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SIDE EFFECTS OF THE ABORTION WARS

Maya Manian*

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

While it remains important to understand abortion access as necessary to sustaining women's right to equal citizenship, the public's perception of abortion as a medical issue has receded to the point that we have lost sight of abortion care as health care—and this shift in framing has contributed to the loss of access to care.³ One way we can recover the notion of abortion as health care is to focus on the side effects of anti-abortion laws on women's health care. This essay challenges the false assumption that abortion care can be segregated from women's medical care and targeted for special restrictions without any ripple effects on women's health more broadly. As a matter of medical reality, abortion cannot be isolated from women's health care more broadly. In fact, existing abortion restrictions

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¹ *Roe v. Wade*, 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 in numerous legal contexts).

³ See, e.g., Yvonne Lindgren, *The Rhetoric of Choice: Restoring Health care to the Abortion Right*, 64 HASTINGS L.J. 385 (2013).

harm women's health even for women not actively seeking abortion care, but these effects remain obscured.⁴

This essay unmasks the ripple effects of abortion restrictions that, perhaps unintentionally, impede the provision of basic health care 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 health care. Uncovering these links could also create stronger support for access to abortion and thereby better promote full health care 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 HEALTH CARE CONSEQUENCES OF ABORTION RESTRICTIONS

Part of the popularity of anti-abortion 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 health care, but the public has failed to discern these harmful impacts. Below, I describe three examples of how existing anti-abortion government regulation detrimentally affects related health care for women.

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*, illustrates how laws aimed at abortion impede medical care even for women not actively seeking abortion care.⁷ 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.⁸ 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

⁴ See *infra*, Part II (discussing the health care implications of abortion legislation).

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 *Gonzales v. Carhart*, 550 U.S. 124 (2007).

⁸ Cynthia Gorney, *Gambling with Abortion: Why Both Sides Think They Have Everything to Lose*, HARPER'S MAG., Nov. 2004, at 33–34.

years of litigation gave the impression that a ban on intact D&E would only affect a small number of women seeking abortions late in their pregnancy.⁹ 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 anti-abortion policies on physicians, found that some physicians who do not routinely provide abortions nevertheless feel constrained by the ban.¹⁰ For example, one physician felt unable to treat her patient in the safest manner she thought possible due to fear of violating the law while attempting to care for a patient who was miscarrying during the second trimester of pregnancy.¹¹ The physician, who told this story confidentially, explained as follows:

Dr. B:

[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 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?'¹²

In fact, technically this situation would not fall within the scope of the federal “partial-birth” abortion ban, since the physician did not start the procedure with an intent to perform an intact D&E.¹³ 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.¹⁴ Professor Tracy Weitz argues that the law has become its own “Panopticon,” a perpetual surveillance system that inhibits not just

⁹ 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.”).

¹⁰ Tracy A. Weitz, *Lessons for the Prochoice Movement from the 'Partial Birth Abortion' Fight*, XXXIII CONSCIENCE, 26, 28 (2012).

¹¹ *Id.* (describing the story of Dr. B, as told by Lori Freedman at a San Francisco General Hospital Abortion Discussion Group).

¹² *Id.* at 28 (quoting from a presentation by Lori Freedman).

¹³ See *id.* (stating that the standard for criminal prosecution would “probably” not be met because Dr. B lacked the requisite intent).

¹⁴ *Id.* 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).

abortion care but also the care of pregnant women suffering from miscarriages.¹⁵

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.

B. “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.¹⁶ Conscience legislation shields institutional and individual actors from liability for their refusal to provide care even if it contravenes accepted medical standards.¹⁷ 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—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.”¹⁸ 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.¹⁹ Research indicates that pregnant women who are

¹⁵ *Id.*

¹⁶ See Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1503 (2012) (describing and critiquing conscience legislation).

¹⁷ 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).

¹⁸ 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 LORI R. FREEDMAN, WILLING AND UNABLE: DOCTORS’ CONSTRAINTS IN ABORTION CARE 119-20 (2010) (discussing the recent growth of Catholic hospitals’ presence across America).

¹⁹ See Freedman et al., *When There’s a Heartbeat*, *supra* note 18, 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); see also

miscarrying, even long before viability, may face serious risks to their health due to anti-abortion policies at some hospitals.²⁰ The increased risks are primarily due to delays in care, in contravention to the accepted standards of care in miscarriage management.²¹

A number of physicians employed at Catholic hospitals have even confessed to subterfuge in the aim of protecting their patients' health.²² 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.²³ 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 just can't do this. . . . This is not worth it to me." That's why I left.²⁴

Dr. Smits had assumed that the prohibition of abortion at his Catholic hospital would only affect his ability to offer abortions to patients with fetal anomalies or medical contraindications to pregnancy who would

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> (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)

²⁰ See Freedman et al., *When There's a Heartbeat*, *supra* note 18, at 1778 (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").

²¹ 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.

²² 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).

²³ See FREEDMAN, WILLING AND UNABLE, *supra* note 18, at 118–21 (discussing Dr. Brian Smits experiences working in perinatology in a Catholic hospital); see also Freedman et al., *When There's a Heartbeat*, *supra* note 18, at 1777 (telling the same story of Dr. Smits).

²⁴ Freedman et al., *When There's a Heartbeat*, *supra* note 18, at 1777.

actively seek abortion care, which he could readily refer to abortion clinics outside the hospital.²⁵ 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.”²⁶ 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.”²⁷

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.²⁸ Medicine, particularly in the context of prenatal care, is not an exact science.²⁹ The overlay of vague legal rules on complex and time sensitive medical decision-making remains insufficient to protect women’s health.

C. Pregnant Women’s End of Life Care

Although not about abortion explicitly, many state laws limit a pregnant women’s ability to effectuate end of life care decisions.³⁰ While men can plan in advance to refuse life-sustaining treatment, women of reproductive

²⁵ FREEDMAN, WILLING AND UNABLE, *supra* note 18, at 121.

²⁶ *Id.*

²⁷ *Id.* at 133.

²⁸ 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 18, 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 (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). 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 70 (2013) (government investigative report stating 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”).

²⁹ See Maria Manriquez et al., Commentary, *Abortion Bills Out of Line with Accepted Standards of Prenatal Care*, ARIZONA CAPITOL TIMES (Apr. 6, 2012), <http://azcapitoltimes.com/news/2012/04/06/abortion-bills-out-of-line-with-accepted-standards-of-prenatal-care/> (“The practice of medicine is as much an art as a science.”). This opinion piece by three OBGYNs 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.*

³⁰ Katherine Taylor, *The Pregnancy Exclusions: Respect for Women Requires Repeal*, 14 AM. J. BIOETHICS, 50–52 (2014).

age cannot because of pregnancy exclusions from laws otherwise respecting advance health care directives. These laws are clearly a part of the anti-abortion movement's push to treat fetuses as separate persons and patients under the law. The tragic case of Marlise Munoz illustrates the disturbing nature of these pregnancy exclusion laws, and demonstrates the ripple effect of anti-abortion policies on a wide range of women's health care.

Marlise Munoz was only thirty-three years old when she collapsed in November 2013 from a pulmonary embolism (a blood clot in the lungs). She was eventually pronounced brain dead. Brain death—in both medicine and law—is death. There is no possibility of “waking up” from brain death. Marlise and her husband Erick Munoz both worked as paramedics. Since their jobs routinely involved them in situations of sudden death and grieving families, Marlise had discussed her end-of-life wishes with her family and made it clear she would never want to be kept artificially alive with no hope of recovery.³¹ In most cases of brain death, the patient would be pronounced dead and medical interventions keeping her body functioning would be withdrawn. However, Marlise was fourteen weeks pregnant at the time of her death. The treating hospital argued that a Texas law forbade withdrawal of medical support from pregnant women, regardless of their wishes for end of life care, and that the law applied to Marlise even though she was dead.³² Although her husband and parents wanted to respect Marlise's desire *not* to receive medical intervention in such a medical state, and fetal health was highly uncertain, Texas officials argued that the state could use her body as an incubator against her and her family's wishes. Marlise's father put it even more bluntly to the New York Times: “All she is[,] is a host for a fetus.”³³ The Munoz family had to watch Marlise's body slowly decompose through two months of court battles before they were finally allowed to bury her.³⁴

The Texas court ultimately decided that the statute did not apply to brain dead pregnant women, but it did not reach the larger question whether limiting end of life decision making for pregnant women in other circumstances is constitutional. The Munoz case thus leaves many

³¹ See Jacquelyn Floyd, *Texas denies pregnant woman's grieving family the right to say goodbye*, DALLAS NEWS (Jan. 2014) <https://www.dallasnews.com/news/news/2014/01/03/texas-denies-pregnant-woman-s-grieving-family-the-right-to-say-goodbye>.

³² See Wendy Adele Humphrey, “*But I'm Brain-Dead and Pregnant*”: *Advance Directive Pregnancy Exclusions and End-of-Life Wishes*, 21 WM. & MARY J. WOMEN & L. 669 (2015) (describing Marlise Munoz litigation).

³³ See Manny Fernandez & Erik Eckholm, *Pregnant and Forced to Stay on Life Support*, N.Y. TIMES (Jan. 7, 2014) http://www.nytimes.com/2014/01/08/us/pregnant-and-forced-to-stay-on-life-support.html?_r=0

³⁴ See *Id.*

questions unanswered about whether pregnant women's end of life decision-making will be equally respected.

In sum, the above stories belie the claim that abortion can be isolated from women's health care as a whole. Laws and policies aimed at curtailing abortion have ripple effects that could impact any pregnant woman's medical care. Any pregnant woman is a potential abortion patient. Limits on access to abortion care place women's health and personal decision-making at risk regardless of whether they are actively seeking abortion care.

III. CONCLUSION

Many types of abortion restrictions have unintended consequences that impede the provision of basic health care for women.³⁵ Surfacing the spillover effects of abortion restrictions could help decision-makers better see and understand the links between abortion and women's health care. 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.³⁶

Realigning abortion with health care 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."³⁷ The public appears to be sympathetic to criticism of government intrusion into health care decision-making, even where abortion may be an aspect of those decisions.³⁸ To be clear, I am not arguing that abortion is *only* a medical issue, as *Roe* incorrectly claimed. Rather, seeing and understanding abortion as health care offers one important and useful approach for

³⁵ Of course, restrictions on abortion also detrimentally affect women's health since many women may resort to more risky illegal measures to terminate unwanted pregnancies when legal abortion is unavailable. See Dan Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 8 CONTRACEPTION 73, 74 (2014) (discussing the rise of "abortion self-induction" in Texas after abortion access was restricted within the state).

³⁶ Ikemoto, *supra* note 2, at 732.

³⁷ B. Jessie Hill, *Abortion as Health Care*, 10 AM. J. BIOETHICS, 48, 49 (2010).

³⁸ For example, the defeat of an anti-abortion "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 health care. Denise Grady, *Medical Nuances Drove 'No' Vote in Mississippi*, N.Y. TIMES, Nov. 15, 2011, at D1.

bolstering access to safe and legal abortion, along with emphasis on the importance of abortion rights for preserving women's equality and liberty. Laws attacking abortion, inevitably, have wider consequences for women's health.