, J., concurring in part and dissenting in part).

Not long after, the Court denied certiorari in *Texas v. Becerra*, leaving the federal courts split on the EMTALA preemption question.[236]

At the state level, abortion rights advocates have sought to use state constitutional law to protect women seeking emergency abortion care but have had virtually no success. For example, in Texas, Ms. Kate Cox received a tragic Trisomy 18 diagnosis when she was about twenty weeks pregnant.[237] Although the trial court ruled that an abortion would fall within the exception to Texas's abortion law in her case, the Texas Supreme Court overruled that court; Ms. Cox traveled out of state for abortion care hours before the Texas high court issued its decision.[238] Similarly, in *Texas v. Zurawski*, more than a dozen women and two board-certified ob-gyns sought to clarify the life-saving exception under Texas law.[239] They described the delays and refusals they encountered in receiving abortion care as well as the out-of-state travel they had to undertake because of those delays and refusals.[240] They argued that health care providers denied them necessary and potentially life-saving obstetrical care because medical professionals throughout the state feared liability under Texas law.[241] As in Kate Cox's case, although the trial court granted the *Zurawski* plaintiffs' request for temporary injunctive relief, the Texas Supreme Court overruled that court and held that the state law's exception was not impermissibly narrow.[242]

Abortion rights advocates have obtained assurance that state constitutional law protects a woman's life if it is endangered because of her pregnancy. In *Oklahoma Call for*

236. Texas v. Becerra, 89 F.4th 529 (2024), *cert. denied*, 145 S. Ct. 139 (2024).

237. *In re* State, 682 S.W.3d 890, 892 (Tex. 2023).

238. *Id.* at 894–95; Eleanor Klibanoff, *Texas Supreme Court Blocks Order Allowing Abortion; Woman Who Sought It Leaves State*, TEX. TRIB. (Dec. 11, 2023), https://www.texastribune.org/2023/12/11/texas-abortion-lawsuit-kate-cox/ [https://perma.cc/8Z4G-MRLU].

239. State v. Zurawski, 690 S.W.3d 644, 654 (Tex. 2024).

240. *Id.* at 655.

241. *Id.*

242. *Id.* at 656, 671.

Reproductive Justice v. Drummond, the Oklahoma Supreme Court explained,

> A woman has an inherent right to choose to terminate her pregnancy if at any point in the pregnancy, the woman's physician has determined to a reasonable degree of medical certainty or probability that the continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer from during the pregnancy.[243]

The court made clear that physicians do not need to be absolutely certain in their determinations, but speculation is not enough.[244]

In sum, the Court's decision in *Dobbs* immediately exposed pregnant women with desired pregnancies to unnecessary health risks and inadequate health care. Although state laws banning abortion often contain narrow exceptions, these exceptions have, historically and since *Dobbs*, proven unworkable for pregnant women in need of emergency care. In addition, litigation surrounding exceptions has produced virtually no success, so cases involving pregnant women not receiving timely and necessary care will persist until there is a shift in the legal landscape that reprioritizes pregnant women and their care.

III. THE LONG-TERM CONSEQUENCES OF *DOBBS* ON PREGNANT WOMEN AND THEIR DECISION-MAKING AUTONOMY AND CARE: COMPELLED MEDICAL INTERVENTION AND CIRCUMSCRIBED CHOICES

Although the Court in *Dobbs* overruled the abortion right, the Court's decision affects a pregnant woman's care and decision-making autonomy throughout pregnancy. For example, before *Dobbs*, some courts used the viability line in *Roe* and

243. Okla. Call for Reproductive Just. v. Drummond, 526 P.3d 1123, 1130 (Okla. 2023).

244. *Id.*

Casey as a threshold inquiry before deciding whether and when a state could intervene in pregnancy care and override a pregnant woman's decisions during childbirth.[245] Without the viability line, courts may be more likely to permit state intervention earlier in pregnancy. In addition, although not all pregnant women will experience state intervention in the form of coerced or compelled medical care during childbirth, in this post-*Roe* era in which states afford fetal life increasing rights, pregnant women are likely to encounter more broadly-applicable laws and recommendations about their care that circumscribe their choices throughout pregnancy. This section explores some of the potential long-term consequences of the Court's decision in *Dobbs* and maintains that this Court has opened the door to states risking and regulating pregnant women's lives as they carry their pregnancies to term. To be sure, the state has an interest in helping a woman carry a healthy pregnancy to term if that is what she has decided to do; there is widespread support for reducing maternal mortality in the United States, which remains one of the highest in the industrialized world.[246] The state's interest in a pregnant woman's health on an individual and policy-based level, however, should not come at the cost of her decision-making autonomy.[247]

A. Coerced or Compelled Medical Care During Childbirth

In cases in which states have sought to override a pregnant woman's decisions during childbirth, some courts have relied on the viability line in *Roe* and *Casey* to decide whether and

245. *See* Burton v. Florida, 49 So. 3d 263, 265 (Fla. Dist. Ct. App. 2010); Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999).

246. MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 5 (2022), https://marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf; KATHERINE SACKS, LAWSON MANSELL & BROOKE SHEARON, MILKEN INST., MATERNAL MORTALITY AMONG VULNERABLE US COMMUNITIES 1 (2023); Dawn Johnsen, *Shared Interests: Promoting Health Births Without Sacrificing Women's Liberty*, 43 HASTINGS L.J. 569, 570 (1992) [hereinafter Johnsen, *Shared Interests*].

247. Johnsen, *Shared Interests*, *supra* note 246, at 571; Siegel, *supra* note 44, at 272 ("When a legislature adopts regulation governing the conditions in which women conceive, gestate, and nurture children, its actions are . . . social judgments about women's roles–and only secondarily, if at all, facts about their bodies.").

when the state can intervene in childbirth.[248] However, in *Dobbs*, the Court overturned *Roe* and *Casey*, rejected the viability line as making "no sense," and emphasized that states have a legitimate interest in "respect for and preservation of prenatal life at all stages of development."[249] In so doing, the Court permitted states to ban abortion before viability but also opened the door for states to intervene earlier in pregnancy and compel pregnant women to undergo certain care.[250]

Some of the states that have aggressively sought to ban abortion after *Dobbs* are the same states with existing records of coercive or compelled medical intervention during childbirth.[251] Take Florida, for example. In *Burton v. Florida*, a state court ordered Samantha Brown to submit to any medical treatment that her physician deemed necessary, including "detention in the hospital for enforcement of bed rest, administration of

248. Kukura, *Obstetric Violence*, *supra* note 23, at 794; Agota Peterfy, *Fetal Viability as a Threshold to Personhood: A Legal Analysis*, 16 J. LEGAL MED. 607, 620 (1995) ("Similar to the abortion context, viability seems to be the dividing line in refusal of medical treatment cases."). It is simply not possible to know how often courts override pregnant women's medical decisions. Courts do not always issue written opinions, so if a pregnant woman does not appeal a court order, the case may have no real record. RACHEL ROTH, MAKING WOMEN PAY: THE HIDDEN COSTS OF FETAL RIGHTS 94–95 (2000). In addition, family courts as well as juvenile courts may hear these cases, and their proceedings are oftentimes sealed or not published. *Id.* at 94. Doctors are also unlikely to publish accounts of overriding a pregnant woman's decision-making and forcing her to undergo a cesarean section. *Id.* at 96.

249. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 263, 301 (2022).

250. Richard, *supra* note 188, at 948 ("Were abortion prohibited on the basis of fetal personhood, more interference in pregnant women's lives, behaviors, and bodies is likely. This interference might raise health care costs for women while enhancing the health of, and perhaps thereby reducing the health costs to, the fetus.").

251. ROTH, *supra* note 248, at 95 n.3 (listing twenty-five states with courts that have overridden pregnant patients' refusal of medical treatment). Cases of compelled medical care are not limited to politically conservative states. *Id.* at 97. In California, for example, 27% of hospitals (205) that offered labor and delivery care did not allow pregnant women to have vaginal births after cesarean sections. Ariane Lange, *California Is a Reproductive Rights Haven. So Why Are Women Being Forced into Surgeries?*, CTR. FOR HEALTH JOURNALISM, https://centerforhealthjournalism.org/our-work/reporting/california-reproductive-rights-haven-so-why-are-women-being-forced-surgeries [https://perma.cc/L7DP-LYM4] (Aug. 26, 2023). Moreover, all fifty states—not just those that have banned abortion—are bound by the Court's decision in *Dobbs*, so patients throughout the United States may experience these types of coerced interventions. Nadia N. Sawicki & Elizabeth Kukura, *From Constitutional Protections to Medical Ethics: The Future of Pregnant Patients' Medical Self-Determination Rights After* Dobbs, 51 J.L. MED. & ETHICS 528, 530 (2023).

intravenous medications, and anticipated surgical delivery of the fetus."[252] Burton, who at the time was twenty-five weeks pregnant,[253] submitted to hospital confinement, treatment, and a cesarean section of her deceased fetus two days after the court issued its order.[254] Although her case was moot, she appealed. The appellate court rejected the lower court's conclusion in the case that "as between parent and child, the ultimate welfare of the child is the controlling factor."[255] The court explained that the state needed a compelling interest to override an individual's right to "choose or refuse medical treatment" under Florida's law.[256] Citing *Roe*, the court emphasized that the state's interest in protecting an unborn fetus or the potentiality of life does not become compelling until viability.[257] The court made clear that "[o]nly after the threshold determination of viability has been made may the court weigh the state's compelling interest to preserve the life of the fetus against the patient's fundamental constitutional right to refuse medical treatment."[258]

Similarly, in *Pemberton v. Tallahassee Memorial Regional Medical Center*, a Florida state court ordered Laura Pemberton to deliver via cesarean section when she desired a vaginal delivery at home.[259] After obtaining the court order, the hospital performed the cesarean section, and she delivered a healthy baby without any complications.[260] Pemberton sued the hospital and physicians in federal court, claiming that they violated her constitutional rights, acted negligently, and falsely imprisoned her.[261] The court explained that whatever Pemberton's

252. Burton v. Florida, 49 So. 3d 263, 264 (Fla. Dist. Ct. App. 2010).

253. Greer Donley, *Commentary on* Burton v. State, *in* FEMINIST JUDGMENTS: HEALTH LAW REWRITTEN 265 (Seema Mohapatra & Lindsay Wiley eds., 2022).

254. *Burton*, 49 So. 3d at 264.

255. *Id.* at 265–66.

256. *Id.* at 265.

257. *Id.* at 266.

258. *Id.*

259. Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1248–49 (N.D. Fla. 1999).

260. *Id.* at 1249.

261. *Id.*

constitutional rights, they did not outweigh Florida's interests in preserving the life of the unborn.[262] Citing *Roe*, the court explained that viability is when the state's interest in the fetus outweighs the woman's right to decide whether she will bear a child, and Pemberton had passed that point.[263] The court concluded that "requiring her to undergo an unconsented cesarean section did not violate her constitutional rights" or constitute negligence or false imprisonment in violation of Florida law.[264]

As an initial matter, legal scholars have criticized courts for applying abortion rights law in cases in which states have sought to override a pregnant woman's medical decisions during childbirth.[265] First, women who seek abortion care have interests that diverge from fetal interests.[266] In contrast, women who seek to carry a pregnancy to term have mutual or shared interests with the fetus.[267] To suggest that women would not make the best decisions on behalf of their fetus's health and well-being ignores women's decision-making process when assessing the benefits and risks of pregnancy care and treatment.[268] Second, the Court in *Roe* and *Casey* concluded that the state's interest in fetal life became compelling at viability, and at that point, states could prohibit abortion, except to save the pregnant woman's life or health.[269] In drawing the viability line

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262. *Id.* at 1251.

263. *Id.* at 1251–52.

264. *Id.* at 1254, 1257.

265. Sawicki & Kukura, *supra* note 251, at 529; Kukura, *Obstetric Violence*, *supra* note 23, at 794–95; Oberman, *supra* note 67, at 475–76; *see also In re* A.C., 573 A.2d 1235, 1244 (D.C. 1990) (explaining that courts are unwilling to violate a person's bodily autonomy for the benefit of another person's health, and "[s]urely . . . a fetus cannot have rights . . . superior to those of a person who has already been born.").

266. Kukura, *Obstetric Violence*, *supra* note 23, at 794.

267. *Id.* at 794–95.

268. *Id.* at 795; *see also* DeBruin & Marshall, *supra* note 2, at 197–98 ("In reality, fetal well-being is almost always consonant with the interests of pregnant women . . . . Yet, in our culture, women's interests are subordinated to concerns about fetal well-being and women's judgments about fetal well-being are subordinated to those of clinicians, judges, and legislators."); MEREDITH, *supra* note 55, at 206 ("Most pregnant women will willingly undergo considerable inconvenience and privation to do what they believe to be best for their foetus.").

269. Roe v. Wade, 410 U.S. 113, 162–63 (1973); Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 846, 870–71 (1992).

for the abortion right, however, the Court did not allow states "to usurp [a] pregnant wom[a]n's right to remain free from unwanted medical treatment in all contexts."[270] Put another way, abortion rights law did not establish that the state has an interest in the viable fetus that goes beyond when states could prohibit abortion.[271] Finally, subordinating pregnant women and overriding their decision-making because they are pregnant or have childbearing capacity is at odds with the U.S. Constitution, which courts have interpreted to protect the right to make personal, autonomous decisions.[272] Indeed, a pregnant woman's decision to refuse medical care is one of the ways that she can assert control and autonomy during childbirth. For example, as Professor Nancy Ehrenreich has described:

> In refusing a Cesarean section, a woman is resisting a patriarchal view of herself and her role in reproduction. A high-income white woman who rejects the medical model of childbirth is resisting a vision of herself as an object to be "managed," as passive, incompetent, selfless, and emotional. Moreover, she is resisting an image of the reproductive process as a pathological, flawed undertaking fraught with danger, and of her own body as incompetent, threatening, and out of control. A low-income woman of color who refuses a C-section is rejecting not only the notion that her body is dangerous but also an image of herself as stupid, irresponsible, and selfish and as impervious to pain, discomfort, or inconvenience. Moreover, she is also engaging in an act of self-preservation, challenging the very profession that has so often

270. Oberman, *supra* note 67, at 476.

271. *Id.*; *see also* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 322–325 (2013) (explaining how prosecutors, hospital counsel, and courts have misrepresented *Roe v. Wade* as standing for the proposition that fetuses should be treated as separate legal persons after viability).

272. Johnsen, *Shared Interests*, *supra* note 246, at 581–83.

> hurt women like her before. In a profound way, she is claiming her humanity and fighting for her survival.[273]

To be clear, court orders overriding a pregnant woman's refusal for a cesarean section mean medical personnel can forcibly restrain, anesthetize, and cut her open against her will for major surgery.[274]

Putting aside the soundness of applying abortion rights law to pregnancy intervention cases, the Court's decision in *Dobbs* creates instability and uncertainty in this area of the law insofar as courts have relied on pre-*Dobbs* abortion rights jurisprudence in these cases. In Florida, for example, a future court could conclude that the viability line is no longer legally required or sensical after *Dobbs* and allow the state to intervene and override a pregnant woman's decisions well before viability or childbirth.[275] Throughout pregnancy, conflicts can arise related to a pregnant woman's lifestyle choices around work, exercise, alcohol, and smoking; the wisdom of whether and when to employ certain testing and innovative therapies; and, of course, the labor and delivery procedures and interventions.[276] A Florida court's decision to permit state intervention before viability could certainly be considered consistent with that state's approach to restricting women's decision-making in connection with abortion.[277] After *Dobbs*, the Florida Supreme Court bucked its precedent and the right to abortion under the Privacy Clause of the Florida Constitution, upheld the state's fifteen-week ban on abortion, and concluded that its state constitution does not protect the right to abortion through the end of the second trimester.[278]

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273. Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 553 (1993).

274. ROTH, *supra* note 248, at 96.

275. *See* notes 252–264 and accompanying text.

276. *See* Oberman, *supra* note 67, at 451.

277. *See* notes 252–264 and accompanying text.

278. Planned Parenthood of Southwest and Central Fla. v. State, 384 So.3d 67, 71 (Fla. 2024). In doing so, the court mentioned that abortion involves "an issue that, unlike other privacy

In *Dobbs*, the Court wrote that it was not taking a position on "if and when prenatal life is entitled to any of the rights enjoyed after birth,"[279] but there is no question that antiabortion lawmakers and activists are seeking recognition of fetal personhood and will continue to use the courts as a means toward that end.[280] For example, not long after *Dobbs*, a Catholic group, along with Michael Benson and Nichole Leigh Rowley, asked the U.S. Supreme Court to review a Rhode Island Supreme Court decision that said fetuses lack proper legal standing to bring a lawsuit.[281] The Supreme Court did not grant certiorari in that case,[282] but the fight for fetal personhood is one of the next battlegrounds over abortion. "Abortion abolitionists" believe that pregnant women who have an abortion should be punished with the same punishment people receive for murder of a born human being.[283] Americans United for Life, one of the antiabortion movement's more pragmatic organizations, is also pushing for fetal recognition with due process and equal protection safeguards under the Fourteenth Amendment.[284]

Regardless of whether a state recognizes fetal personhood, a state's coercive or compelled medical intervention overrides a

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matters, directly implicates the interests of both developing human life and the pregnant woman." *Id.* at 76. Although the court upheld the state's fifteen-week abortion ban, it triggered the state's subsequently enacted six-week abortion ban. FLA. STAT. § 390.0111 (2024).

279. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 263 (2022). For now, fetal rights are seemingly a state policy decision. *See* Okla. Call for Reproductive Just. v. Drummond, 526 P.3d 1123, 1147 (Okla. 2023) (Combs, J., with Edmonson, J., concurring) ("[W]hether or not a bright line for a determination of viability is necessary to provide some protection for the viable fetus as well as a clear boundary for both the medical practitioners and all Oklahomans becomes a policy question for the people of the State of Oklahoma.").

280. *See* Rachel Rebouché & Mary Ziegler, *Fracture: Abortion Law and Politics After* Dobbs, 76 SMU L. REV. 27, 49–53 (2023).

281. Benson v. McKee, 273 A.3d 121, 124, 131 (R.I. 2022); *see also* Paltrow & Flavin, *supra* note 271, at 335 (stating that personhood measures mean "[a]ll pregnant women, not just those who try to end a pregnancy, will face the possibility of arrest, detention, and forced intervention as well as threats to an actual loss of a wide range of rights associated with constitutional personhood").

282. Doe v. McKee, 143 S. Ct. 309 (2022).

283. Mary Ziegler, *The Next Step in the Anti-Abortion Playbook Is Becoming Clear*, N.Y. TIMES (Aug. 31, 2022), https://www.nytimes.com/2022/08/31/opinion/abortion-fetal-personhood.html [https://perma.cc/2WL8-FR4W].

284. *Id.*

pregnant woman's autonomous choices and violates her self-determination, bodily integrity, and well-being; such interventions are also problematic for the fiduciary relationship between a provider and patient.[285] The American Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics have made clear that pregnant women should be able to decide about proposed medical interventions once health care providers have offered them neutrally presented information.[286] These same medical organizations consider criminal charges, threats of arrest, and punishment as deterrents to women seeking care and speaking openly with their doctors.[287]

Moreover, even assuming a state recognizes fetal personhood in this post-*Roe* era, recognizing fetal personhood does not necessarily undermine the legal and ethical arguments against coerced or compelled medical intervention during pregnancy.[288] Although conflicts during pregnancy and childbirth are often framed as a maternal-fetal conflict, Professor Michelle Oberman and others have sought to clarify that the actual conflict is a maternal-doctor conflict.[289] If a pregnant woman opposes or resists her doctor's advice, the doctor's treatment preferences become tied to fetal interests.[290] The doctor then enters as a "neutral" party to settle the conflict, masking the fact that the doctor is actually a party to the conflict and violating doctor-patient legal and ethical norms in overriding a pregnant woman's decision-making about her care.[291] In any case, one person should not be forced to undergo medical procedures for the benefit of another person.[292] In fact, the case against

285. DeBruin & Marshall, *supra* note 2, at 191.

286. FENTIMAN, *supra* note 51, at 87.

287. Paltrow & Flavin, *supra* note 271, at 320.

288. DeBruin & Marshall, *supra* note 2, at 197.

289. Oberman, *supra* note 67, at 454; *see* ROTH, *supra* note 248, at 90; MEREDITH, *supra* note 55, at 80.

290. Oberman, *supra* note 67, at 454.

291. *Id.*

292. *See* DeBruin & Marshall, *supra* note 2, at 197.

intervention may become more compelling if a state recognizes fetal personhood.[293] In cases involving two born persons or adults, courts have not permitted one party to force the other to submit to unwanted medical care for their benefit.[294]

Finally, even where states do not initiate formal legal proceedings against a pregnant woman, mere threats of such action, including threats to pursue court-ordered cesareans or report women to child welfare authorities, are enough to encroach on women's decision-making autonomy and may be enough to coerce a woman to submit to care.[295] For example, a Florida hospital's Chief Financial Officer sent Jennifer Goodall a letter informing her that it was going to pursue "expedited judicial intervention" to compel her to have a cesarean section.[296] At the time, she was thirty-nine weeks pregnant and had already told her providers she would consent to a c-section as needed.[297] A federal court denied her request to stop the hospital from carrying through with its threat, so she found another provider and ultimately consented to deliver her baby via cesarean section when it became medically necessary.[298]

In sum, after the Court's decision in *Dobbs*, pregnant women may find themselves navigating a new-fangled web of compelled and coerced medical intervention. More people will be

293. *Id.* at 197, 200.

294. *See id.* at 197; *see also* Donley, *supra* note 253, at 274 ("[F]orcing women to be self-sacrificial is anomalous in the American legal tradition, where courts have historically opined that individuals have no legal obligation to save the lives of others."); Farah Diaz-Tello, *In Re Madyun*, 114 Daily Wash. L. Rptr. 2233 (D.C. Super. Ct. 1986), *in* FEMINIST JUDGMENTS: REPRODUCTIVE JUSTICE REWRITTEN 111 (Kimberly M. Mutcherson ed., 2020) ("Even if the woman is at full-term and in labor, a court cannot order invasion of one person's body to protect the life of another person – born or unborn. Such a court order is profoundly at odds with our legal tradition protecting bodily integrity.").

295. Kukura, *Obstetric Violence*, *supra* note 23, at 741–42; DeBruin & Marshall, *supra* note 2, at 192 ("Sometimes, clinicians forgo court orders and simply coerce women to sign 'consent' forms for the procedures in question, for example, by threatening them with removal of child custody or abandonment by the clinician if she refuses.").

296. Kukura, *Obstetric Violence*, *supra* note 23, at 741–42 (describing how Michelle Mitchell's provider in Virginia threatened to get a court order compelling a cesarean section and to report her to child welfare authorities); DeBruin & Marshall, *supra* note 2, at 192.

297. Kukura, *Obstetric Violence*, *supra* note 23, at 741.

298. *Id.*

carrying pregnancies to term, and they will do so in a culture in which states afford fetal life more rights, and providers are increasingly concerned about running afoul those rights. Although pregnant women are not new to state intervention or provider pressure, abuse, and coercion,[299] they may now have fewer legal rights or protections to rely on after the Court's decision in *Dobbs*.

B. Circumscribed Choices—Broad-Based Pregnancy Care Laws and Recommendations

Even without state intervention in childbirth, pregnant women should expect to encounter circumscribed choices related to pregnancy care in the post-*Roe* era. As an initial matter, the Court's decision has resulted in a decrease in doctors and maternity services available to pregnant women in states with abortion bans.[300] These laws create an occupational hazard, drive physicians out of state, and discourage new and future physicians from obtaining their licenses or education in-state.[301] Moreover, the Court decided *Dobbs* at a time when a prevailing assumption is that women are exclusively responsible for producing a healthy pregnancy but are not capable of making the right choices for their pregnancy—not just during childbirth but throughout pregnancy and even prior to conception. This section predicts that, left unchecked, states will increasingly regulate women and exert control over their lives during pregnancy with broadly-applicable laws and recommendations simply because of their pregnancy status or capacity.

First, one of the profound consequences of the Court's decision in *Dobbs* is a decrease in the availability of maternity

299. Kukura, *Coerced Interventions*, *supra* note 3, at 123–24; Kukura, *Obstetric Violence*, *supra* note 23, at 730–38.

300. *See* Rachel Treisman, *States with the Toughest Abortion Laws Have the Weakest Maternal Supports, Data Shows*, NPR (Aug. 18, 2022, 6:00 AM) [hereinafter Treisman, *States with the Toughest Abortion Laws*], https://www.npr.org/2022/08/18/1111344810/abortion-ban-states-social-safety-net-health-outcomes [https://perma.cc/PNW7-542V].

301. *See* Sheryl Gay Stolberg, *As Abortion Laws Drive Obstetricians from Red States, Maternity Care Suffers*, N.Y. TIMES, https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html [https://perma.cc/XV6D-MNHG] (Sept. 7, 2023).

services and doctors who provide the range of reproductive health care in states with abortion bans.[302] According to the March of Dimes, which focuses on improving maternal and infant health, millions of women in the United States lack access to maternal care.[303] Thirty-six percent of counties in the United States—primarily in the Midwest and South—are classified as "maternity care deserts" because they have no obstetric providers, obstetric hospitals, or birth centers.[304] Indeed, access to quality maternity care is most lacking in states with restrictive abortion policies.[305] The Court's decision in *Dobbs* will exacerbate this problem because state laws that ban abortion drive physicians out of state and discourage new and future physicians from obtaining their licenses or education in-state.[306]

Some doctors are leaving states with abortion bans because, as detailed above, abortion bans interfere with doctors' ability to practice medicine and, in turn, threaten their livelihood.[307]

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302. *Id.*; *see* Treisman, *States with the Toughest Abortion Laws*, *supra* note 300.

303. *See* MARCH OF DIMES, *supra* note 246, at 5; Rachel Treisman, *Millions of Americans Are Losing Access to Maternal Care. Here's What Can Be Done.*, NPR (Oct. 12, 2022, 9:37 AM) [hereinafter Treisman, *Americans Losing Access to Maternal Care*], https://www.npr.org/2022/10/12/1128335563/maternity-care-deserts-march-of-dimes-report [https://perma.cc/592L-F3FX].

304. Treisman, *Americans Losing Access to Maternal Care*, *supra* note 303.

305. *See id.*; KATHERINE SACKS, LAWSON MANSELL & BROOKE SHEARON, MILKEN INST., MATERNAL MORTALITY AMONG VULNERABLE US COMMUNITIES 4 (2023) (noting the highest rates of maternal mortality were in Mississippi and Alabama); Allison McCann & Amy Schoenfeld Walker, *Tracking Abortion Bans Across the Country*, N.Y. TIMES, https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html (Dec. 3, 2024, 3:44 PM) (categorizing Mississippi and Alabama as states with full bans).

306. *See* Erika L. Sabbath, Samantha M. McKetchnie, Kavita S. Arora & Mara Buchbinder, *US Obstetrician-Gynecologists' Perceived Impacts of Post-*Dobbs v. Jackson State *Abortion Bans*, JAMA NETWORK OPEN, Jan. 17, 2024, at 1, 5; Alexandra L. Woodcock, Gentry Carter, Jami Baayd, David K. Turok, Jema Turk, Jessica N. Sanders, Misha Pangasa, Lori M. Gawron & Jennifer E. Kaiser, *Effects of the* Dobbs v. Jackson Women's Health Organization *Decision on Obstetrics and Gynecology Graduating Residents' Practice Plans*, 142 OBSTETRICS & GYNECOLOGY 1105, 1105 (2023).

307. Sabbath et al., *supra* note 306, at 5 (noting 11% of participants moved their medical practices to states with legal protection for abortion); Nadine El-Bawab, *Doctors Face Tough Decision to Leave States with Abortion Bans*, ABC NEWS (June 23, 2023, 5:04 AM), https://abcnews.go.com/US/doctors-face-tough-decision-leave-states-abortion-bans/story?id=100167986 [https://perma.cc/MM4A-LNC9]; Poppy Noor, *The Doctors Leaving Anti-Abortion States: "I Couldn't Do My Job at All,"* THE GUARDIAN (Oct. 26, 2022, 6:00 AM),

For example, Dr. Alireza Shamshirsaz is a maternal-fetal medicine physician who specializes in operating on pregnant women to fix fetal anomalies while babies are still in the womb.[308] He lived in Houston for almost ten years, but he decided to move to Boston because he feared being targeted under Texas' abortion bans.[309] Dr. Lauren Miller, also a maternal-fetal specialist, used to live in Idaho but recently moved to Colorado.[310] She explained, "I was finding that I felt very anxious being on the labor unit, just not knowing if somebody else was going to second-guess my decision. That's not how you want to go to work every day."[311] Five of Idaho's nine maternal-fetal specialists have left the state since *Dobbs*.[312] Oklahoma and Tennessee are experiencing similar trends where their obstetricians are concerned.[313]

At the same time, new doctors are refusing to practice in states with abortion bans.[314] For example, Dr. Nicole Teal is a fetal medicine specialist who completed her medical training in North Carolina.[315] Although she received a good employment offer in-state, which would have allowed her to stay close to her family, she accepted a position in California because of North Carolina's twelve-week abortion ban.[316] Dr. Teal explained that she diagnoses fetal anomalies on a weekly basis, so being able to provide abortion care between eighteen and twenty weeks of

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https://www.theguardian.com/world/2022/oct/26/us-abortion-ban-providers-doctors-leaving-states [https://perma.cc/E7SH-CNCR]; Emily Corrigan, *My Own Idaho Crisis*, ACOG (June 22, 2023), https://www.acog.org/news/news-articles/2023/06/my-own-idaho-crisis [https://perma.cc/D8P4-BMGR] ("At least 13 reproductive health physicians have left Idaho, and two rural labor and delivery units have closed. We have lost four out of nine maternal-fetal medicine specialists.").

308. El-Bawab, *supra* note 307.

309. *Id.*; Noor, *supra* note 307.

310. Gay Stolberg, *supra* note 301.

311. *Id.*

312. *Id.*

313. *Id.*

314. CANTWELL ET AL., TWO YEARS POST-DOBBS, *supra* note 19, at 17; Woodcock et al., *supra* note 306, at 1105.

315. El-Bawab, *supra* note 307.

316. *Id.*

gestation is a critical part of her practice.[317] Medical students are also pursuing residency in states where they can obtain abortion care training, setting up an increasing shortage of ob-gyns in states with restrictive abortion policies.[318] Emory University asked medical students in their third and fourth year about the importance of abortion training to their medical education, and more than three-fourths (490 students) said "abortion access would likely or very likely influence decisions about their residency location."[319]

Even when pregnant women are able to access comprehensive pregnancy care, pregnant women will likely find themselves facing circumscribed choices with respect to that care. Some of the most publicized legal conflicts that arise in connection with pregnancy care take place when a pregnant woman and her doctor experience a disagreement, and the state and a court eventually get involved, such as with coerced or compelled cesarean sections.[320] As noted above, however, pregnancy conflicts arise throughout pregnancy, sometimes even before a woman is pregnant, and pregnant women have suffered criminal and civil penalties for conduct perceived to be harmful to fetal well-being.[321] In this post-*Roe* era, in addition to potential individual patient-doctor conflicts, women should anticipate an increase in broadly-applicable laws and recommendations that limit their control over pregnancy care and prescribe their behavior from pre-pregnancy to childbirth.

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317. *Id.*

318. *See* CANTWELL ET AL., TWO YEARS POST-DOBBS, *supra* note 19, at 19–21; Kendal Orgera & Atul Grover, Association of American Medical Colleges, *States with Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants*, AAMC RSCH. & ACTION INST. (May 9, 2024), https://www.aamcresearchinstitute.org/our-work/data-snapshot/post-dobbs-2024 [https://perma.cc/QC8X-Z9CE]; Pasha et al., *supra* note 18, at 502 ("When states ban or restrict abortion access, training opportunities in abortion and other reproductive health services are reduced."); James Pollard, *Abortion Access Looms over Medical Residency Applications*, AP NEWS (Oct. 19, 2022), https://apnews.com/article/abortion-health-business-education-family-medicine-3fbeef4338fbdcaf48f4f133055c9f78 [https://perma.cc/47HC-T3ET]; WARREN ET AL., ABORTION BANS THREATEN LIVES, *supra* note 19, at 4–5.

319. Pollard, *supra* note 318.

320. *See supra* Section III.A.

321. GOODWIN, *supra* note 58, at 5; *see* FENTIMAN, *supra* note 51, at 3–5.

As an initial matter, the Court's decision in *Dobbs* offers no comfort that a pregnant woman will find constitutional protection from broadly-applicable laws and recommendations about her care—quite the contrary. First, in overturning the abortion right in *Dobbs*, the Court distinguished other privacy rights it has recognized under the Fourteenth Amendment's Due Process Clause, including interracial marriage, the right to contraception, and the right to refuse medical care because they do not involve "potential life."[322] The Court has not recognized a constitutional right to pregnancy care or childbirth, and it is certainly unlikely to do so now—both because of what it perceives to be this unique interest and because it seems unwilling to acknowledge that pregnancy is a deeply personal, biological, social, and political event. Also, a pregnant woman's fetus is dependent on her until childbirth, or at least until viability, so even a pregnant woman's constitutional right to refuse medical treatment appears weakened after *Dobbs*.[323]

Second, the Court in *Dobbs* rejected the argument that the Fourteenth Amendment's Equal Protection Clause protects the right to abortion.[324] Although the *Casey* plurality recognized that "the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives,"[325] the *Dobbs* majority does not appear to agree that pregnancy implicates sex equality.[326] The Court took a permissive view of pregnancy-based regulations and wrote, "The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t]

322. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 256–57 (2022).

323. *See* Madeleine Carlisle, *Fetal Personhood Laws Are a New Frontier in the Battle over Reproductive Rights*, TIME (June 28, 2022), https://time.com/6191886/fetal-personhood-laws-roe-abortion/ [https://perma.cc/E4YC-CX3L].

324. *Dobbs*, 597 U.S. at 236–37.

325. Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 856 (1992).

326. *See Dobbs*, 597 U.S. at 405 (Breyer, Sotomayor, Kagan, JJ., dissenting) (the majority opinion lacks "any serious discussion" of women and instead prioritizes the state's interest in protecting fetal life).

designed to effect an invidious discrimination against members of one sex or the other.'"[327]

Finally, the Court in *Dobbs* discarded the viability line and undue burden standard and upheld Mississippi's law banning abortion under the rational basis test, making clear that the state has a legitimate interest in "respect for and preservation of prenatal life at all stages of development," "the mitigation of fetal pain," and "protecting the life of the unborn."[328] If rational basis is indeed the standard by which courts will judge laws and regulations governing pregnant women's conduct, the Court has authorized states to increasingly exert control over pregnant women's lives.[329] Under the rational basis standard, the state can regulate pregnant women and a range of their actions in the name of fetal well-being, including pregnant women's weight, work/employment, medical care, exercise, diet, smoking, drinking, caffeine intake, use of prescription, nonprescription, or illegal drugs, and so on because these all potentially affect fetal well-being.[330] Arguably, "there is no logical stopping point to the kinds of personal decisions by women that could be second guessed by zealous prosecutors, estranged husbands and former lovers, or judges scrutinizing an isolated decision with the benefit of hindsight."[331]

Some states will take the Court's decision in *Dobbs* as a green light to pursue broader policies in the name of fetal well-being, even if they encroach on a pregnant woman's autonomy. Of course, some law and policy makers will be motivated to regulate pregnancy care to improve women's health and well-being. With the increase in women carrying pregnancies to term after

327. *Id.* at 236.

328. *Id.* at 301.

329. *See* Johnsen, *Shared Interests*, *supra* note 246, at 585.

330. Dawn Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After* Webster, 138 U. PA. L. REV. 179, 191–92 (1989) ("Were these laws subject only to rational relationship review, the government would have a free hand to single out women for special restrictions that could amount to virtually totalitarian control of a woman's physical being and life during pregnancy.").

331. Johnsen, *Shared Interests*, *supra* note 246, at 586.

Dobbs, inevitably, there will be an increase in maternal morbidity and mortality in the United States.[332] The medical establishment, the public health community, women's rights advocates, and others will insist on policies to respond to it.[333] However, as discussed below, broad-based policies related to pregnancy care are not always evidence-based or effective at addressing morbidity and mortality, and they can be grounded in sex-based stereotypes.

Of course, other law and policy makers will be motivated to regulate pregnancy care based on a political agenda. The antiabortion movement will continue to press for recognition of fetal personhood to achieve its ultimate goal of outlawing abortion nationwide, not just in politically conservative states.[334] *Dobbs* opens the door for states to recognize fetal personhood interests in ways they have not been able to for nearly fifty years because of *Roe* and *Casey*. Fetal personhood recognition can come in the form of abortion bans but also with incremental recognition of fetal personhood interests, such as with pregnancy care regulation more generally.[335] Also, as pregnant women and advocates develop workarounds to improve access to abortion care in spite of state laws banning it, the most zealous antiabortion advocates and lawmakers may seek to track women, and may try to get ahead of them to prevent abortion, which would require knowing when women become pregnant with mechanisms like a pregnancy registry.[336]

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332. *See* Dench et al., *supra* note 15, at 15 (finding that states with abortion bans experienced increases in births compared to states without abortion bans post-*Dobbs*).

333. *See* Usha Ranji, Karen Diep, Ivette Gomez, Laurie Sobel & Alina Salganicoff, *Health Policy Issues in Women's Health*, KFF, https://www.kff.org/health-policy-101-health-policy-issues-in-womens-health/?entry=table-of-contents-future-outlook [https://perma.cc/4FKU-9ABB] (July 29, 2024).

334. Rebouché & Ziegler, *supra* note 280, at 30, 40–41.

335. Meghan M. Boone & Benjamin J. McMichael, *Reproductive Objectification*, 108 MINN. L. REV. 2493, 2498, 2503 (2024); *see also* LePage v. Ctr. For Reprod. Med. P.C., No. SC-2022-0515 2024 WL 656591, at *1 (Ala. Feb. 16, 2024) (holding that Alabama's wrongful death law applies to the unborn, including embryos frozen in a cryogenic nursery).

336. *See, e.g.*, Ed Holt, *Poland to Introduce Controversial Pregnancy Register*, 399 LANCET 2243, 2256 (2022).

Regardless of the motivation, without healthy skepticism of broad-based laws and recommendations governing pregnancy care, pregnant women will find themselves in a web of regulation and surveillance in which they are not entitled to the same rights, respect, and dignity as other members of society. Moreover, although broad-based policies are applicable to all pregnant women, and all pregnant women are assigned primary responsibility for fetal welfare, not all pregnant women are subject to enforcement of that responsibility in the same ways.[337] Marginalized women, especially women of color, women experiencing poverty, religious minorities, immigrants, and women with limited English speaking skills, are most likely to experience enforcement of that responsibility.[338] As Professor Khiara Bridges explains, "we might expect that fetal protectionism will be punitive, violent, and cruel for women without racial privilege, but more paternalistic (and less vicious) for white women."[339]

Midwifery regulations and zero-trimester (or pre-pregnancy) recommendations are two modern examples that help demonstrate the way in which broad-based pregnancy care policies can unnecessarily strip pregnant women of their autonomy. First, with respect to midwifery regulations, although state regulation of women's reproductive decisions has been most prominent in connection with abortion, lawmakers' treatment of midwives and hyperregulation of that form of pregnancy care is akin to lawmakers' treatment of abortion

337. ROTH, *supra* note 248, at 91–92.

338. *Id.* ("Those women most likely to experience unwanted medical treatment are women whose social standing is already vulnerable in some way: They are poor, members of religious minorities, members of ethnic or racial minorities, immigrants, or speakers of a primary language other than English. These women are more likely to give birth at large public institutions in which they have not developed ongoing personal relationships with a health care provider. They are more likely to be perceived as an incomprehensible 'other' by the medical staff, for not only are they female and thereby automatically different [from] most obstetricians, but they are also 'foreign' by virtue of culture.").

339. Khiara M. Bridges, *Pregnancy and the Carceral State*, 119 MICH. L. REV. 1187, 1200–01 (2021) [hereinafter Bridges, *Pregnancy and the Carceral State*].

providers,[340] so much so that these regulations have been labeled Targeted Regulations of Midwifery Providers or TROMP laws (like Targeted Regulations of Abortion Providers or TRAP laws).[341]

By way of background, midwives and midwifery take a patient-centered and noninterventionist approach to pregnancy care; the care is safe, effective, and less costly where patients have low-risk pregnancies.[342] Midwives obtain credentials as a Certified Professional Midwife (primary practice at home or birthing centers), a Certified Nurse Midwife (primary practice is in hospitals), or a Certified Midwife (primary practice is in hospitals), and many hold separate state licenses as a "licensed midwife."[343] Although they are not engaged in the practice of medicine, midwives are engaged in "monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle."[344] They provide "individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support."[345]

As Professor Elizabeth Kukura explains, there are well-established benefits to integrating midwives into pregnancy care, and states' regulation and restriction of their practice stands in the way of improving maternal and infant health outcomes.[346] From the perspective of the pregnant woman, her health and satisfaction with childbirth fare better.[347] When a midwife is present during childbirth, women have lower rates of pregnancy induction, oxytocin augmentation, epidural anesthesia, and cesarean sections.[348] They also experience lower rates of

340. *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2210, 2220.

341. *See id.* at 2226–27.

342. Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243, 271, 276–79 (2021) [hereinafter Kukura, *Better Birth*].

343. *Id.* at 272–73; *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2221–22.

344. Kukura, *Better Birth*, *supra* note 342, at 271.

345. *Id.*

346. *Id.* at 280–81.

347. *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2213–14.

348. *See id.* at 2212–13; Kukura, *Better Birth*, *supra* note 342, at 272, 278.

severe tearing or postpartum hemorrhage.[349] Newborns fare better, too. Among infants that are birthed under the supervision of a midwife, the rate of neonatal intensive care admission is "exceptionally low," and their breastfeeding rate at six weeks old is more than 97%.[350]

The medical community overall would benefit from midwives involved in pregnancy care, too. For example, if midwives were allowed to help care for more low-risk patients, they could help free up medical doctors and specialists to spend more time with high-risk patients both during pregnancy and childbirth.[351] Integrating midwives into pregnancy care would offer more people the option of a low-intervention birthing environment, too.[352] Increasing numbers of women report childbirth as a pathologized experience that they lacked agency over, even when they did not experience medical complications.[353] Of course, patients could continue to see medical doctors too, but if they work with a midwife, they would have the benefit of holistic pregnancy care, including longer appointments for pregnancy care, education, and counseling.[354]

Despite state recognition of the practice and the established benefits of integrating midwives into pregnancy care, states have restricted licensing and midwifery practice, contributing to the scarcity of midwives.[355] Some states restrict midwife practice by requiring them to enter into relationships and agreements with physicians,[356] which can be particularly problematic given the history of distrust that exists between physicians and midwives.[357] Other medical and nursing professionals are self-

349. *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2212–13.

350. *Id.* at 2213.

351. Kukura, *Better Birth*, *supra* note 342, at 280.

352. *Id.*

353. *Id.* at 247.

354. *Id.* at 280.

355. *Id.* at 283–84.

356. *Id.* at 286; *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2227–28.

357. Kukura, *Better Birth*, *supra* note 342, at 297 (noting the distrust stems from a "long history of competition between physicians and midwives in the United States").

regulated by their own practice guidelines.[358] Of course, protecting public health should be a priority, but there is no evidence that requiring midwives to enter these agreements when they are already licensed health care professionals serves that goal.[359] In practice, these regulations inhibit midwifery growth and serve as an anti-competitive restraint for physicians.[360]

Some states also impose restrictions on the practice of midwifery by limiting their prescriptive authority, which prevents them from obtaining medications, and prohibiting who midwives can see, including pregnant women who are carrying twins, have a baby in the breech position, or wish to deliver vaginally after previously having had a cesarean section.[361] Other states require midwives to obtain malpractice insurance without considering their malpractice risk and the number of patients they serve, rendering malpractice premiums cost prohibitive, especially for independent midwives.[362] Some states also restrict midwifery care by limiting their practice to a childbearing year, so they are not offering family planning and other health care like pap smears, which are within the scope of their credentials.[363] These restrictions negatively impact the ability of midwives to practice care that they are qualified, trained, and licensed to do and reflect that midwives have not been integrated into health care systems.[364]

Midwifery regulations can also circumscribe cultural choices and be especially burdensome for women of color who need and prefer to use traditional midwifery for pregnancy care

358. *Id.* at 286.

359. *Id.*

360. *Id.*; *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2221 ("The complexity and irregularity of midwifery regulation in the United States reflect the extensive efforts of medical associations to prohibit the practice of midwifery.").

361. Kukura, *Better Birth*, *supra* note 342, at 286; *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2224–25.

362. Kukura, *Better Birth*, *supra* note 342, at 286.

363. *Id.* at 287.

364. *See id.*

and childbirth or do not have easy access to a hospital.[365] In Hawaii, traditional Native Hawaiian birthing practices have been on a collision course with the state's regulations.[366] In 2019, Hawaii passed Act 32, which requires midwives to obtain formal education and meet certain licensing requirements.[367] Although intended to promote women's health and safety, the law has encroached on women's autonomy and ability to use traditional Native Hawaiian birthing practices and has raised concerns about access for women in rural areas where hospitals can be hours away.[368]

Specifically, Traditional Midwives (or Birth Attendants) with experience and established reputations do not meet the requirements of the law because they obtained their training in Native Hawaiian practices through apprenticeship—a way midwives have trained for centuries.[369] For example, Ki'i Kaho'ohanohano, a Native Hawaiian healer, trained to become a pale keiki, a traditional Hawaiian midwife, for more than a decade with Tina Garzero, who had worked for nearly forty years as a midwife.[370] She assisted hundreds of women with Garzero's guidance, and none of the mothers ever needed emergency medical care.[371] Garzero taught her how to identify and support women who would need a hospital birth or an obstetrician's care.[372] Kaho'ohanohano has long practiced without a

365. *See* Harley Broyles, *Act 32 and Perpetuating Practices of Hawai'i Nā Pua O Haumea: How Hawai'i's Midwifery Licensure Law Adversely Impacts Traditional Native Hawaiian Birthing Practices*, 23 ASIAN-PAC. L. & POL'Y J. 1, 18 (2022).

366. *Id.*

367. S.B. 1033, 30th Leg., Reg. Sess. (Haw. 2019) (codifying HAW. REV. STAT. §§ 457J-1–13 (2019)).

368. Broyles, *supra* note 365, at 4; Sabrina Bodon, *How a Lapsing Birth Attendant Exemption Affects Access to Care in Hawai'i*, HAWAI'I PUB. RADIO (June 30, 2023, 10:51 AM), https://www.hawaiipublicradio.org/local-news/2023-06-30/how-a-lapsing-birth-attendant-exemption-affects-access-to-care-in-hawaii [https://perma.cc/9N8A-ER8B].

369. Broyles, *supra* note 365, at 35.

370. Marina Starleaf Riker, *Midwives Will Soon Need a License to Practice in Hawaii. Many Are Pushing Back*, HONOLULU CIV. BEAT (Feb. 15, 2023), https://www.civilbeat.org/2023/02/midwives-will-soon-need-a-license-to-practice-in-hawaii-many-are-pushing-back [https://perma.cc/W4WN-WYYU].

371. *Id.*

372. *Id.*

license in service to women who share similar views of childbirth as a sacred ceremony that allows families to connect to their ancestors.[373] She explained, "This is not just midwifery or a baby coming, this is reclaiming who we are in such bigger ways and healing each other in the process."[374] Although Act 32 exempted Traditional Midwives like her from its requirements until 2023, the legislature failed to extend that exemption or otherwise protect Traditional Midwives, despite the recommendation from The Hawai'i Home Birth Task to do so.[375] The Act has been criticized as mandating midwives meet certain requirements without providing a pathway to achieve them and interfering with Native Hawaiian birthing traditions and practices.[376] Although Kaho'ohanohano attended her last birth before the law exemption lapsed, she is now a lead Plaintiff in a lawsuit challenging the law as unconstitutional.[377]

"Zero trimester" or pre-pregnancy regulations are another modern example of broad-based pregnancy care policies that can unnecessarily strip pregnant women of their autonomy. By way of background, for the last one hundred years, prenatal care has been central to the prevailing medical model for pregnancy health.[378] Under this model, maternal and child health experts believed that if a pregnant woman engaged in healthy habits and received good medical care during pregnancy, she would optimize childbirth outcomes.[379] A "prenatal care revolution" took place in the 1980s when large increases of women

373. *Id.*

374. *Id.*

375. THE HAWAI'I HOME BIRTH TASK FORCE, A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAI'I PER ACT 32, SESSION LAWS OF HAWAII, 2019 14 (Dec. 11, 2019), https://humanservices.hawaii.gov/wp-content/uploads/2020/01/FINAL-12.10.19-HHBTF-Report-12.11.19.pdf.

376. Broyles, *supra* note 365, at 32, 37–38.

377. *See* Bodon, *supra* note 368; Complaint, Kaho'ohanohano v. Hawaii, No. 1CCV-24-0269 (Haw. 1st Cir. Ct. Feb. 27, 2024) (complaint filed), https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf.

378. WAGGONER, *supra* note 32, at 11.

379. *Id.*

sought and accessed prenatal care.[380] Experts had hoped the increase in prenatal care would translate into better birth outcomes, but prenatal care was not a "magic bullet" and did not improve birth outcomes.[381] In fact, by the end of the twentieth century, the United States had one of the highest rates of negative birth outcomes in the industrialized world.[382] To be sure, health care providers are able to diagnose and treat problems that arise during pregnancy with prenatal care, but prenatal care does not prevent the problems from arising in the first place and does not effectively address preterm birth or low birthweight, which are the major causes of poor infant outcomes.[383]

In the twenty-first century, maternal and child health experts began to argue that women in the United States are simply not healthy enough when they become pregnant, and they need to plan well in advance of pregnancy.[384] Pre-pregnancy care—health care before pregnancy or during the "zero trimester"—is now the answer to achieving better birth outcomes and reducing maternal and infant mortality.[385] To this end, in 2006, the federal Centers for Disease Control and Prevention ("CDC") included pre-conception health recommendations in its *Morbidity and Mortality Weekly Report* ("MMWR").[386] For example, the CDC recommended that women not using birth control avoid alcohol to prevent harming a pregnancy, even if the woman is not pregnant at the time.[387] Texas started a similar pre-

380. *Id.*

381. *Id.*

382. *Id.*

383. *Id.* at 12–14 (noting the inability of pre-natal care to provide "primary prevention" of birth issues despite its "individual-level benefits"). This is not a new issue. *See, e.g.*, COMMITTEE TO STUDY THE PREVENTION OF LOW BIRTHWEIGHT, INST. OF MED., *Prenatal Care and Low Birthweight: Effects on Health Care Expenditures*, *in* PREVENTING LOW BIRTHWEIGHT 212, 212 (1985) (explaining the committee's work was hobbled by a lack of research into costs of preventing low birthweight).

384. WAGGONER, *supra* note 32, at 12.

385. *Id.* at 12–13.

386. *Id.* at 5, 63.

387. *Id.* at 1.

pregnancy campaign called "Someday Starts Now" with television ads that featured women engaged in daily activities with future due dates looming in bubbles above them.[388] The campaign website told women: "[Y]our health today is important – and even more important to the baby you might have some day."[389] It further stated, "If there's a baby in your future, even if it's months or years from now, today matters. Take control. Stop smoking, eat right and exercise and do something about your stress."[390] The March of Dimes also claims that a proper pregnancy should be twelve months, not nine months, and begin three months before conception.[391]

According to these kinds of pre-pregnancy campaigns, women of reproductive age are responsible for healthy pregnancies and childbearing; whether they are pregnant or not, women of reproductive age should act as if they are.[392] To be sure, there is evidence that some pre-pregnancy care, like prenatal care, can improve birth outcomes, including being sure chronic conditions like diabetes, obesity, and addiction are under control, but blanket recommendations addressed to any woman of reproductive age—as opposed to those at risk—will not necessarily produce better birth outcomes.[393]

First, although there is widespread agreement that the United States wants healthy mothers and healthy babies, we do not actually know much about what causes negative pregnancy outcomes.[394] Specifically, the medical community does not understand preterm birth or congenital anomalies (two leading

388. *Id.* at 2.

389. *Id.*

390. *Id.*

391. *Id.* at 2, 4.

392. *See id.* at 4. Although the zero trimester focuses on the three months prior to conception, because a woman's behavior throughout her lifetime could affect pregnancy, even her pre-reproductive years are within the zero trimester. *Id.*

393. *Id.* at 15–16. "Reproductive surveillance became less about a specific period – nine months or a specific body part – the womb – but rather about the whole of a woman's reproductive body and lifespan." *Id.* at 64. *See also* Anya E.R. Prince, *Reproductive Health Surveillance*, 64 B.C. L. REV. 1077, 1080 (2023) (describing the vast network of data collection already undermining privacy in pregnancy).

394. *See* WAGGONER, *supra* note 32, at 17.

causes of infant mortality), but the majority of these adverse outcomes happen to healthy women.[395] Equally important, it is not at all clear that pre-pregnancy care is effective at addressing negative pregnancy outcomes. Evidence is ambiguous and suggests pre-pregnancy care might be "inconsequential and misleading" or "profoundly important."[396] In this regard, pre-pregnancy care could be empowering for women and health care providers, or it could be a form of control over women and invite new social surveillance of non-pregnant women.[397] Either way, what we know about pre-pregnancy risks has not changed much, but pre-pregnancy care has expanded to cover more of a woman's life.[398]

Second, blanket recommendations of pre-pregnancy care do little to address systemic problems that we know contribute to unhealthy pregnancy and birth outcomes.[399] If all women engaged in optimal behavior, there would still be groups that are at risk because of systemic problems like poverty, structural racism, pollution or proximity to environmental hazards and toxins, and access to quality health care and food.[400] Pre-pregnancy care has done a poor job of addressing racial and ethnic disparities despite the disproportionately high rates of maternal and infant mortality among women of color and Black women in particular.[401] In fact, some of the pre-pregnancy care

395. *Id.* at 18 ("[A]nalyses of the increase in preterm births find that high rates of labor induction, cesarean deliveries, and assisted reproductive technologies might be key drivers—factors that are not necessarily related to the pre-pregnancy health status of women but rather to the institutionalized culture of medical intervention in reproduction.").

396. WAGGONER, *supra* note 32, at 15, 23.

397. *See id.* at 15.

398. *Id.* at 65; *see also* COMMITTEE TO STUDY THE PREVENTION OF LOW BIRTHWEIGHT, INST. OF MED., *supra* note 383, at 132 (indicating this same ambiguity back in 1985).

399. WAGGONER, *supra* note 32, at 19.

400. *See id.* at 19–20, 132.

401. *See id.* at 132, 164–65; Janice Ellis, *Systemic Racism, Politics Prevent Black Expectant Mothers From Getting Needed Health Care*, MO. INDEPENDENT (Apr. 22, 2024, 5:50 AM), https://missouri-independent.com/2024/04/22/systemic-racism-politics-prevent-black-expectant-mothers-from-getting-needed-health-care/ [https://perma.cc/Y6VM-Z5MA]; Adetola Louis-Jacques, *What I'd Like Everyone to Know About Racism in Pregnancy Care*, AM. COLL. OF OBSTERICIANS & GYNECOLOSTS (Jan. 2024), https://www.acog.org/womens-health/experts-and-stories/the-

campaigns "unwittingly reinscribed racialized notions of reproduction."[402] CDC's "Show Your Love Campaign" featured preconception health "planners," who were all white, light-skinned women, and "non-planners," who were Black women or Latina women.[403] Campaign videos also reproduced racialized tropes and stereotypes, situating white women as model citizens and women of color on the margins of "good" motherhood.[404]

Finally, to state the obvious, pre-pregnancy campaigns place the burden on women alone and not men, perpetuating sex stereotypes around motherhood and underscoring how intertwined womanhood and motherhood remain.[405] In reality, pregnancy outcomes would improve if 60% of men received pre-pregnancy care.[406] Men can pose risks to a healthy pregnancy when they drink, abuse drugs, or smoke.[407] They can also help contribute to a healthy pregnancy by helping make a reproductive plan, making good sperm, and supporting pregnant women.[408] Still, the assumption is that women should shoulder the burden of pre-pregnancy care.[409]

Pre-pregnancy care recommendations may seem benign on their face because they are recommendations and not requirements, but in the same way that a woman can receive applause and gratitude for complying with recommendations, she can also be held responsible if she is not adhering to recommendations.[410] Take the CDC's recommendation about pre-pregnancy

latest/what-id-like-everyone-to-know-about-racism-in-pregnancy-care [https://perma.cc/SUP3-SG62].

402. WAGGONER, *supra* note 32, at 18–19, 160–65.

403. *Id.* at 160–61.

404. *Id.* at 163–65.

405. *See id.* at 22.

406. *See id.* at 141–42.

407. *Id.* at 21, 142–44.

408. *Id.* at 21, 144; *accord* Ifta Choiriyyah, Freya L. Sonenstein, Nan M. Astone, Joseph H. Pleck, Jacinda K. Dariotis & Arik V. Marcell, *Men Aged 15–44 in Need of Preconception Care*, 19 MATERNAL CHILD HEALTH J. 2358–59 (discussing options for pre-pregnancy care for men and how to reach that population).

409. *See* WAGGONER, *supra* note 32, at 21, 143–44.

410. *Id.* at 168.

alcohol consumption as an example. As an initial matter, recent research shows that state-level alcohol policies targeted at pregnant women are ineffective at reducing harm.[411] In fact, some policies, such as Reporting Requirements for Assessment/Treatment and Mandatory Warning Signs, are associated with decreases in prenatal care utilization and increased preterm birth and low birth weight.[412]

Nevertheless, the CDC telling non-pregnant women to avoid alcohol could invite social sanctioning (as well as individual guilt) and possible legal ramifications, even when it is not clear that pre-pregnancy behavior will impact fetal health.[413] To be clear, the CDC stated that it is not safe to drink alcohol at any point during pregnancy.[414] The CDC has not said that pre-pregnancy drinking adversely affects fetal health; the point of the recommendation was to avoid the scenario that a woman would drink while not realizing she is pregnant.[415] In addition, although pre-pregnant women have not faced legal action for their conduct, punishing pregnant women for not adhering to recommendations could extend to pre-pregnant women.[416] A law enforcement officer or prosecutor could understand a recommendation to mean that punishment is in order and exercise their discretion, even though well-established medical organizations have made clear that punitive laws can deter women from seeking the very care they need.[417] Providers could also be

411. Sara C. M. Roberts, Alex Schulte, Claudia Zaugg, Douglas L. Leslie, Tammy E. Corr & Guodong Liu, *Association of Pregnancy-Specific Alcohol Policies with Infant Morbidities and Maltreatment*, JAMA NETWORK OPEN, Aug. 2023, at 1, 2.

412. *Id.* at 2, 7.

413. WAGGONER, *supra* note 32, at 14–15.

414. *Id.* at 15.

415. *Id.* ("[T]he evidence is ambiguous regarding whether specific pre-pregnancy behaviors will impact fetal health.").

416. *See id.* at 168.

417. *See* Seiler, *supra* note 60, at 626 ("Most pregnant women who have an occasional glass of wine are unlikely to be arrested or lose custody of their babies, but those women who are most vulnerable to punitive approaches, namely low-income and black women, could face further pressures."); *see also* Khiara Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1283 (2020) [hereinafter Bridges, *Racial Disparities*] (widespread screening of

conscripted as enforcers because of state mandatory reporting requirements.[418] In these ways, recommendations can "encourage law enforcement actions that go well beyond influencing individual decision making to affect personal liberty and parental rights."[419]

As noted at the outset of this section, the state has an interest in helping a woman carry a healthy pregnancy to term if that is what she has decided to do. The most effective government intervention at an individual or broad-based policy level facilitates women's choices when it comes to pregnancy health and care.[420] A facilitative model of intervention recognizes that pregnant women will make countless decisions related to their pregnancy that affect their lives and fetal development and will make the sacrifices necessary to achieve a healthy pregnancy.[421] It assumes that pregnant women are best situated to balance any competing interests. Rather than the state depriving women of the right to make these decisions or punishing them for their decisions, the government strives to offer women greater choices and resources to overcome obstacles, including lack of health insurance and care, inadequate information, poverty, and addiction.[422]

Meanwhile, the least effective government intervention is adversarial and imposes restrictions on women simply because they are pregnant, which in turn discourages women from obtaining pregnancy care.[423] An adversarial model of intervention involves the state compelling pregnant women to comply with

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pregnant women for substance use, even though well-intentioned, "could result in substance-using and -dependent women being funneled into the criminal legal system.").

418. Seiler, *supra* note 60, at 625; *see also* Laura Huss, Farah Diaz-Tello & Goleen Samari, *Self-Care, Criminalized: Preliminary Findings*, IF WHEN HOW, Aug. 2022, at 1, 3 (stating that cases of self-managed abortion "came to the attention of law enforcement most often by care professionals who are designated mandatory reporters").

419. Seiler, *supra* note 60, at 624.

420. Johnsen, *Shared Interests*, *supra* note 246, at 571.

421. *Id.* at 571, 573.

422. *Id.* at 573–76; *see also* MEREDITH, *supra* note 55, at 218 (discussing a model that encourages doctors to "focus on the mutual needs of pregnant women and [fetuses], rather than on their mutually exclusive needs").

423. *See* Johnsen, *Shared Interests*, *supra* note 246, at 571.

a court, the legislature, a physician, or other third-party opinion about what would be optimal for the fetus.[424] It also involves the state second-guessing pregnant women, depriving or overriding their decisions about medical treatment, and creating an atmosphere where women fear the state.[425] To be sure, if a criminal statute prohibits certain conduct, pregnancy does not grant pregnant women immunity from such criminal conduct.[426] Still, pregnant women should not be singled out because of their pregnancy status, which happens under adversarial intervention.[427] In fact, prosecutors have brought actions under statutes that were never designed to prosecute pregnant women.[428]

In sum, although the Court in *Dobbs* overturned the abortion right, its decision has direct consequences for pregnant women who are carrying a pregnancy to term. In discarding the viability line, the Court invites courts to discard the viability line in pregnancy care cases too, potentially allowing states to compel or coerce care earlier in pregnancy. In recognizing the state's interest in fetal life throughout pregnancy, the Court also green lights increased regulation of pregnancy care in the future.[429] Pregnant women are already willing to make considerable sacrifices in the best interest of their pregnancy and fetus, but they should not be forced to undergo care, some of which has significant risks to them, or relinquish their decision-making autonomy based on state laws and recommendations that seek to circumscribe their choices rather than facilitate them.

IV. PREGNANCY JUSTICE

As health care providers, lawmakers, courts, and other stakeholders begin to address the fallout from *Dobbs*, their responses should not come at the cost of women's privacy,

424. *Id.* at 571, 576.

425. *See id.*; Kitchen, *supra* note 33, at 208.

426. Johnsen, *Shared Interests*, *supra* note 246, at 578–79.

427. *See id.* at 571, 579.

428. *Id.* at 579.

429. *See* Siegel, *supra* note 44, at 276.

equality, and dignity. Historically, women had the most autonomy during pregnancy under the law, but now, they arguably have the least after *Dobbs*.[430] This section argues for a reversal of course, and prescribes an alternative path forward—one grounded in pregnancy justice—that recenters pregnant women to improve pregnancy health and maternal and infant outcomes. In addition to advocating for a cultural shift in the way in which American society understands pregnancy, this section advances public policy recommendations to improve access to abortion and midwifery care and to address two of the leading causes of poor maternal and infant outcomes—domestic violence and poverty.

A. The Culture of Pregnancy

As described above, the law and culture surrounding pregnancy care have increasingly recognized fetal rights, offering greater protection for "potential life" to the detriment of women's rights and decision-making autonomy.[431] Although advancing changes in law is certainly one approach to addressing the fallout from *Dobbs*, there also needs to be a cultural shift in the way that American society values, treats, and understands pregnant women for meaningful and lasting changes in law. Indeed, a culture that does not respect pregnant women may very well have produced the existing legal landscape.[432]

American society continues to hold women exclusively responsible for pregnancy outcomes without considering the actual risks involved in pregnancy or the structural context in which bad pregnancy outcomes occur.[433] First, the American public is not well informed when it comes to pregnancy loss: more than 15% of pregnancies will end in either a miscarriage (before twenty weeks of pregnancy) or a stillbirth (in the

430. *See supra* Section I.B; *see also supra* note 27.

431. ROTH, *supra* note 248, at 90.

432. *See* Bridges, *Pregnancy and the Carceral State*, *supra* note 339, at 1202, 1205.

433. FENTIMAN, *supra* note 51, at 76–77.

twentieth week of pregnancy or later).[434] The public has yet to realize that oftentimes, negative pregnancy outcomes happen by unfortunate chance and not because of a pregnant woman's behavior.[435] Second, even when a woman has the good fortune of experiencing a healthy pregnancy, American society looks to her behavior without considering that factors beyond her control also affect the health of a pregnancy.[436] For example, one of the leading causes of pregnancy-related death and harm is domestic violence.[437] Finally, in holding women accountable for pregnancy outcomes, American society as a whole absolves itself of its responsibility to pregnant women.[438] Compared to prior decades, blame for maternal morbidity and mortality is cast on women.[439] *They* have chronic conditions like hypertension, diabetes, and heart disease, and *they* are more obese.[440] *They* get pregnant later in life, and *they* are older when carrying pregnancy to term.[441] This cultural narrative lacks the social context in which women come to develop and suffer chronic conditions.[442] If food is not affordable, or women spend their days (and/or nights) working, fitting in healthy eating and exercise can become an insurmountable challenge.[443] As noted at the outset of this Article, in addition to being a biological event, pregnancy is a social event because societal pressures influence when women conceive, what kind of reproductive health care is available to them, and whether they have support during their pregnancy.[444]

Understanding pregnancy from the perspective of pregnant women, including the considerable sacrifices they willingly

434. *Id.* at 76.
435. *See id.* at 77.
436. *See id.*
437. *Id.*
438. *See* Bridges, *Racial Disparities*, *supra* note 417, at 1280.
439. *See id.* at 1278–79.
440. *Id.* at 1278.
441. *Id.*
442. *Id.* at 1280.
443. *Id.*
444. Siegel, *supra* note 44, at 267, 272.

make already, is a step towards reimagining pregnancy in society. Professor Rona Kaufman Kitchen advances a holistic view of pregnancy that involves treating pregnant women in a way that is woman-centered but recognizes the relational reality of pregnancy; such care would not involve treating her like a non-pregnant person but also not involve treating pregnancy as involving two separate people.[445] A holistic view of pregnancy empowers women to make choices for themselves and their pregnancies under the presumption that they are acting in the interest of themselves, their pregnancies, and the fetus.[446]

Understanding pregnancy in ways that are inconsistent with or counter to the existing narrative around pregnancy can also be helpful in reimagining pregnancy in society.[447] For example, Professor Khiara Bridges explores pregnancy as an injury in the context of rape statutes.[448] Although states define sexual assault and rape in varied ways, many include aggravating factors for "substantial bodily injury" and similar categories of harm.[449] In this regard, under existing law, pregnancy can be a form of this bodily harm.[450] Professor Rachel Camp explores pregnancy as coercion.[451] Partners can use physical and sexual violence to coerce pregnancy and limit a woman's independence and movement; pregnancy can force a pregnant woman to depend on her abusive partner.[452] Women who experience domestic violence report that abuse begins or intensifies during pregnancy or after childbirth, especially if the pregnancy is unintended.[453] Pregnancy has even been recognized as a form of medical negligence.[454] In cases where a doctor's negligence

445. Kitchen, *supra* note 33, at 241–42.

446. *Id.* at 250.

447. Bridges, *When Pregnancy Is an Injury*, *supra* note 48, at 458.

448. *See id.* at 457–58.

449. *See id.* at 466–67.

450. *See id.* at 467.

451. *See generally* Camp, *supra* note 44, at 279 (exploring the connection between coercion and pregnancy as a way to help broaden laws and policies).

452. *Id.* at 279.

453. *Id.* at 291–92.

454. *Id.* at 306.

results in either an unplanned child or a child with significant disabilities, parents have sued and won damages in connection with the birth of that child (albeit not with the pregnancy itself).[455]

Creating a culture that prioritizes women's rights and autonomy is crucial as courts nationwide apply rational basis to review laws that encroach on or second-guess pregnant women's decision-making. Judges and justices live and work in the same cultural context in which these laws will emerge, and although rational basis is the most deferential standard of review, it is not static.[456] As Professor Katie Eyer explains, social movements have long employed rational basis to disrupt the status quo and create constitutional change, including the women's movement to eradicate sex discrimination.[457] In the first modern sex discrimination case, *Reed v. Reed*, the Supreme Court did not declare women a suspect class or apply heightened scrutiny but nevertheless concluded in their favor.[458] As Professor Meghan Boone also describes, when a law like an abortion restriction is perverse, meaning it "clearly contravenes the overarching legislative intent because the law is solely or primarily responsible for producing the opposite result from the stated or obvious legislative intent," courts should be willing to strike it down under the rational basis standard.[459] For example, states that restrict abortions have the worst maternal and infant health outcomes, so even if these laws are intended to protect potential life, the ways in which lawmakers have gone about achieving that goal are demonstrably perverse and, therefore, irrational.[460]

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455. *Id.*

456. *See* Meghan Boone, *Perverse and Irrational*, 16 HARV. L. & POL'Y REV. 393, 401, 404 (2022); *see also* Katie R. Eyer, *The Canon of Rational Basis Review*, 93 NOTRE DAME L. REV. 1317, 1320, 1342–43 (2018).

457. Eyer, *supra* note 456, at 1320, 1327.

458. *Id.* at 1327–28.

459. Boone, *supra* note 456, at 406.

460. *See id.* at 442–45.

In sum, much like the existing narrative around pregnant women is reflected in law and policy in ways that are increasingly encroaching on women's autonomy, a new narrative that reprioritizes pregnant women should find its way into law and policy in ways that increasingly advance pregnancy justice. An invigorated narrative can influence and even drive social and legal change.

B. Advancing Pregnancy Care Through Public Policy

Any public policy solutions to pregnancy care can and should facilitate women's access to care. The remainder of this section recommends improving abortion access and midwifery access as well as addressing two major risk factors for positive pregnancy outcomes—domestic violence and poverty.

First, ensuring legal access to abortion would improve pregnancy outcomes.[461] As discussed above, abortion bans have harmful consequences for pregnant women whose pregnancies have become health- or life-threatening because of pregnancy complications, severe fetal abnormality, or loss. Regaining legal access to abortion in states where lawmakers have banned it either by challenging these laws in court under state constitutions or by repealing these laws is a crucial step. In addition, since *Dobbs*, direct democracy or using ballot initiative processes to enshrine abortion rights in state constitutions has been a promising and arguably durable option. In 2024, seven of the ten states that considered abortion rights regained or fortified the right—Arizona, Colorado, Maryland, Missouri, Montana, Nevada, and New York.[462] Before that, four states amended their state constitutions to protect the abortion right—California,

461. *See supra* Section II.A; *see also* Eugene Declercq, Ruby Barnard-Mayers, Laurie C. Zephyrin & Kay Johnson, *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, COMMONWEALTH FUND (Dec. 14, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes [https://perma.cc/2UL5-FEAD].

462. *Ballot Tracker: Outcome of Abortion-Related State Constitutional Amendment Measures in the 2024 Election*, KFF, https://www.kff.org/womens-health-policy/dashboard/ballot-tracker-status-of-abortion-related-state-constitutional-amendment-measures/ [https://perma.cc/2Q7W-NLRN] (Nov. 6, 2024).

Michigan, Ohio, and Vermont; Kansas and Kentucky also rejected ballot measures that would have restricted legal abortion.[463] Of course, legal abortion does not ensure access to abortion care, so prioritizing access to abortion care through use of telemedicine, for example, is a crucial step.[464] Enlisting health care providers who have not previously been involved in abortion care is also a worthwhile pursuit to expand access to abortion care.[465] Kaiser Permanente in Colorado decided to provide abortion care because the wait times for their patients at existing providers were too long in light of the influx of out-of-state patients after the Court's decision in *Dobbs*.[466]

Second, providing pregnant women with access to midwives would improve pregnancy outcomes. As discussed above, there are well-established benefits to integrating midwives into pregnancy care for pregnant women, newborns, and the medical community.[467] Nevertheless, states have unnecessarily restricted midwifery practice to minimize any perceived risk (not actual or empirical risk) to the fetus.[468] To this end, lawmakers should broaden the spectrum of pregnancy care available to pregnant women, facilitating additional choices,

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463. *Id.*

464. *See* Ederlina Co, *Abortion Privilege*, 74 RUTGERS L. REV. 1, 22 (2021) (emphasizing how privilege heavily influences whether someone experiences abortion as a form of ordinary health care or as an event associated with oppression, even where abortion is legal).

465. *See* Nicole Leonard, *1 Year After* Dobbs*, Pa. Clinicians Say It's Time to Revise the State's Physician-Only Abortion Law*, WHYY (June 26, 2023), https://whyy.org/articles/pa-abortion-law-advanced-practice-clinicians-dobbs-roe-v-wade/ [https://perma.cc/DVQ3-YBWN]; Alice Miranda Ollstein & Megan Messerly, *Blue States Expand Who Can Provide Abortions as They Brace for a Flood of Patients*, POLITICO, https://www.politico.com/news/2022/05/17/states-expand-abortions-flood-of-patients-00032815 [https://perma.cc/VJ7A-HLL8] (May 18, 2022, 10:34 AM).

466. Claire Cleveland, *Kaiser Permanente to Offer Abortion Services in Response to Long Planned Parenthood Wait Times*, CPR NEWS (Nov. 28, 2022), https://www.cpr.org/2022/11/28/kaiser-permanente-colorado-abortion-services [https://perma.cc/J8YH-Q8EG].

467. *See supra* Section III.B; Kukura, *Better Birth*, *supra* note 342, at 280–81; *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2212–14.

468. *See The Legal Infrastructure of Childbirth*, *supra* note 25, at 2230–31; *see also* MEREDITH, *supra* note 55, at 206 ("[M]any current recommendations are not evidence-based, and many are influenced by factors quite separate from any health risks to the pregnant woman or the [fetus] – including scheduling convenience, staffing availability, litigation fears and financial considerations, as well as prevailing medical dogma.").

including midwifery care.[469] Whether unduly restricting entry into midwifery, establishing rules that restrict competition, or limiting their scope of practice, the law has unnecessarily limited childbirth options as a result, even when these options have demonstrated good outcomes.[470]

Third, pregnancy cannot be an individual woman's exclusive responsibility—addressing systemic causes of poor pregnancy outcomes is necessary to improve pregnancy outcomes. As noted above, year after year, a leading cause of death for pregnant women in the United States is murder, not any obstetric cause like hypertension, hemorrhage, or sepsis, and it is preventable.[471] Homicide typically follows physical abuse from their domestic partner.[472] Women who experience such abuse "routinely report that the abuse begins or intensifies during pregnancy" or after childbirth.[473] In fact, pregnant women are more likely to experience abuse than non-pregnant women, and they are more likely to experience it more frequently and in more severe forms, especially if the pregnancy is unintended.[474] Such abuse can cause significant harm to the pregnant woman and fetus' health because abuse is often "directed towards a woman's womb;" women routinely report being kicked or punched in the stomach.[475] Not surprisingly, pregnant women suffering from domestic violence are more likely to experience bleeding during their first and second trimesters.[476] At the same time, women who are abused are also less likely to obtain prenatal care, and they and the fetus are at risk of additional harm, including risks related to substance use, low-weight gain,

469. *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2231.

470. *See* Kukura, *Better Birth*, *supra* note 342, at 294 (discussing various categories of occupational licensing restrictions); *The Legal Infrastructure of Childbirth*, *supra* note 25, at 2231.

471. Rebecca B. Lawn & Karestan C. Koenen, *Homicide Is a Leading Cause of Death for Pregnant Women in US*, 379 BRIT. MED. J., Oct. 2022, at 1, 1; Camp, *supra* note 44, at 296; FENTIMAN, *supra* note 51, at 77.

472. Camp, *supra* note 44, at 296.

473. *Id.* at 291.

474. *Id.* at 291–92.

475. *Id.* at 294.

476. FENTIMAN, *supra* note 51, at 77.

infection, and low birthweight.[477] Increasing screening for domestic violence and education about the connections between pregnancy and violence, and advancing policy that prevents violence against women is a crucial step.[478]

Finally, poverty remains a systemic cause of poor pregnancy outcomes and the most significant barrier to improving children's health and well-being.[479] When we think of poor pregnant women, who are more likely to be women of color, they are more likely to suffer from poorer health before they become pregnant.[480] Poverty has a negative effect on people's health.[481] People living in poverty may struggle to pay for healthy food causing them to have a diet higher in sodium, fat, and sugar.[482] They are also more likely to live in an environment with pollution and toxins.[483] Under these circumstances, they are "more likely to suffer from stress and to be either under-nourished and/or overweight or obese."[484] At the same time, poor people

477. *Id.* (listing the various potential complications an abused individual could experience during pregnancy, including: (1) physical injury to themselves or the fetus, (2) stress-induced disorders, (3) placenta previa, (4) diabetes, (5) hypertension, (6) fetal bleeding, (7) infections, and (8) issues with weight gain); Alexander Testa, Jacqueline Lee, Daniel C. Semenza, Dylan B. Jackson, Kyle T. Ganson & Jason M. Nagata, *Intimate Partner Violence and Barriers to Prenatal Care*, 320 SOCIAL SCI. & MED., Mar. 2023, at 1, 5.

478. *See* Camp, *supra* note 44, at 317–18; *see also* FENTIMAN, *supra* note 51, at 287; NAT'L DOMESTIC VIOLENCE HOTLINE, REPRODUCTIVE COERCION AND ABUSE REPORT 20 ("States must do more – especially for survivors of domestic violence and sexual assault – to support people's access to the information, resources, and healthcare they need to determine when and whether to have children, and to raise the children they have in safety.").

479. FENTIMAN, *supra* note 51, at 284; Bridges, *Racial Disparities*, *supra* note 417, at 1285 ("[S]ystemic and structural factors – like 'weathering,' our two-tiered healthcare system, residential segregation and the concentration of health-damaging factors in neighborhoods of color, the closure of obstetric units in public hospitals, the racist discourses that attach to pregnant bodies of color – likely bear a greater share of the responsibility for the indefensibly high MMR among black women in the United States."); WAGGONER, *supra* note 32, at 19 ("[R]ather than addressing widespread social problems such as structural racism, poverty, or limited access to healthy food choices, our standard public health and medical agendas simply tell all women to practice the healthiest lifestyle possible to ensure healthy babies.").

480. *See* FENTIMAN, *supra* note 51, at 78.

481. *See id*.

482. Bridges, *Racial Disparities*, *supra* note 417, at 1258–59.

483. *Id.*

484. FENTIMAN, *supra* note 51, at 78; Bridges, *Racial Disparities*, *supra* note 417, at 1258–59.

not only lack access to abortion care but also lack access to health care and prenatal care in particular.[485]

Although Medicaid pays for about half of the births in the United States, women with Medicaid do not obtain access to prenatal care until later in pregnancy.[486] Even so, socioeconomic status is not solely responsible for racial disparities in maternal mortality.[487] It is important that prospective parents receive care for their overall health, including their reproductive health, because, although prenatal care is important, it cannot erase years of inadequate health care or poor health.[488] At the same time, about one in three pregnancy-related deaths take place during the "fourth trimester" or during the postpartum period.[489] Under the American Rescue Plan of 2021, states can elect to extend Medicaid coverage from sixty days postpartum to up to one year postpartum to ensure new parents have continuous coverage.[490] As of August 2024, more than forty states and the District of Columbia have elected to extend Medicaid (or CHIP) during this postpartum period, helping demonstrate that providing pregnancy care is, in fact, achievable, notwithstanding a state's abortion policies.[491]

In sum, the Court's decision in *Dobbs* had the immediate effect of subjecting pregnant women to unnecessary health risks

485. FENTIMAN, *supra* note 51, at 78; Harris v. McRae, 448 U.S. 297, 338 (Marshall, J., dissenting) ("The Court's opinion studiously avoids recognizing the undeniable fact that for women eligible for Medicaid – poor women – denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether.").

486. FENTIMAN, *supra* note 51, at 78, 287.

487. Bridges, *Racial Disparities*, *supra* note 417, at 1257.

488. *See* FENTIMAN, *supra* note 51, at 78, 287; Bridges, *Racial Disparities*, *supra* note 417, at 1257–59; WAGGONER, *supra* note 32, at 19 ("Without systemic change, will only well-off women (or women seeking fertility services) be the ones to reap potential health rewards? We must ask who benefits from an expanded population health focus on pre-pregnancy health and health care.").

489. Kate Bradford, Khanh Ngyuen & Emily Blanford, *States Act on Postpartum Medicaid Coverage*, NCSL (Mar. 29, 2022), https://www.ncsl.org/state-legislatures-news/details/states-act-on-postpartum-medicaid-coverage [https://perma.cc/S5QY-WNLB].

490. *Id.*

491. *See id.*; *Medicaid Postpartum Coverage Extension Tracker*, KFF (Jan. 17, 2025), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ [https://perma.cc/DNG3-5WBU].

and inadequate pregnancy care in states with laws that ban abortion, so new law—whether legislative, judicial, or by ballot initiative—that restores legal access to that care must be a priority. Moreover, as the fallout from *Dobbs* continues where pregnancy care is concerned, we have to resist measures, whether required or recommended, that place exclusive responsibility for pregnancy outcomes on women. Instead, we should promote pregnant women's health and autonomy, facilitate access to choices and care, such as midwifery care, and share responsibility for pregnancy outcomes by addressing systemic causes of negative pregnancy outcomes, including domestic violence and poverty.

CONCLUSION

This Article sought to reveal some of the immediate consequences of the Court's decision in *Dobbs* and predict some of the long-term consequences of the decision where pregnant women's decision-making autonomy and care are concerned—*Dobbs* was not just about abortion. At the same time, this Article sought to summon a healthy skepticism about any future demands on pregnant women that perpetuate their exclusive responsibility for maternal and infant outcomes. If we reprioritize pregnant women in the cultural narrative around pregnancy and advance policy that promotes and facilitates their decision-making autonomy and care, we will see improved outcomes. Put another way, pregnancy justice is possible in the post-*Roe* era.