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The Consequences of Abortion Restrictions for Women's Healthcare

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The Consequences of Abortion Restrictions for Women's Healthcare

Maya Manian*

Abstract

This Essay challenges the false assumption that abortion care can be segregated from women's medical care and targeted for special restrictions without any effects on women's health more broadly. As a matter of medical reality, abortion cannot be isolated from the continuum of women's healthcare. Yet policymakers and the public have failed to understand the interconnectedness of abortion with other aspects of women's medical care. In fact, existing abortion restrictions harm women's health even for women not actively seeking abortion care, but these impacts remain obscured. For example, antiabortion laws and policies have spillover effects on miscarriage management, prenatal care, and the treatment of ectopic pregnancies. Focusing the public's attention on the broader effects of abortion restrictions on women's health could help make visible the links between abortion and healthcare. Furthermore, educating the public about the full healthcare consequences of abortion restrictions could be one key means to preserving access to abortion care. Repositioning the law to recognize abortion care as an integral part of the continuum of women's medical needs is critical to protecting women's health.

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I. Introduction

Over the last several decades, as part of the movement against abortion rights, abortion has become increasingly stigmatized and isolated in women’s health. The current segregation of abortion from the rest of women’s medical needs brings us full circle back to questions raised by *Roe v. Wade*.¹ Although *Roe* was rightly criticized as over-medicalizing the abortion decision and empowering doctors rather than women, we have now shifted to the opposite extreme of severing abortion completely from the realm of women’s health.² Thus far, the public has failed to understand the interconnectedness of abortion with women’s health generally. In fact, existing abortion restrictions harm women’s health even for women not actively seeking abortion care, but these effects remain obscured.³ For example, antiabortion laws and policies have spillover effects on

1. 410 U.S. 113 (1973).

2. See Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women’s Health*, 55 HOW. L.J. 731, 762–64 (2011) (describing the fact that abortion has been separated from other women’s health issues and treated as a distinct issue).

3. See *infra* Part II (discussing the healthcare implications of abortion legislation).

miscarriage management, prenatal care, and the treatment of ectopic pregnancies.⁴

As a matter of medical reality, abortion cannot be isolated from women's healthcare more broadly. We can see this by unmasking the ripple effects of abortion restrictions that, perhaps unintentionally, impede the provision of basic healthcare other than abortion. Focusing the public's attention on the broader effects of abortion restrictions on women's health could help make visible the links between abortion and healthcare. Uncovering these links could also create stronger support for access to abortion and thereby better promote full healthcare access for women. Repositioning the law to recognize access to abortion care as integral to women's medical needs remains critical for protecting women's health.

II. *The Healthcare Consequences of Abortion Restrictions*

Part of the popularity of antiabortion measures rests on the faulty belief that those laws affect only the "bad" women who seek abortions. This belief rests on the false assumption that abortion can be isolated from other aspects of women's health. However, as a practical matter, abortion cannot be isolated from the continuum of women's medical care.⁵ Thus far, policymakers have remained blind to the interconnectedness of abortion care with women's health generally.⁶ In fact, various abortion restrictions already obstruct women's healthcare, but the public has failed to discern these harmful impacts.⁷ Below, I describe how existing antiabortion government regulation detrimentally affects care for women in the context of miscarriage management, prenatal care, and the treatment of ectopic pregnancies.

4. *Infra* Parts II.A, II.B, II.D.

5. *See* Ikemoto, *supra* note 2, at 732–34 (arguing that a "whole-body" understanding of women's health-care is necessary for gender equality).

6. *See id.* at 738–39 (discussing the fact that the "abortion wars" have focused political efforts on abortion legislation "to the near-exclusion of the rest of women's bodies").

7. *See infra* Part II (discussing the impact abortion legislation has had on miscarriage management, prenatal informational control and care, pregnancy related care at sectarian hospitals, and ectopic pregnancy treatment).

A. *The Federal “Partial-Birth” Abortion Ban and Miscarriage Management*

The federal “partial birth” abortion ban, upheld by the U.S. Supreme Court in *Gonzales v. Carhart*,⁸ illustrates how laws aimed at abortion impede medical care even for women not actively seeking abortion care. The federal ban purports to prohibit one type of abortion procedure called “partial birth” abortion by its opponents, but known medically as intact D&E.⁹ Although the federal ban received much attention when the Supreme Court upheld the law, the public has heard little about the effects of this ban since its implementation. The discussion of the law during the years of litigation gave the impression that a ban on intact D&E would affect only a small number of women seeking abortions late in their pregnancy.¹⁰ In fact, research on the effects of the federal “partial-birth” abortion ban suggests a much wider impact not only on abortion care, but also in the management of miscarriages.

Lori Freedman, a leading researcher on the impact of antiabortion policies on physicians, found that some physicians who do not routinely provide abortions nevertheless feel constrained by the ban.¹¹ For example, one physician felt unable to treat her patient in the safest manner she thought possible due to a fear of violating the law while attempting to care for a patient who was miscarrying during the second trimester of pregnancy.¹² The physician, Dr. B, who told this story confidentially, explained as follows:

[The patient] was kind of in the process of delivering but it wasn't coming fast enough and she's trying to hemorrhage to death So I took her to the OR to basically do a D&E . . . so I could get her to quit hemorrhaging. Well, you know the

8. 550 U.S. 124 (2007).

9. Cynthia Gorney, *Gambling with Abortion: Why Both Sides Think They Have Everything to Lose*, HARPER'S MAG., Nov. 2004, 33, 34.

10. See *Gonzales*, 550 U.S. at 155 (“A fetus is only delivered largely intact in a small fraction of the overall number of D&E abortions.”).

11. Tracy A. Weitz, *Lessons for the Prochoice Movement from the ‘Partial Birth Abortion’ Fight*, XXXIII CONSCIENCE, no. 1, 2012, at 26, 28.

12. See *id.* (describing the story of Dr. B, as told by Lori Freedman at a San Francisco General Hospital Abortion Discussion Group).

whole thing about the partial birth abortion. I mean, [it's] being born breech, it's still kicking, it still has a heartbeat, its head is stuck in her cervix. What would make sense would be to punch a hole in the back of its skull, collapse its brain, get it out of there and save the patient. But you've got all these people in the OR that don't know what the background situation [is] And it's just like that would've made perfect sense to do that but I didn't primarily because I was worried that all these, you know, the techs and circulating nurses in the OR are going to think, 'Oh, Dr. B is a baby killer,' you know, 'And she just did a partial birth abortion and doesn't everybody know that's illegal?'¹³

In fact, technically this situation would not fall within the scope of the federal “partial-birth” abortion ban because the physician did not start the procedure with an intent to perform an intact D&E.¹⁴ Nevertheless, regardless of the technicalities of the law, the law's effect has been to create a system in which doctors feel circumscribed in the exercise of their medical judgment.¹⁵ Professor Tracy Weitz argues that the law has become its own “Panopticon,” a perpetual surveillance system that inhibits not just abortion care but also the care of pregnant women suffering from miscarriages.¹⁶

We do not know how often circumstances like these arise and at what risks to patients because these stories are rarely told. The federal “partial-birth” abortion ban and similar state bans leave physicians with a Hobson's choice—even in medical situations where abortion care was not intended or sought—pitting physicians' medical judgment of what procedures would best protect their patients against the threat of criminal sanction.

13. *Id.* at 28 (quoting from a presentation by Lori Freedman).

14. *See id.* (stating that the standard for criminal prosecution would “probably” not be met because Dr. B lacked the requisite intent).

15. *See id.* (“[P]hysicians make decisions in the operating room based on their fears about who might be watching, worried that onlookers will misinterpret the situation.”). In this particular case, the physician completed a disarticulation D&E (non-intact D&E) and was able to save the patient's life. *See id.* (describing the method of abortion used by Dr. B).

16. *Id.*

B. Information Control and Prenatal Care

The regulation of information surrounding abortion care also has spillover effects on medical care for pregnant women. Oklahoma provides one stark example of information control as reproductive control. On the same day that Oklahoma passed legislation mandating that abortion patients undergo an ultrasound, it also passed a law protecting physicians who fail to disclose fetal anomalies to prenatal patients from tort liability.¹⁷ In other words, Oklahoma law forces unwanted information on some pregnant patients while empowering physicians to conceal wanted information from others. Furthermore, under this liability preclusion law, physicians have no duty to disclose to their patients that they would intentionally hide information about fetal anomalies.¹⁸ Proponents of this legislation claim that liability preclusion laws of this sort are antiabortion measures only, thwarting women who would seek an abortion if they knew of a fetal anomaly.¹⁹

In reality, laws that permit concealing information in the context of prenatal care affect not only those women who may consider terminating a pregnancy but also those who would not choose an abortion but could use the information to better plan

17. See OKLA. STAT. tit. 63, § 1-741.12 (2013) (“In a wrongful life action or a wrongful birth action, no damages may be recovered for any condition that existed at the time of a child’s birth if the claim is that the defendant’s act or omission contributed to the mother’s not having obtained an abortion.”).

18. *Id.*

19. See Sherry F. Colb, *An Oklahoma Abortion Law Raises New and Different Rights Questions*, FINDLAW (July 21, 2010), <http://writ.news.findlaw.com/colb/20100721.html> (last visited Dec. 31, 2013) (analyzing liability preclusion law) (on file with the Washington and Lee Law Review). As with any medical intervention, physicians are generally expected to engage in counseling that should be nondirective and should err on the side of disclosure. See AM. MED. ASS’N COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, OP. 8.082: WITHHOLDING INFORMATION FROM PATIENTS (2006), reprinted in AM. MED. ASS’N, CODE OF MEDICAL ETHICS: COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS CURRENT OPINIONS WITH ANNOTATIONS 253–54 (2008–2009 ed. 2008) (“Withholding medical information from patients without their knowledge or consent is ethically unacceptable.”); see also Sonia M. Suter, Note, *Whose Genes Are These Anyway?: Familial Conflicts Over Access to Genetic Information*, 91 MICH. L. REV. 1854, 1894 (1993) (discussing the nondirective counseling approach used in genetic counseling, in which patients are given full access to information so that they can make informed decisions based on their values and beliefs).

for their families. Dr. Rina Anderson's story illustrates this point.²⁰ Dr. Anderson worked in private practice after her OB/GYN residency.²¹ Her practice allowed her to provide pregnancy terminations in cases of fetal anomalies.²² Dr. Anderson regularly performed second trimester abortions in these circumstances.²³ Unfortunately, she found herself faced with making the same difficult decision as her patients when, during her second trimester of pregnancy, her doctor discovered a fatal diagnosis.²⁴

Dr. Anderson initially decided to terminate the pregnancy since she had four months remaining and was told the fetus would likely die in utero.²⁵ Describing her own loss, Dr. Anderson explained how she made a choice that surprised even her:

Actually, with our daughter we were faced with the same decision. And in the end we actually ended up choosing perinatal hospice. Kind of funny, how life takes you. We got all of her diagnoses And I called my [practice] partner and my friend and I'm like, "Okay, I'm coming to the hospital tomorrow. I'm signing the forms. We'll induce over the weekend."

And then I changed my mind. You know, for me there was no—I don't really know, you know, it was kind of the inner voice that said, "Don't do it. Maybe you might get time with her or something." And we ultimately, we did, we got ten days with her.²⁶

Dr. Anderson further explained her feelings about her decision and the time she had left as follows:

We just waited to see whatever would happen. . . . And I actually thought she was probably going to die in utero but she didn't And then we ended up going into labor and having a regular labor up here [in the hospital] They had said with

20. LORI FREEDMAN, WILLING AND UNABLE: DOCTORS' CONSTRAINTS IN ABORTION CARE 86–89 (2010) [hereinafter FREEDMAN, WILLING AND UNABLE].

21. *Id.* at 90.

22. *Id.*

23. *Id.* at 77–78.

24. *Id.* at 86–87.

25. *Id.* at 87.

26. *Id.* at 87 (footnotes omitted).

one of the birth defects that she had, only about 3 percent make it to term, so we felt pretty lucky from that respect.²⁷

In telling her story, Dr. Anderson emphasized that “people can be pro-choice and still choose other options, as she did,”²⁸ but it is only a *choice* if patients have the information to make that decision. As stated in *Canterbury v. Spence*,²⁹ a landmark case on the law of informed consent, “the patient’s right of self-decision . . . can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.”³⁰ Without information, women and their families who would choose to keep the pregnancy as Dr. Anderson did will not have the opportunity to prepare emotionally for an infant’s serious illness or death and thus, as in her case, appreciate the time they might have; or to arrange appropriate care such as perinatal hospice; or to take financial steps to provide for a disabled child.³¹ Furthermore, certain fetal conditions require special care in utero. Early knowledge, decision-making, and intervention “[are] key to a positive outcome.”³² In addition, in some cases testing can reveal information about fetal characteristics that could threaten the mother’s health.³³ Once again, this assertedly antiabortion law affects far more than simply abortion decisions.

27. *Id.*

28. *Id.* at 88 (internal quotation marks omitted).

29. 464 F.2d 772 (D.C. Cir. 1972).

30. *Id.* at 786.

31. See Jaime Staples King, *Not This Child: Constitutional Questions in Regulating Noninvasive Prenatal Genetic Diagnosis and Selective Abortion*, 60 UCLA L. REV. 2, 65 (2012)

[Early prenatal screening information] could help inform prospective parents’ decisionmaking regarding how best to care for their children both while they are in the womb and after they are born. . . . [A]dvanced knowledge regarding a child’s medical or behavioral conditions can enable a parent to prepare for a child’s medical, nutritional, educational, and social needs as early as possible.

See also Sujatha Jesudason & Julia Epstein, Editorial, *The Paradox of Disability in Abortion Debates: Bringing the Pro-Choice and Disability Rights Communities Together*, 84 CONTRACEPTION 541, 541–43 (2011) (arguing for a reproductive justice approach to protecting disability rights and reproductive rights, which includes access to information).

32. King, *supra* note 31, at 65.

33. See Jaime S. King, *And Genetic Testing for All . . . The Coming Revolution in Non-Evasive Prenatal Genetic Testing*, 42 RUTGERS L.J. 599, 605–

Furthermore, liability preclusion laws that provide an incentive for physicians to withhold material information and deviate from standards of care do little to address substantive concerns about disability discrimination. Laws like Oklahoma's obfuscate more substantive conversation about the need for government resources to support families with disabled children so that real choices can be made.³⁴ As early genetic screening becomes easier and more effective, we are likely to see more efforts towards information control as a method of regulating abortion. These information prohibitions targeted at abortion inevitably will affect all women and their families making decisions in the context of prenatal care, regardless of what may be their ultimate choice.³⁵ The implications of information restrictions on a wide array of pregnant women's healthcare options may raise concerns for the public if these side effects were made visible.

*C. "Conscience" Protection and Pregnancy-Related Care at
Sectarian Hospitals*

Both federal and state laws—known as “conscience clauses”—protect the right of institutions and individuals to refuse to provide abortion care and other medical care to which they conscientiously object.³⁶ Conscience legislation shields

06 (2011) (discussing a variety of pregnancy complications which can be discovered through prenatal testing).

34. See Jesudason & Epstein, *supra* note 31, at 541–42 (noting that “[a]nti-choice advocates tend to idealize disability while opposing the entitlement programs and government funding of social services, such as state developmental disability programs . . . that would make raising a child with a disability more possible”).

35. For example, a number of states have already passed bans on abortion if the reason for seeking the abortion is because of the fetus's sex. See King, *supra* note 31, at 26 n.128 (citing statutes from Illinois, Pennsylvania, and Oklahoma prohibiting abortions based solely on the fetus's sex). If states choose to ban access to information on the sex of the fetus, such an information ban could also affect health issues since some genetic diseases are sex-linked. See *id.* at 26–30 (discussing sex-based abortion bans, and stating that they provide an obstacle to a woman's ability to access the necessary information to make an informed abortion decision).

36. See Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1503 (2012) (describing and critiquing conscience legislation).

institutional and individual actors from liability for their refusal to provide care even if it contravenes accepted medical standards.³⁷ Although claiming to restrict only abortion provision, the refusal policies of many privately owned sectarian hospitals, ensured protection by conscience legislation, impede physicians' ability to provide appropriate care for pregnant women who are not actively seeking abortion care. In particular, pregnant women with emergent conditions such as a miscarriage or an ectopic pregnancy face risks to their health due to abortion restrictions.

Although other types of hospitals may also prohibit or limit reproductive health services, Catholic-owned hospitals represent the largest percentage of religiously affiliated hospitals, "operating 15.2% of the nation's hospital beds, and increasingly they are the only hospitals in certain regions within the United States."³⁸ This market share results in both Catholic and non-Catholic patients depending on Catholic hospitals for their care. Yet Catholic hospitals neither inform women of the full extent of the limits of their care, nor do they leave the decision of whether and when to terminate a pregnancy to the patient even in the context of a dire emergency.³⁹ Research indicates that pregnant women who are miscarrying, even long before viability, may face serious risks to their health due to antiabortion policies at some hospitals.⁴⁰ The increased risks are primarily due to delays in

37. See *id.* (discussing the protections conscience clause legislation provides to doctors who refuse to perform procedures they object to, even if they violate institutional policies).

38. Lori R. Freedman, Uta Landy & Jody Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1774 (2008) [hereinafter Freedman et al., *When There's a Heartbeat*]; see also FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 119–20 (discussing the recent growth of Catholic hospitals' presence across America).

39. See Freedman et al., *When There's a Heartbeat*, *supra* note 38, at 1174–75 (discussing the fact that Catholic hospitals follow their own internal protocols as to whether or not an abortion can be performed without regard for the woman's decision, even in cases of medical emergency); JoNel Aleccia, *Catholic Hospital's Religious Rules Led to Negligent Care Miscarriage*, *ACLU Says*, NBC NEWS (Dec. 2, 2013, 5:37 PM), <http://www.nbcnews.com/health/catholic-hospitals-religious-rules-led-negligent-care-miscarriage-aclu-says-2D11674429> (last visited Dec. 31, 2013) (describing the story of a pregnant woman who was not told that her fetus had little chance of survival, despite the fact that the pregnancy was endangering the woman's health) (on file with the Washington and Lee Law Review).

40. See Freedman et al., *When There's a Heartbeat*, *supra* note 38, at 1778

care, in contravention to the accepted standards of care in miscarriage management.⁴¹

A number of physicians employed at Catholic hospitals have even confessed to subterfuge in the aim of protecting their patients' health.⁴² In one case, Dr. Brian Smits, a perinatologist, reported resigning his position at a Catholic hospital rather than be subject to hospital ethics committee decisions that harmed his patients.⁴³ Dr. Smits described the situation that instigated his resignation and his surreptitious violation of protocol in order to save his patient's life:

I'll never forget this; it was awful—I had one of my partners accept this patient at 19 weeks. The pregnancy was in the vagina. It was over. . . . I'm on call when she gets septic, and she's septic to the point that I'm . . . trying to keep her blood pressure up, and I have her on a cooling blanket because she's 106 degrees. And I needed to get everything out [of the uterus]. And so I put the ultrasound machine on and there was still a heartbeat, and [the ethics committee] wouldn't let me because there was still a heartbeat. This woman is dying before our eyes. I went in to examine her, and I was able to find the umbilical cord through the membranes and just snapped the umbilical cord and so that I could put the ultrasound—"Oh look. No heartbeat. Let's go." She was so sick she was in the [intensive care unit] for about 10 days and very nearly died. . . . Her bleeding was so bad that the sclera, the white of her eyes, were red, filled with blood. . . . And I said, "I

(discussing the fact that women seeking abortion treatment at Catholic hospitals "may receive treatment that is riskier and less comfortable than the care provided in non-Catholic medical settings").

41. *See id.* at 1775

According to the generally accepted standards of care in miscarriage management, abortion is medically indicated under certain circumstances in the presence of fetal heart tones. Such cases include first-trimester septic or inevitable miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman.

42. *See id.* at 1776–77 (detailing several stories of physicians who circumvented ethics committee dictates in order to follow the standards of care they had learned in residency).

43. *See* FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 118–21 (discussing Dr. Brian Smits's experiences working in perinatology in a Catholic hospital); *see also* Freedman et al., *When There's a Heartbeat*, *supra* note 38, at 1777 (telling the same story of Dr. Smits).

just can't do this. . . . This is not worth it to me." That's why I left.⁴⁴

Dr. Smits had assumed that the prohibition of abortion at his Catholic hospital would affect only his ability to offer abortions to patients with fetal anomalies or medical contraindications to pregnancy who would actively seek abortion care, which he could readily refer to abortion clinics outside the hospital.⁴⁵ He had not expected "a disjuncture between what he considered to be the standard of care in miscarriage management and what was acceptable to his hospital's ethics committee."⁴⁶ When asked what eventually happened to his patient, Dr. Smits stated: "She actually had pretty bad pulmonary disease and wound up being chronically oxygen-dependent, and as far as I know, [she] still is, years later. But, you know, she's really lucky to be alive."⁴⁷

In addition to the miscarriage management scenarios, sectarian hospitals may also deviate from standards of medical care in the context of ectopic pregnancies. An ectopic pregnancy occurs when a fertilized egg implants outside the uterus (such as in the fallopian tube), has no chance of survival, and threatens the life of the pregnant woman.⁴⁸ The generally accepted standard of care dictates termination of the pregnancy, which can be done directly with medication that ends the pregnancy but preserves the fallopian tube.⁴⁹ However, strict interpretation of Catholic doctrine would require the entire fallopian tube be removed so the physician only indirectly kills the fetus.⁵⁰

44. Freedman et al., *When There's a Heartbeat*, *supra* note 38, at 1777.

45. FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 121.

46. *Id.*

47. *Id.* at 133.

48. See NAT'L HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN 56–58 (2010), http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf (discussing ectopic pregnancies, the method of removal for ectopic pregnancies, and the fact that ectopic pregnancies "by definition cannot be brought to term").

49. FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 170 n.5 (stating that the use of medication abortion preserves a woman's use of both fallopian tubes).

50. See *id.* (discussing the strict Catholic position on abortion); Marie A. Anderson, et al., *Ectopic Pregnancy and Catholic Morality: A Response to Recent Arguments in Favor of Salpingostomy and Methotrexate*, 11.1 NAT'L CATH. BIOETHICS Q. 667, 681–83 (2011), <http://johnpaulbioethics.org/FinalProofs.pdf>

Assuming two functioning fallopian tubes, the woman would lose fifty percent of her fertility.⁵¹

The research on “conscience” refusals at Catholic hospitals also belies the claim that a “health exception” to abortion restrictions will be sufficient to preserve women’s health in the case of medically necessary pregnancy terminations.⁵² Medicine, particularly in the context of prenatal care, is not an exact science.⁵³ The overlay of vague legal rules on complex and time-

(discussing various Catholic positions on salpingostomy and methotrexate).

51. See FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 170 n.5 (discussing the impact of the Catholic position on fertility); see also Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, 21 WOMEN’S HEALTH ISSUES 104, 106–07 (2011) (recounting physicians’ reports and stories about the effect that the Ethical and Religious directives for Catholic Health Care has had on their treatment of ectopic pregnancies).

52. The exceptions to protect the woman’s health outlined in Catholic hospital directives are vague and contested, and hospital ethics committees’ effectuation of Catholic doctrine has led to delays in care resulting in psychological trauma, physical injury, and, in one recent case in Ireland, death. See FREEDMAN, WILLING AND UNABLE, *supra* note 20, at 122–27 (discussing history of the Catholic health care Directives, vagueness on whether the exception only protects life or also health, and debates in implementing the Directives); Shawn Pogatchnik, *Savita Halappanavar Dead: Irish Woman Denied Abortion Dies from Blood Poisoning*, HUFFINGTON POST (Nov. 14, 2012, 4:20 PM), http://www.huffingtonpost.com/2012/11/14/savita-halappanavar-death-irish-woman-denied-abortion-dies_n_2128696.html (last visited Dec. 31, 2013) (describing abortion law in Ireland and the story surrounding the death of a pregnant woman in Ireland who was denied an abortion during a miscarriage) (on file with the Washington and Lee Law Review). See also SABARATNAM ARULKUMARAN ET AL., FINAL REPORT: INVESTIGATION OF INCIDENT 50278 FROM TIME OF PATIENT’S SELF REFERRAL TO HOSPITAL ON THE 21ST OF OCTOBER 2012 TO THE PATIENT’S DEATH ON THE 28TH OF OCTOBER, 2012, at 70 (2013) (stating, in the government’s investigative report, that a key causal factor in Savita Halappanavar’s death was “legislative factors affecting medical considerations” that resulted in a “failure to offer all management options to a patient experiencing inevitable miscarriage”).

53. See Maria Manriquez et al., Commentary, *Abortion Bills Out of Line with Accepted Standards of Prenatal Care*, ARIZ. CAPITOL TIMES (Apr. 6, 2012) <http://azcapitoltimes.com/news/2012/04/06/abortion-bills-out-of-line-with-accepted-standards-of-prenatal-care/> (last visited Feb. 19, 2014) (“The practice of medicine is as much an art as a science.”) (on file with the Washington and Lee Law Review). This opinion piece by three OB/GYNs also discusses the side effects of bans on abortion at 20 weeks, stating that Arizona’s 20-week ban on abortion would affect all physicians practicing obstetrics even if they do not provide abortions since the 20-week timeline “is simply not in line with routine prenatal care” and may even instigate abortions without full information “because of the arbitrary time constraints.” *Id.*

sensitive medical decision-making remains insufficient to protect women's health.

D. Medication Abortion Restrictions and Ectopic Pregnancy

Similarly to concerns about treatment at sectarian hospitals, state laws restricting access to medication abortion may impede appropriate care for ectopic pregnancies. The United States Food and Drug Administration (FDA) approved medication abortion—termination of pregnancy by drugs as opposed to surgery—in 2000.⁵⁴ Since that time, states have enacted several types of legislation aimed at restricting access to medication abortion.⁵⁵ A few states have enacted legislation demanding that medication abortion be provided in accordance with outdated FDA-approved protocols rather than more recently developed regimens.⁵⁶

Medication abortion is highly effective and safe.⁵⁷ Between 2000 and 2011, 1.52 million women in the United States used medication abortion.⁵⁸ Of that group, only 612 suffered complications requiring hospitalization.⁵⁹ The drug used for a medication abortion, sold in the United States under the brand

54. See GUTTMACHER INST., STATE POLICIES IN BRIEF: MEDICATION ABORTION (2013), http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (discussing the state law restrictions created after the FDA's approval of medication abortions in 2000).

55. Oklahoma adopted one such law, which was nearly reviewed by the U.S. Supreme Court. See *id.* (summarizing state legislation restricting medication abortion).

56. See OKLA. STAT. tit. 63, § 1-729a (2011), *invalidated by* Okla. Coal. for Reprod. Justice v. Cline, 292 P.3d 27 (Okla. 2012) (restricting the use of medical abortions to the methods expressly allowed by FDA protocol).

57. See Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, GUTTMACHER POL'Y REV., Winter 2013, at 18 (stating that medication abortion's success rate, at 92–95%, is comparable to that of surgical abortion, and summarizing data on safety).

58. See *id.* (discussing statistics for the use of medication abortions in the United States).

59. See *id.* (noting that those hospitalizations occurred “most frequently because they required a transfusion due to excessive bleeding”). From 2000 to 2011, there were eight documented cases of U.S. women dying from a severe infection after taking the drug approved for medication abortion. *Id.* FDA investigations into these deaths found no evidence of a causal connection between Mifeprex and the infections. *Id.*

name “Mifeprex,” actually consists of two different medications. The first, mifepristone, blocks a hormone (progesterone) necessary for a pregnancy to continue.⁶⁰ “The second drug, misoprostol, induces uterine contractions.”⁶¹ The FDA protocol for Mifeprex approved in 2000 specified a 600 milligram (mg) oral dose of mifepristone, and then two days later a 400 microgram oral dose of misoprostol.⁶² The FDA regimen also approved use of medication abortion for up to 49 days after a woman’s last menstrual period.⁶³

The FDA based these treatment protocols on a French regimen developed in 1988 that was already out of date when it was adopted in 2000.⁶⁴ Researchers had confirmed that alternative evidence-based treatment regimens were safe and effective. These alternative regimens had numerous benefits, including a significantly lower dose of mifepristone (200 mg as opposed to 600 mg), enhanced patient privacy through in-home administration of misoprostol, and effectiveness of medication abortion through 63 days’ gestation.⁶⁵ These alternative regimens quickly became the accepted standard of care for medication abortion as early as 2001.⁶⁶

To understand how this came to be, it is important to understand how medical practice related to the FDA’s regulation of drugs generally operates in the United States. In American medicine, it is standard medical practice to prescribe medications “off label”—that is to prescribe medications in ways that deviate from FDA-approved protocols.⁶⁷ The American Medical

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at 19.

65. *Id.*

66. *See id.* (noting that as far back as 2001 approximately 83% of U.S. providers were no longer using the FDA-approved regimen); *see also* M.J. Wiegierinck et al., *Medical Abortion Practices: A Survey of National Abortion Federation Members in the United States*, 78 *CONTRACEPTION* 486, 488–89 (2008) (noting that “alternative evidence-based regimens had already been shown to be associated with a lower frequency of side effects”).

67. *See* Boonstra, *supra* note 57, at 19 (describing the prevalence of off-label prescriptions, and stating that “[i]n an examination of 160 commonly used medications, 21% of prescriptions were for off-label use”).

Association strongly defends off-label (or “evidence-based”) uses, and it is a widespread practice by physicians in every specialty of medicine, far outside of abortion care.⁶⁸ As evidence-based practice develops, the off-label uses of a drug can become the standard of care. In many cases, off-label prescriptions of particular medications become widely entrenched in clinical practice without being returned to the FDA for revised labeling, to the point that strictly *following* FDA drug regimens could lead to malpractice verdicts or professional discipline for violating the standard of care.⁶⁹

Despite alternative regimens becoming the accepted standard of care in medication abortion, and despite evidence that the availability of Mifeprex has appeared to accelerate the trend to earlier abortion care, Oklahoma and several other states have enacted legislation prohibiting off-label uses for abortion-inducing drugs.⁷⁰ There do not appear to be any other state laws that prohibit off-label uses of drugs in any other medical specialty, even for children.⁷¹ Oklahoma’s legislation is so broadly

68. See *id.* (“In an examination of 160 commonly used medications, 21% of prescriptions were for ‘off-label’ use”); *Use of Approved Drugs for Unlabeled Indications*, FDA DRUG BULLETIN, Apr. 1982, at 4, 4–5 (stating that “‘unapproved’ or, more precisely, ‘unlabeled’ uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature”); David C. Radley et al., *Off-label Prescribing Among Office-Based Physicians*, 166 ARCHIVES OF INTERNAL MED. 1021, 1021–26 (2006) (discussing the frequent use of off-label medications).

69. See Christopher M. Wittich et al., *Ten Common Questions (and Their Answers) About Off-Label Drug Use*, 87 MAYO CLINIC PROCEEDINGS 982, 983 (2012) (discussing the fact that off-label drug use can “become the predominant treatment for a given clinical condition”); Mark Herrmann & Pearson Bownas, *Keeping the Label Out of the Case*, 103 NW. U. L. REV. COLLOQUY 477, 486 (2009) (discussing situations in which off-label use is the standard of care and instances when it may be a violation of the standard of care *not* to prescribe off-label); Veronica Henry, *Off-Label Prescribing: Legal Implications*, 20 J. LEGAL MED. 365, 380 (1999) (“Off-label drug use often is medically appropriate and, in some cases, may represent the standard of care. The failure to administer a drug for an off-label indication when it is clearly in the patient’s best interest creates potential liability.”) Furthermore, in many cases drug companies do not seek approval for off-label uses “because of the expensive and time-consuming process in obtaining the FDA’s approval.” *Id.* at 369.

70. See GUTTMACHER INST., *supra* note 54 (listing Arizona, North Dakota, Oklahoma, Ohio, and Texas as states that have statutes requiring FDA protocol to be followed when medical abortion is used).

71. See Boonstra, *supra* note 57, at 19 (noting that off-label use of

worded that it appeared not only to ban medication abortion in its entirety but also to ban the safest method of treatment for ectopic pregnancies.⁷² In particular, the statute prohibits the off-label use of “any abortion-inducing drug,” which the statute defines to include methotrexate.⁷³ Yet the standard of care for treatment of early ectopic pregnancy is the off-label use of methotrexate—the go-to drug for medical as opposed to surgical termination of the pregnancy.⁷⁴

In 2012, the Oklahoma Supreme Court struck down the statute. The trial court, which also held the statute unconstitutional, stated that the law was “so completely at odds with the standard that governs the practice of medicine that it

medication is common in pediatric care since children are typically excluded from clinical drug studies); Hank Greely, *Cline v. Oklahoma Coalition for Reproductive Justice: A Fascinating Supreme Court (Sort of) Abortion, FDA, and First Amendment Case*, STANFORD LAW SCH. (July 4, 2013), <http://blogs.law.stanford.edu/lawandbiosciences/2013/07/04/cline-v-oklahoma-coalition-for-reproductive-justice-a-fascinating-supreme-court-sort-of-abortion-fda-and-first-amendment-case/> (last visited Jan. 1, 2014) (noting that neither federal nor state statutes prohibit off-label uses of medications, with the exception of certain performance enhancing drugs that are treated as controlled substances due to abuse by athletes) (on file with the Washington and Lee Law Review).

72. See OKLA. STAT. tit. 63, § 1-729a (2011), *invalidated by* Okla. Coal. for Reprod. Justice v. Cline, 292 P.3d 27 (Okla. 2012). The statute provides in relevant part:

No physician who provides RU-486 (mifepristone) or any abortion-inducing drug shall knowingly or recklessly fail to provide or prescribe the RU-486 (mifepristone) or any abortion-inducing drug according to the protocol tested and authorized by the U.S. Food and Drug Administration and as authorized in the drug label for the RU-486 (mifepristone) or any abortion-inducing drug.

Id. § 1-729a(C) (emphasis added).

73. See *id.* § 1-729a(A)(1) (“Abortion-inducing drug’ means a medicine . . . dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman This includes off-label use of drugs . . . such as misoprostol (Cytotec), and methotrexate.”).

74. Wiegerinck et al., *supra* note 66, at 488 (noting that methotrexate has never been labeled for use as an abortifacient by the FDA, but “it has long been used off-label for several indications, including management of early ectopic pregnancy”); Am. Soc’y for Reprod. Med., *Medical Treatment of Ectopic Pregnancy: A Committee Opinion*, 100 FERTILITY & STERILITY 638, 639 (2013) (“Medical treatment protocols for MTX were established in the late 1980s and have become widely accepted as primary treatment for ectopic pregnancy.”).

can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those women who do.”⁷⁵ In a terse memorandum opinion, the Oklahoma Supreme Court declared the legislation facially unconstitutional, relying solely on the U.S. Supreme Court’s holding in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁷⁶

The state petitioned for certiorari to the U.S. Supreme Court and, on June 27, 2013, the Court granted the petition. However, in a surprising move, the U.S. Supreme Court utilized a procedure provided for in Oklahoma law asking the state court for a legal interpretation of the state’s statute. The Court placed the case on hold pending the Oklahoma Supreme Court’s response to several questions posed to it by the U.S. Supreme Court, including whether the Oklahoma statute bans methotrexate to treat ectopic pregnancies.⁷⁷ The Oklahoma Supreme Court concluded that the statute “restricts the long-respected medical discretion of physicians in the specific context of abortion” and in fact bans all medication abortions, including medical termination of ectopic pregnancy by off-label use of

75. Okla. Coal. for Reprod. Justice v. Cline, No. CV-2011-1722 (Okla. Dist. Ct. Okla. City May 11, 2012) (order granting summary judgment).

76. 505 U.S. 833 (1992). *See also* Okla. Coalition for Reprod. Justice v. Cline, 292 P.3d 27, 27 (Okla. 2012) (stating that the holding in *Planned Parenthood of Southeastern Pennsylvania v. Casey* is controlling on the facts of the case and that Supremacy Clause binds the Oklahoma Supreme Court to follow that holding).

77. Cline v. Okla. Coal. for Reprod. Justice, 133 S. Ct. 2887 (2013) (mem.). The Court’s order reads, in full:

The petition for a writ of certiorari is granted. This Court, pursuant to the Revised Uniform Certification of Questions of Law Act, Okla. Stat., Tit. 20, § 1601 *et seq.* (West 2002), respectfully certifies to the Supreme Court of Oklahoma the following question: Whether H.B. No. 1970, Section 1, Chapter 216, O.S.L. 2011 prohibits: (1) the use of misoprostol to induce abortions, including the use of misoprostol in conjunction with mifepristone according to a protocol approved by the Food and Drug Administration; and (2) the use of methotrexate to treat ectopic pregnancies. Further proceedings in this case are reserved pending receipt of a response from the Supreme Court of Oklahoma.

Id.

methotrexate.⁷⁸ The Supreme Court ultimately dismissed the case as improvidently granted.⁷⁹

Although the Supreme Court has yet to opine on restrictions on medication abortion, the Oklahoma case once again illustrates how laws apparently targeted at abortion inevitably affect other related areas of women's medical care.

* * *

All of the above stories illustrate that abortion care cannot be isolated from women's healthcare as a whole. Any pregnant woman is a *potential* abortion patient. Limits on access to abortion care place pregnant women's health and personal decision-making at risk regardless of whether they are actively seeking abortion care.

III. *Roe v. Wade and Abortion as Medical Care*

The current segregation of abortion from women's healthcare brings us back to questions that have long been raised by *Roe v. Wade*. One oft-heard criticism of *Roe* is that it overemphasized abortion as a medical decision and the physician's role in that decision.⁸⁰ Although *Roe* was rightly criticized as overmedicalizing abortion decision-making and empowering doctors rather than women, we have now shifted to the opposite extreme. Today, abortion is hardly considered medical care at all. The Supreme Court's most recent abortion decision, *Gonzales v. Carhart*,⁸¹ bears a striking contrast to *Roe* in this regard. In *Carhart*, the Supreme Court described the abortion decision as purely political in nature and one that is made as a matter of "convenience."⁸² The Court ignored extensive medical evidence on

78. *Cline v. Okla. Coal. for Reprod. Justice*, 313 P.3d 253, 262 (Okla. 2013).

79. *Cline v. Okla. Coal. for Reprod. Justice*, 134 S. Ct. 550, 550 (2013).

80. See, e.g., Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L. REV. 183, 197–201 (1985) (discussing the fact that the language in *Roe* "portrays the doctor, and not the patient as the primary decision-maker in the abortion context").

81. See *supra* note 8 and accompanying text.

82. *Gonzales v. Carhart*, 550 U.S. 124, 186–87 (2007) (Ginsburg, J., dissenting).

the health reasons for employing the banned procedure, leaving it to legislatures and courts, rather than physicians and their patients, to determine how best to protect women's health.⁸³

Yet many types of abortion restrictions have unintended consequences that impede the provision of basic healthcare for women.⁸⁴ Focusing the public's attention on the side effects of various antiabortion laws could help to unmask the links between abortion and women's healthcare. The public needs more education about how attacks on abortion affect women along a spectrum of medical needs. Efforts in this direction could help bring back "a whole body, experience-based understanding of women's health that is predicate to gender equality and civic participation"—a view of women's health that Professor Lisa Ikemoto argues is being eroded under current health policies.⁸⁵

Surfacing the spillover effects of abortion restrictions could help decision-makers better see and understand the links between abortion and women's healthcare. Realigning abortion with healthcare and repositioning the law to recognize access to abortion care as a critical part of the continuum of women's medical needs is essential to protecting women's health. As Professor Jessie Hill has argued, "describing abortion as an aspect of health care may get members of the public to recognize the intrusive and harmful nature of anti-choice legislation, much of which . . . directly regulates the intimate relationship between physician and patient."⁸⁶ The public appears to be sympathetic to criticism of government intrusion into healthcare decision-making, even where abortion may be an aspect of those

83. See *id.* at 164–68 (majority opinion) (discussing the deference that must be given to the legislature and the fact that "[t]he Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health").

84. Of course, restrictions on abortion also detrimentally affect women's health since many women may resort to riskier illegal measures to terminate unwanted pregnancies when legal abortion is unavailable. See Dan Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, CONTRACEPTION (forthcoming) (discussing the rise of "abortion self-induction" in Texas after abortion access was restricted within the state).

85. Ikemoto, *supra* note 2, at 732.

86. B. Jessie Hill, *Abortion as Health Care*, AM. J. BIOETHICS, Dec. 1, 2010, at 48, 49.

decisions.⁸⁷ To be clear, I am not arguing that abortion is *only* a medical issue, as *Roe* incorrectly claimed. Rather, seeing and understanding abortion as healthcare offers one important and useful approach for bolstering access to safe and legal abortion, along with emphasis on the importance of abortion rights for preserving women's equality and liberty.

IV. Conclusion

Abortion is both a social *and* a medical issue. Although some segments of the public have been supportive of legislation that appears to target only abortion, that support may wane if the detrimental effects of these laws on women's health were more fully understood. As a practical matter, abortion cannot be isolated from women's healthcare. Educating the public about the interconnectedness of abortion care with other aspects of women's medical care remains crucial to unmasking the links between abortion and healthcare. Laws attacking abortion, inevitably, have wider consequences for women's health.

87. For example, the defeat of an antiabortion "personhood" proposal in Mississippi appeared due at least in part to "concerns that the measure would empower the government to intrude in intimate medical decisions" related to pregnancy care and reproductive healthcare. Denise Grady, *Medical Nuances Drove 'No' Vote in Mississippi*, N.Y. TIMES, Nov. 15, 2011, at D1.