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WEBINAR

ABORTION ACCESS IS A MEDICAL ISSUE. WHY ISN'T IT BEING TREATED LIKE ONE?

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KAMARCK: Welcome, everyone to our Brookings seminar: "Abortion access is a medical issue. Why isn't it being treated like one?" You can send questions to #AbortionHealth or to on X @Brookings.BrookingsGov with #AbortionHealth. So, let's let's begin. When the Dobbs case came down on June 4th, 2022. I told my friends somewhat, but not entirely in jest, that America was about to be exposed to a lengthy seminar on obstetrics. Most people think pregnancies are straightforward and not dangerous. And compared to the rest of human history, they are right. But in the 21st century, pregnancies still go wrong, and when they do, they create serious health consequences for women. They can impair their ability to have future children, or they can even die. Ectopic pregnancies, pre-eclampsia and a host of other pregnancy related emergencies have slowly but surely entered our public policy lexicon. And sure enough, as could have been predicted, almost two years later, we hear on a nearly daily basis a litany of horror stories about what has been happening to women because of abortion bans imposed by people, mostly men, who have no idea what the health consequences can be and who never consulted the experts when writing their legislation. For instance, Melissa Farmer, 17 weeks pregnant, was denied an abortion in Joplin, Missouri, after her amniotic fluid had emptied and the baby would not survive. She could have had a serious infection or lost her uterus, but they wouldn't terminate because there was still a fetal heartbeat. In Texas, Amanda Zurawski, 18 weeks pregnant, experienced a pre-term, pre-labor rupture of the membranes. This is fatal to the fetus, but her doctors refused to terminate because there was a fetal heartbeat. Heartbeat. She says when she went into sepsis and spent three days in intensive care. Also in Texas, Lauren Hall, a 27 year old, learned that her baby was developing without a skull or brain. She had to travel to Seattle to get an abortion. Kate Cox had a non-viable pregnancy, and she'd regularly been to the emergency room for complications. A mother of two, Kate said I never thought I would ever want or need an abortion, but this is a medical decision and it's what's needed for my health. She had to travel out of state and sued the state of Texas. We'll hear more about that later. The point here is that most post Dobbs, most women have not only denied -- they've been denied the right to control their bodies, there have been serious health consequences for many all over the country. Confusion has reigned in emergency rooms. A federal law, EMTALA – the Emergency Medical Treatment and Labor Act – requires that emergency rooms treat patients in distress. But that is not always the case, especially in states with strict abortion laws. To this point is the experience of South Carolina Representative Neal Collins, who had previously voted in favor of the fetal heartbeat bill, which bans all abortions. After a fetal heartbeat is detected around six weeks into a pregnancy. Shortly after that bill became law. Collins got a call from a doctor about a 19 year old who was at a local emergency room. She was 15 weeks pregnant. Her water broke. The attorneys told doctors that because the fetal heartbeat, because of the fetal heartbeat bill, the 15 week old had a heartbeat and the doctors could not extract the fetus. So their only choices were

to admit the 19 year old or discharge her. He said. The representative Collins, asked, how long would it take for the heartbeat to stop and was told seconds, minutes, hours, maybe days. Doctors ultimately discharged the 19 year old, who Collins said was sent home to deal with the loss on her own and faced a 50% chance of losing her uterus in the process. The doctor also told Collins there was a 10% chance the teen would develop sepsis and die. That weighs on me. Collins said, quote, I voted for that bill. These are affecting people and we're having a meeting about this. After a brief cause, Collins says Collins said he didn't get any sleep for days. A week later, he said he reached out to. A doctor who did not know how the teenager was doing. Two weeks later, she came back to the ER and the heartbeat was gone. Like Representative Neal, the whole nation is coming to terms with the consequences of the Dobbs decision and just how difficult these issues are, especially to cope withvia legislation. So to discuss these issues today, we have have with us four experts in the field. I'm going to start with Dr. Leah Torres. She is currently the medical director of the West Alabama Women's Center in Tuscaloosa, Alabama. As an OB/GYN who has fellowship trained in abortion care, she was initially hired to expand the services beyond beyond abortion in what was previously Alabama's busiest independent abortion clinic. She attended med school at the University of Illinois at Chicago. Completed her residency in Philadelphia, and earned a Master of Science in Clinical Investigation by completing her family planning fellowship at the University of Utah in Salt Lake City. Stephanie Pell is a fellow and a colleague of mine here at Brookings, and a senior editor at Lawfare. Prior to joining Brookings, she was a tenured associate professor and cyber ethics fellow at West Point's Army Cyber Institute, with a joint appointment to the departments of English and Philosophy. Her scholarly work focuses on privacy and reproductive rights and justice, surveillance, cyber ethics, cyber security, law and conflict, and the impact of technology on racial equity. Her most recent scholarly article, coauthored with Jolynn Dellinger, examines the criminalization of abortion and surveillance of women in a post Dobbs world and offers policy suggestions for mitigating privacy threats and harms catalyzed by Dobbs. Louise King is a doctor and a lawyer, and an assistant professor of obstetrics, gynecology and reproductive biology at the Harvard Medical School and a surgeon within the Division of Minimally Invasive Gynecologic Surgery at Brigham and Women's. Doctor King completed her Juris Doctorate at Tulane Law School before attending med school at the University of Texas Southwestern Medical Center. She completed her residency in obstetrics and gynecology at Parkland Hospital in Dallas, Texas, and her fellowship in middle minimally invasive surgery at Stanford University. Her areas of interest in medical ethics focus on questions of informed decision making and assisted reproduction, as well as equitable access to advanced gynecologic survey surgery. And last but not least is Doctor Suzanne Bell, PhD. She's an assistant professor at the Johns Hopkins School of Public Health. She studies patterns of contraceptive use and abortion, particularly in the context of population

based surveys. She has studied reproductive coercion in Africa, abortion restrictions on people in prison, post abortion care in Burkina Faso, and the experiences of women seeking abortion here care right here in Maryland. So with that introduction, I'm going to start with Leah. And Leah can you give us an overview of women's health in the United States today and the effects that abortion restrictions are having on pregnant women and their health?

TORRES: Absolutely. And thank you so much for having me join this amazing panel of folks here to talk about something so important, as well as life altering and life saving. I think getting information out is critical in ways I can't even describe. So on that note, our health care system. In the United States is not designed to actually help people. And it is a capitalist health care system. And I need to start with that, because after that, everything else sort of falls into place and we see the pitfalls that are failing pregnant people. And I say pregnant people instead of women very intentionally. One not only are other genders able to become pregnant, but also, unfortunately, our society devalues women and devalues certain groups of people. And so it's sort of a constant reminder that people able to become pregnant are, in fact, people and deserve the access to health care that is life saving and also, respectful of their own autonomy and their ability to determine their own life. So in the past few years and this is pre pandemic, pandemic was a little bit of an anomaly when discussing all of this right. Our maternal mortality rate has been increasing. There was a spike in 2021. In 2022, there was a decrease, but again, that was due to the Covid spike that, you know, mortality rates everywhere we're increasing. The pattern is still from even before 2018, but from 2018 to present day, an increase of maternal mortality, that is, people who are pregnant, dying during pregnancy, during birth, or within 42 days after giving birth. You can't talk about abortion without talking about maternal health. Abortion is part of a spectrum of maternal health and reproductive health care from infertility. That being, I want to be pregnant but cannot be. To abortion care, which is I am pregnant and don't want to be. And so many things fall in between. And we are in a situation right now where, as Elaine said earlier, we have attorneys telling doctors what they can and can't do. And you can imagine how absurd that sounds, but also how dangerous and terrifying that is. So in the spectrum of health care. Pregnancy is health care. Abortion is health care. Abortion care is evidence based and standard medical practice. According to the World Health Organization, the American Medical Association, the American College of Obstetricians and Gynecologists, as well as a number of other national and international organizations. Abortion care standard. It is evidence based and it is needed to save lives. Access to abortion saves lives. Consequently when pregnancy is not taken seriously. When pregnancy is not respected as the very dangerous health condition that it is, people do have death. People have morbid consequences. Heart failure for life. Diabetes for life. Blood pressure for life.

Post. You know, morbidity from stroke during pregnancy can happen. All of these consequences can result from pregnancy, which in our culture does not, is not respected as something that is potentially life threatening and 100% of the time changes one's physiology such that you do incur risks to your health and risks to your life. Every time someone is pregnant, that is a fact. That is not a belief, that is not a feeling, that is a fact. And only people who are pregnant should be the ones deciding whether or not they want to undergo those very real. Life altering and life threatening risks. It should not be some politician. It should not be some lawyer. It shouldn't even be the health care provider. It needs to be the pregnant person making those decisions. And we do not have that right now. If you take nothing else away from this discussion going forward, I would like everybody to. When reading about abortion, it has been so stigmatized as to lose its significance. So instead of thinking about abortion as abortion, I want you to think about it as autonomy. I've done this exercise myself. You can read any article. Pick one out of the news. Replace the word abortion with the word autonomy. Because that's what it is. Abortion is autonomy. It is the ability for someone to say, no, I do not want to undergo these risks. No, I do not want to risk my life. No, I do not want these changes to my body. And that is a basic human right and should be respected. Elaine. Elaine you're muted. Please start over.

KAMARCK: Okay. I'm sorry about that. I muted myself so I can cough without bothering everyone. Stephanie, we're in the courts on abortion and, as you know, today at 10:00, perhaps even while we're on this webinar, the Supreme Court will start announcing its decisions. And there are two big cases about to be decided by the court. So, Stephanie, can you bring us up to date on the legal landscape here?

PELL: Absolutely. And again, Elaine, thank you for having me as a part of this panel. As Doctor Torres noted, health care for pregnant people was far from ideal in this country. Even pre Dobbs post Dobbs, things have gotten worse because of abortion bans. Nearly two dozen states have banned or severely restrict abortion somewhere. The only exception is to save the life of the pregnant person. To enforce these bans, states have passed laws that criminalize doctors and abortion providers and those that may assist pregnant people in obtaining abortion care. From a legal perspective, I'm going to give three different examples that illustrate how abortion bans complicate, delay, or prevent pregnant people from receiving needed health care when they suffer serious complications during pregnancies, and how these issues are being addressed by the court. The first case I want to talk about was decided by the Texas Supreme Court on May 31st of this year, Zurawski v. the state of Texas. Elaine, you referenced one of the plaintiffs in your opening remarks. In this case, the center for Reproductive Rights represented 20 women and two doctors who sued the state of

Texas and certain state officials. These women suffered serious complications during their pregnancies, but were denied abortion care in Texas, with some having to travel hundreds of miles out of state to receive care. And what is important to note here is that texass abortion laws do contain exceptions for when the mother's life is at risk, or to prevent substantial impairment of a bodily function. And the center for Reproductive Rights argued that the women's medical conditions in the in these cases fell within these exceptions. But Texas doctors who treated the women feared the legal consequences for providing the care the women needed. To be clear, these consequences include felony convictions that come with significant jail time, hefty fines and loss of a medical license. There was and continues to be, confusion about how to understand and interpret the exceptions. The plaintiffs in this case were seeking to prevent the enforcement of three different Texas abortion laws because of this confusion. And one of the center for Reproductive Rights goals in bringing the case was to obtain greater clarity so that pregnant people who suffered complications and needed abortion care could receive it in Texas. Unfortunately, the court really didn't do that. It discussed what reasonable medical judgment means and how that may enable a doctor to make decisions about a patient's care. And it discussed the fact that a patient's death may not need not be imminent to receive abortion care, but it largely left the legislature or perhaps a medical board to provide further guidance. And as, other panelists, discussed, are going to discuss and have discussed, there are problems with relying on those entities. Another case illustrating how abortion bans are harming or preventing needed health care for pregnant people. As you said, Helen is due to be decided by the Supreme Court.

KAMARCK: And I. Can I interrupt right now?

PELL: Sure.

KAMARCK: The Supreme Court unanimously rejected an effort to restrict access to the abortion pill Mifepristone.

PELL: Mifepristone. Yes, yes. And that is the the other important case. I wasn't going to do it or that wasn't the case and.

KAMARCK: Oh that wasn't what they're is not. Okay.

PELL: Exactly. But but so we having I have not read obviously the Mifepristonean opinion yet. There is still one very significant case that goes directly to this issue. And as Elaine is, as you, prefaced, this involves the Emergency Medical Treatment and Labor Act, or EMTALA. And now it it's important to to start with the concept that about what EMTALA is meant to do. And it was originally passed to prevent hospitals from patient dumping. If someone showed up to an emergency room and needed care to stabilize an emergency condition, they shouldn't be denied treatment or sent to another hospital. So EMTALA says a hospital that participates in Medicare must offer stabilizing treatment to any patient with an emergency condition that seriously threatens their life or health. Pregnant people can suffer dangerous conditions that require immediate medical treatment to prevent death or serious injury, including organ failure or loss of fertility, and in some tragic cases, the required stabilizing care the only treatment that can save the person's life or prevent grave harm to their health involves terminating the pregnancy. Now, the federal government in this case sued Idaho because Idaho has passed an abortion ban, where the only exception is to save the life of the mother. There is not an exception for when termination of a pregnancy seriously threatens their health. Federal. The federal government sued Idaho because its abortion ban in so far is it would not permit a doctor to perform an abortion to prevent serious injury to a pregnant person's health. Did not comply with the EMTALA statute. And as the government argued to the Supreme Court, many pregnancy complications do not pose a threat to the women's life. When they arrive at the emergency room, but delaying care until necessary to prevent their deaths could allow the condition to deteriorate. Placing pregnant people at risk of acute and long term complications. The government explained that the situation on the ground in Idaho is showing the devastating consequences of this gap. The government told the court that one hospital system in Idaho says that right now, it's having to transfer pregnant women in medical crisis out of the state about once every other week. That is simply an untenable situation. And any day now, we will learn whether the courts resolution of the case will enable Idaho doctors to once again provide abortion care consistent with the requirements of EMTALA. The third example I'd like to briefly raise is a broader issue that is coming up in a number of different contexts. Post stops. It is the issue of personhood, where laws give personhood status to embryos or fetuses at various stages of development. You can find examples of such laws in Georgia, Alabama, and Mississippi. In these instances, embryos or fetuses are given the same rights as people under the law. And look, the anti-abortion movement has been advocating for personhood rights for embryos and fetuses for a number of years, and one of the many implications of providing personhood status to embryos or fetuses under the law is that it can create a conflict between the rights and health of the pregnant person and that of the fetus. And while EMTALA should not be construed as a statute granting fetuses personhood status, we saw a version of this argument play out in the tall a case in 1986 during the Reagan

administration. The statute was updated to expand the protection for pregnant people so that they could get the same duties to screen and stabilize if they came to an emergency room and presented a condition that was threatening the health or well-being of the fetus, even if it wasn't threatening the life or health of the pregnant person. Justice Alito suggested at oral argument that the amendment to the statute requiring the hospital to eliminate any immediate threat to the fetus makes performing an abortion, quote, antithetical to that duty, even if the pregnant person's life or health is at risk. Now, the Solicitor General pushed back forcefully on this argument, stating that the statute did nothing to displace the woman herself as an individual with an emergency medical condition when her life or health is in danger. That stabilization obligation runs to the pregnant person and makes clear that the hospital has to give the necessary stabilizing treatment. The Solicitor General also pointed out that in most of these cases, we're dealing with situations where the fetus is not viable, viable, and it is inevitable that the pregnancy will be lost. So we await the court's decision.

KAMARCK: Thank you. Thank you, Stephanie. And we are right in the middle of a court's decision now. So but we'll we'll come to that in in a minute. Luis, you are really in a unique position here, being both a doctor and a lawyer. In fact, an obstetrician and a lawyer. And the ethical questions around abortion care are myriad. How do you approach these? How do you teach these at the medical school? And finally, is there any way that a state legislature or even the Congress can come up with guidance, workable guidance on abortion?

PERKINS KING Thank you so much. I'm also deeply honored to be a part of this exceptional panel, and I do have some direct answers to your question, but before I do, I just want to highlight something that's come up in the discussions we've had so far, which is this tension of seeing a pregnant person in front of us, still a full person deserving of rights and protections. As you've been listening to the different things that have come up, including your example of the 19 year old woman that gets sent home to supper at home, right? And probably in great pain and a great rest of her life. She's incredibly lucky to be alive. That means that we've completely discounted her simply by virtue of her being pregnant as herself, a person. So in the United States, Americans are polled regularly on the topic of abortion. And it's true. And in my teaching of, medical students, master's students, many people can disagree individually about how they feel regarding the ethics of abortion for themselves. But Americans have consistently, since the 1960s, said that they wish abortion to be legal and accessible. They intuitively understand, or perhaps they've experienced something that helps them understand themselves or family members, that pregnancy is incredibly dangerous and complicated, and to ensure the safety of the people who are engaging in pregnancy. We need to ensure that abortion is

accessible as health care and as as safe as it possibly can be. Americans are not divided on this question at all, and the entirety of this debate is a political one based on desire to gain political control. It has absolutely nothing to do with ensuring that the voices and beliefs and desires of the American people are honored. So, Katie Watson is somebody I'd love to recommend everybody to read if you want to understand this tension a bit better. She wrote a lovely book. She's a colleague who's a lawyer and ethicist, titled "The Scarlet A: The Ethics, Law, and Politics of Ordinary Abortion. And I bring that up because, there's a classic story that many of us have experienced where a person who overtly describes abortion as a moral evil, maybe even, votes in that way, maybe even helps to campaign for people in that way, will then themselves avail themselves of abortion in a particular instance, and then go right back to campaigning on it in a different way. That is the tension here. And gets to Doctor Torres's discussion of the stigma of abortion. It's become a firebrand of a topic that people can center themselves around, and when they do center themselves around it, they forget either their own experience or the experience of loved ones. So again, I believe the majority of Americans don't want us to legislate abortion. They want it to be legal, and they want these decisions to happen between patients and their doctors. We've talked about a variety of different, situations in which the need for abortion can arise. And we've also talked about how difficult, in the context of restrictive statutes it can be for physicians to to decide where they can act. They know what the standard of care is. That's been defined for many years. It is a rigorous process to define the standard of care that involves the American College of OBGYN. The Society for Maternal Fetal Medicine, to some degree, the American the AMA. And physicians and experts come together and carefully define how to proceed forward in a preventative fashion to, to to ensure that we have the least amount of complications and the best outcome as a whole, taking into account the goals of care of a particular patient. So, for example, for that 19 year old woman, or for some of the issues that have arisen and in various states, the idea is to intervene before things get really bad. And that's why I'm taller, provides some protections, but in all honesty, not many. Right. Stabilizing a patient is very different from acting ahead of something becoming a real issue. As an example, again, I keep coming back to the 19 year old woman because things could have gone so terribly wrong for her. When infection arises, when somebody who's ruptured their membranes, infection can arise in the uterus and it can brew and the body can fight it off for a certain time. But if it gets into the bloodstream, what we think of as sepsis, we use that terminology. Things can turn on a dime. And the classic story of the woman in Ireland who passed away after a rupture of membranes, she. This was prior to the constitutional change in Ireland, where abortion was similarly restricted, and she presented with rupture of membranes, and she was not sick enough to proceed forward with an abortion until she was. And then it was too late and she died. We will or have seen this happen in the United States as physicians, when you come into an emergency room, if things look a little off,

we intervene quickly. If you have a slight bump in your white count indicating an infection, we start antibiotics. We figure out what's going on for you, and we intervene as fast as we can to mitigate any potential damage. But if you're pregnant, we can no longer do so. And that is the key difference here. So can legislatures encompass the entirety of obstetrics, which is incredibly complex area of medicine with an entire discipline devoted to it, multiple national organizations studying it. Can a legislator with no exact expertise somehow encompass all of the potential scenarios that will arise, and all of the potential appropriate reactions? No. First of all, it's already been done. That's our standard of care. We've established that, and this is an end run around that evidence based approach to medicine, to try to restrict and and restrict the autonomous rights of pregnant persons for political gain by changing the standard of care that would be appropriate. No, not even appropriate. Excuse me. The standard of care that we could follow. Not at all appropriate in these various states. Americans don't want that. They want to be able to make decisions with their physicians in the privacy of clinical spaces that are right for them, that are consistent with their goals of care, and that optimize the right outcomes and the best, least complicated outcomes for them.

KAMARCK: Well, thank you, Louise, that was great. And, by the way, you made reference to people who say that they're against abortion and then, in fact, have them or have their daughters or something have one. Stephanie and I, did a little bit of investigation, and we talked to Planned Parenthood in this region, in the Washington region. And you would be surprised or maybe not surprised at the number of famous people, pro, pro-life activists, etc., who in fact had somebody in their family or even themselves go in for abortion care. So, exactly to your point, and people in this area see it, see the hypocrisy pretty often. Okay. Suzanne, you have looked at abortion, and women's health in places where there's been long standing restrictions on abortion. What happens to the women in these places? And why is this topic so dangerous to women's health?

BELL: Great. Great questions. Elaine. Thank you for the introduction. I'm delighted to be here today to discuss this issue with you all. So I'm a demographer who studies fertility and fertility related behaviors, examining patterns of contraceptive use, abortion and infertility, and associated disparities at the at the population level. And much of the abortion related research I lead occurs in countries outside the United States. So I want to start briefly with a global picture of this issue and what we know from other contexts about what happens when abortion is politicized and not treated like the medical issue that it should be. Currently, two thirds of reproductive age women in the world live in settings where abortion is broadly legal. And there's been a trend towards liberalization of abortion laws in recent decades, with more than 60

countries expanding abortion access in the last 30 years, including Ireland, to to Louise's point. In contrast, only four countries have imposed legal restrictions to abortion during this period El Salvador, Nicaragua, Poland and most recently, the United States, which highlights how the US is a real outlier globally in terms of its abortion policies, particularly among peer high resource countries. In many settings in sub-Saharan Africa, where I have done population based survey research on abortion, we see that abortions are quite common among all types of women. Even amidst legal restrictions to this health care service, however, we consistently observe disparities in who is able to access safe abortion in these restrictive contexts. With women who have fewer economic resources, those who reside in rural areas, those who have less education, and adolescents generally less able to obtain safe abortion, thus unsafe abortions. These unsafe abortions, which involve non recommended methods and or untrained providers, are a leading cause of maternal mortality globally, responsible for an estimated nearly 30 nearly 40,000 maternal deaths each year and significantly, significant maternal morbidity as well, nearly all of which is preventable and occurs in settings where abortion is legally restricted. And while the period immediately after abortion restrictions are imposed typically results in an increase in births, we actually tend to see similar rates of abortion in countries with and without abortion restrictions, but more unsafe abortions and related maternal death and injuries in contexts where safe abortion access is limited. Shifting here to the United States. Currently, 14 states have full bans on abortion and seven more have gestational age restrictions pre viability. But even prior to the Dobbs decision, Texas had passed a six week abortion ban in 2021, which provided the first opportunity to examine the impact of severe abortion restrictions in the United States. My colleagues Allison Gammel, Elizabeth Stuart and I estimated that in the first nine months of births exposed to Texas a six week ban, the number of births in Texas was 3% above what we would have expected in the absence of this policy, indicating that many pregnant people were unable to overcome barriers to abortion and travel to obtain timely care. Recently published work on the impact of Dobbs by Duntsch and colleagues similarly estimated a 3% increase in the birth rate above expectation in the first six months following the Supreme Court's decision. In the 13 states that initially banned abortion, structural inequities result in an overrepresentation of poor and minoritized individuals among people experiencing unintended pregnancies and seeking abortion care in the U.S., suggesting these populations may be disproportionately impacted by abortion bans are ongoing. Work on Texas's six week abortion ban indicates just that, with unmarried women, Hispanic women and those without a high school degree experiencing the greatest increase in live births. And it's important to note that maternal death is 14 times higher and maternal complications are significantly more likely to develop among pregnancies ending in a live birth compared to safe abortion. Thus, abortion bans and subsequent birth increases can lead to worse maternal health outcomes among these populations, simply by

forcing more people to be exposed to the risk of pregnancy and birth. And we know from research on prior, less severe abortion restrictions in the United States that imposing barriers to abortion care is associated with worse maternal health, infant morbidity and mortality, and a range of other outcomes with disparities in who is most impacted. A major challenge created in moving the decision to terminate a pregnancy from being between a pregnant person and their medical provider into the policymaking arena is the variability in people's interpretation of what types of care is considered an abortion. There's a real lack of consensus among the general population, and even among medical providers, around what care constitutes an abortion, and how to interpret the myriad exceptions in current abortion bans. As Stephanie and others have discussed here. And nearly all of the abortion bans do include some number of exceptions. However, it's unclear, for example, how much risk of death or how close to death a patient must be for the life exception to apply and how to interpret the health endangerment legislative language. Similarly, there's no consensus around what constitutes a lethal fetal anomaly or how imminent or likely. An infant death must be for a fetal diagnosis to fall under this exemption. Failing to treat abortion like a medical issue has taken the decision making away from providers and patients and involve hospital administrators and lawyers. We're trying their best to interpret the state's abortion law, which was written by policymakers who lack the nuanced understanding of how reproductive health care actually works in practice. The law is really incapable of itemizing all of the ways in which a pregnancy can go wrong. As Louise discussed, yet these bands are trying to make a medical issue that is inherently gray into one that's black and white, which fundamentally will not work. We would perhaps encounter similar challenges if policy makers tried to legislate other health care services. However, abortion is really unique in the extent to which policymakers seek to regulate how and when related care is provided. Making this medical issue a political one constrains physicians ability to provide evidence based pregnancy care, as my panelists have described, and can potentially impact even the availability of care to pregnant people. As we see emerging evidence of providers leaving or considering leaving abortion hostile states. Ultimately, pregnant people and their families suffer in a society in which any aspect of reproductive health care is politicized and not left to the pregnant person to decide what is best in their specific situation.

KAMARCK: Wonderful. Thank you very much. I've been trying to listen and also look at the news. And what, what I want to do is, I mean, it looks like the Supreme Court. I mean, we'll know more later, but it looks like they they did this on a they made this decision on a standing issue that they didn't think the they didn't think the people had standing to bring this, this case. So they kind of wiggled out of it. But nonetheless it was unanimous. And that's that's good. Leah. And and what I want to ask people, but, start with Leah and Louise

because you are actually seeing patients. What does this mean? What does this mean going forward? And, how important has the abortion pill, which, is? I don't say because I can never pronounce it correctly, but how important is the abortion pill and access to it to this whole discussion?

TORRES: Leah I mean, it's as important as access to insulin for diabetics. It's as important as access to a beta blocker for people with hypertension. It's it's medical care. It is a medical technology advancement that is very safe and needs to be accessible for everybody who needs it, who needs it, anybody who is pregnant and does not want to be. Period. We use this medicine also in miscarriage management. So it's not just people who are pregnant and want to end a continuing and continuing to develop pregnancy. Mifepristone, also known as MIFI, amongst ourselves. So you can call it.

KAMARCK: Oh that's easier to say.

TORRES: Mifepristone is used in miscarriage management. We can use this medicine in a variety of situations in order to provide less invasive, which means incurring less risk, less invasive procedures, medical management of miscarriage, medical management, and and ensuring, less risk of complications during a delivery of a fetal demise at in the third trimester, which is very tragic. And you want to use every advantage you have to take care of that person to make that is less traumatic than it already has to be. So if a person is not just an abortion pill, it is a tool in many of our medical advancements among these tools that is necessary. And and I'm in Alabama right now, I came here providing abortion care. And from one day to the next, my medical expertise, my over a decade of training and education was declared a class A felony. Not by the American College of Obstetricians and Gynecologists, not by the World Health Organization. But by the Supreme Court of the United States, and by default, the state of Alabama decided that I was going to be a felon if I exercised and provided the evidence based medical care that I was trained to do. That being said, in Alabama. I have pregnant people coming to me. Terrified. Our clinic serves a predominantly black population. Most likely due to our anti-racist policies. And people come with wanted and unwanted pregnancies. But let's speak to the wanted pregnancies for a moment. Pregnant people in Alabama who are also black people know they are 3 to 5 times more likely to die in pregnancy because of the color of their skin. And it is every week I hear somebody come to me and say, oh yes, I'm really excited about my pregnancy. I don't want to die. Those are the words they say to me. And as a provider, what can I do? How do I respond to that if I besides saying I am going to do everything in my power to make sure that doesn't happen, but that's the reality we are in and it's not uncommon. Not like people know that pregnancy is risky.

People know there's systemic racism in medicine. People know that Alabama has one of the top three highest maternal mortality rates in the nation, three times the national average, and then increase that by 3 or 4 times if you're Black. So the access to. Allowing people to undergo the risks of pregnancy only if and when they want to. Is required to save lives. It's that simple.

KAMARCK: Good. And, Louise, could you pick up on something and just explain to our audience why abortion care is necessary in in the cases of miscarriage? I think people don't fully understand that. I think they think miscarriages just happen and that's too bad. And and that's it. Just like all of the medicine there.

PERKINS KING Absolutely. When you have a miscarriage. And I'd like to highlight for you, by the way, that miscarriage is incredibly common if you're undergoing IVF. And so I just want to make sure you understand that we're talking about the necessity of abortion care and safe abortion care in a variety of contexts, including that IVF cannot proceed safely without access to safe abortion care. But when, a pregnancy, stops growing, and you are undergoing what is medically termed a spontaneous abortion. By the way, I'd like to circle back just so briefly to, a statement earlier that medical professionals might be confused about what's abortion. We're not we just might use different terminology to ensure that a patient or a member of the public, sort of understands what we're talking about, or we're using terms that work for them. So any time a pregnancy event is evacuated with some sort of help or on its own, that's an abortion. So a miscarriage is actually, medically speaking, a spontaneous abortion. And sometimes a spontaneous abortion will not proceed forward without help. And then you are at risk of developing infection or dying from that infection, or developing bleeding and dying from that bleeding. So to make sure that this happens safely for you will offer you a combination of MiFi and Messo, two different medications that combined together, can ensure that your, miscarriage or spontaneous abortion will proceed safely and will monitor you carefully. I know I keep coming back to this 19 year old girl, but her story just really affects me because of course, she had no supports. None of us as Americans want people to be suffering at home for anything if we can avoid it. So ensuring that she had access to those medications, potentially to that she had supports and careful monitoring, all of those things are not accessible to the physicians that wish to care for her in these restrictive states.

KAMARCK: Great. Let's see. Stephanie. Suzanne, comment on anything you've heard or on today's Supreme Court case. I'll start with Stephanie.

PELL: With the caveat that I have not read today's Supreme Court case, but Elaine, with with your, instruction that, the court dismissed it on standing grounds. Look, that that that is I mean, that is a positive thing. Basically standing as a is a legal precedent that in in order to bring a suit, you have to show some kind of cognizable harm. And, and, the doctors, in this case, who were, who were the plaintiffs who were trying to get mifepristone originally taken off the market altogether or rolled back, the, greater access that has been provided by, by chain changing, the FDA made changes in certain ways that the drug could be, dispensed. These doctors could, and this was argued, could not be seen as, articulating a cognizable harm. Their argument was that, you know, some theoretical patient might show up at one of their, offices or in an emergency room, having taken mifepristone and have needing medical care, and that they would be put in this situation, that they would have to treat it. And they were against doing that. So if it was you, would you would really be altering the standing document if that kind of, standing was recognized under the law, and it would have much broader implications. If you start also overruling the determine the medical determinations that the FDA is made, that undermines our entire entire system of approving drugs. And and I am I invite Louise to please say more about that. With all of that said, I and I, I, I don't I don't want to be like and just on a bad note because this is, this is good. But there are arguments lurking in the press stone case. One having to do with something called the CALM Stock Act that I can go into more in, in Q&A. But, you know, this issue hasn't gone away. We're going to be dealing with many tentacles of Dobbs for a long time. And while this is, you know, again, a positive thing today, there are, there are, there are other problematic issues, that still lurk.

KAMARCK: Suzanne.

BELL: Great. Yeah. I just want to add Mifepristone has been safely used by millions of pregnant people globally during, 36 years since its development in France. I think as many as 80 countries currently approve it, including the US. And it's an incredibly safe and effective drug, with less than a half of 1% of medication abortions experiencing serious complications. And I think it's great. It sounds like, from what we've gathered from from your news, two tidbits, that the Supreme Court ruled that there was not standing, but just to think about what the implications of that would have been if they had ruled in favor of the Alliance for Hippocratic Medicine. It would have reduced access to, if a per stone. As Leah Leah mentioned, across the nation, not just in abortion hostile states and I think set up a really dangerous legal precedent, as there's no prior instance of an FDA approved medicine with an excellent safety profile like Mifepristone losing approval, approval, the judicial judicial ruling in this in this manner. So I think it's encouraging that the Supreme Court acknowledged that in this case.

KAMARCK: Okay, we've got some audience questions and I encourage those of you listening to please send in any questions that have come up with you. But one interesting question, and maybe Suzanne, we can start with you as is, is why is the abortion such a big political issue in America, particularly compared to other, first world countries?

BELL: Oh, gosh, that is quite the big question. And one that I can, I can, you know, come up with some basic ideas. I think the US is just really, unique in how big and diverse it is in 1 in 1 regard, compared to many of our peers, smaller countries that are more homogenous, there's a lot of diversity. And I think, you know, ostensibly we have this separation of church and state, but we do see a lot of bleeding together of those, kind of entities in the way that our politics work in the US and influence that, you know, financial contributions have been policymaking and policy makers in this context. And so, we do really stand out as an outlier globally, especially among the peer countries in terms of, the, the policymaking around abortion and the fact that it is not left to primarily, pregnant people and, and providers to decide in specific situations. I, I don't know if my, my fellow panelists have more thoughts on on the uniqueness of the United States in this regard.

KAMARCK: Yeah. Leah. Go ahead.

TORRES: We have to recognize. And I said this earlier, but again. I. I believe we are the only developed nation that has a capitalist health care system, and that cannot be ignored because in that comes money and power and that feeds political divisiveness, political rhetoric, everything can be traced back to that. And the fact that our health care system is capitalist, I think can't be ignored and should not be ignored.

KAMARCK: Okay. Louise

PERKINS KING Mary Ziegler as a historian who could, if she were here, answer this. Or you could read her book. But, the the gist of this is if you trace this back to some of the platforms when the GOP had an influx of, significant, religious influence from, from the Baptist organizations and a variety of others, and they realized that this topic, because it's so simplistic when you're presented as pro-life and it doesn't involve all of the nuance we've discussed, it's a firebrand to to spark a certain proportion of voters to vote. And then you add into that what's been alluded to, which is that politics in our country makes money, and that we have no

restriction on the amount of money we can donate to, various campaigns, essentially, which is highly problematic. Add to that the fact that we can do gerrymandering and we use an electrical electoral college. So all of those things together combined to create a reason for people to use a firebrand topic to gain political power in a space in which they can make a great deal of money as politicians. If we removed all of those impetuses, I don't think we'd have a problem electing officials who were, going into politics to achieve good at that. They would follow the will of the people. And and clearly the will of the people has been expressed many times is very different from what our politics actually look like.

BELL: Well, I can just add a little bit, to that point, Louise mentioned that there is broad majority support for abortion, and it's actually increased since Dobbs. So people are realizing what is encompassed in these laws. And actually, attitudes are shifting towards support for their support of abortion. And when you look at opportunities for direct democracy with, ballot initiatives, related to changing state constitutions to include protections for abortion, those have unanimously, you know, resulted in further expansion and defense of reproductive rights in those states. And so I think, there is this disconnect that Louise, alluded to in her earlier remarks where there is support and in the broad populace, it's kind of politics and politicians that are the intermediaries that are not necessarily representing the will of the people.

KAMARCK: It isn't that for sure. And by the way, look at the New York Times today. It has a piece on women going out of state for abortions, and they have a map, and it just shows how much this is centered in the South. It is it is a series of states. Leah, you're right in the middle of that. And it shows the arrows of where where women are having to travel to. And of course, there's a lot of injustice that comes with forcing women to go out of state, for abortion care. And that's, that's clearly one of the and and the result of that is that it, it spills over into our politics because of the Electoral College and things like that. Stephanie, did you ever have any last words on this?

PELL: I'll just comment briefly on what you, were observing about the South. I mean it to watch what is happened in the southern states, where Florida for a while was considered a buffer state, if you will, because, it was legal to provide abortion for 15 weeks. Now it's it six weeks. You have Georgia at six weeks, which also is a a state with a personhood statute giving, giving fetuses the, the again the rights of of of people. and and so you've got additional pressure on North Carolina and Virginia, but but it is just, you know, Elaine sort of harkening back to our some of our discussions with our Planned Parenthood friends. I mean,

clinics are having to look at how to redesign their business models based on this changing landscape. And again, I'll just say it's not tenable.

KAMARCK: Okay. Another question that's come from the audience, which I think is pretty interesting. Is, what are strategies for advocacy that can be utilized by physicians, health care systems, and families to voice health care? Decisions are not legislative decisions. Is there anything positive that you've seen happening? One other person also asked about the storytelling, and I would say to that person, the storytelling is now appearing mostly in political ads. And if you're in a state that's a swing state, you've probably seen the ad featuring the woman in Texas that I referred to. There are political ads telling, telling these stories. The press does tell these stories. But I suspect that they miss most of the stories. You know, and so the sheer number of them is not showing up, but but what are the strategies to, to combat this problem? Who wants to take that first? Leah.

TORRES: I want. I just kind of piggybacks off of the other remarks that we're just making is, you know, we we and when I say we, I mean, physicians, especially, even non physicians, anyone working in the reproductive health care field can attest to this. We're the canary in the coal mine. We're the ones who are telling have been telling people that these things would happen.

KAMARCK: Yeah.

TORRES: For decades. We've been saying this. Ever since Roe passed, states have been implementing restrictive, more restrictive, more restrictive laws. And we see what this does. And we've been saying for a long time, this is what's going to happen. Roe is going to fall. People are going to die, etc., etc.. That being said, we need stories now more than ever. What we also need is anyone in health care. Not just OB/GYNS, not just midwives, not just MFMs. We need emergency room physicians. We need ophthalmologists. We need anyone who will back us in the hay providing evidence based standard. High quality medical care is vital to save lives. That also includes abortion. We need everybody to come into the fold and advocate for the ability to provide medical care that is needed, that is evidence based, that is not based on leeches and humors and snake oil that we actually utilize modern technology, modern medicine, and modern research to understand what we should be doing, that we could do that unfettered by political interference. We need everybody to have the backs of pregnant people. We need everybody to have the backs of people providing

reproductive health care. So that's my call to arms. We need everybody's stories. We also need everyone providing medical care to say, hey, right, we need to be able to do this without interference.

KAMARCK: Okay. Any other comments here? Louise. Yes.

PERKINS KING I think that will be exceptional. Storytelling is exceptional as well. There's been a recent call, for example, for the American College of Cardiology to issue better supports because the major contributor to maternal mortality is cardiovascular. And so they should be on board, for example. But I also think comparative stories are important, for example, comparing, the level of physicians, both, Leah and I, every year go through, a recertification from our board, and we're both educated on the standard of care. And yet Leah faces felony charges if she proceeds forward with care that is clearly defined as a standard of care, and she has to show that she's proficient in it to continue her board certification or, showing Americans how it's so different, the experience that patients here in Massachusetts have versus the experience that patients in Alabama have in a wide variety of areas, but all also specific to abortion. If we want to consider ourselves a nation, we have to find a way to ensure that every person within this nation has access to care. And I think Americans would understand that better if the stories we were telling really brought forward how there's such a stark difference that's happening because of these restrictive law.

KAMARCK: Anybody else. Okay. I'd like to remind our audience we only have a couple of minutes left. And you can send questions via x, at brookings.gov with hashtag abortion health. Or you can email events@brookings.edu. We do have a question. and I'll just read the read the question to you. Louisiana really passed recently passed a law that classifies Memphis myth of stone as a controlled substance, making possession without a prescription, punishable by jails and fines. Does today's Supreme Court decision have any impact on this law? Stephanie, I think that's pretty straightforward.

PELL: Well, with the caveat again, I haven't read the opinion. I don't think so, because the issues are very different. I again, would would need to read the the opinion to see if there's any, any, any language. But it that issue really wasn't raised, in the context of the challenge to move a stone that the court was ruling on.

KAMARCK: Okay. Any other comments? We got two lawyers here. Yeah.

PERKINS KING I mean, I yeah, I it highlights the insanity, right? We have an FDA approved medication that they're going to make illegal. How does that make any sense? This is complete insanity. And again, circling back to our discussion of why does this happen in the US politically. It has to do with the fact that that, obtaining political power in the United States and I'm actually an elected official in Brookline, Massachusetts. So obtaining political power, in this country is associated with potential financial gain. We have to change that entirely. There should be no link between those two things. And that would slow the roll of this insanity, I think.

KAMARCK: And I would like to add that as the political scientist on the panel, that, one of the interesting things about this is how much this seems to be a backlash against women's rights. The Southern Baptist Conference met yesterday and declared that IVF was that they were against IVF, but that these that these were these were the fetus with the or the fertilized egg was the person. And I'm like, what? How can you have a fertilized egg become a person without a woman's body to hold it and to nurture it? I mean, maybe in the future there's a space age thing and we'll put these in, in, you know, make believe. We'll put these in pretend uteruses in a laboratory someplace. Okay. That's a sort of fantasy, science fiction fantasy. But the fact of the matter is, the taking women out of the business of creating human beings is strikes me as so, quite frankly, just crazy. And such a backlash to women and such an insult to women's role in important role in society as, the bearer of the next generation. So it's it's just it's just weird. And I think that things like this, a lot of women are going to say what? You did that I want to have a baby. And, you're going to declare my fertilized eggs, people, even though I can only take one at a time in my uterus, maybe two. But who would do that voluntarily? Right? You know, so it's it's there's something going on here that is even bigger than the abortion issue itself, which seems to me to strike at, at women, whether it's anger at women, etc.. It doesn't escape me that in these legislatures in the South, they are mostly white men opining on things that they have no idea about. And finally, I, you know, for, for political purposes, the reason I think so many people miss the importance of this issue is that for half of the population, they have this represented on this panel. We think about reproduction for 40 to 50 years from the time we get that first period at 13 or so and well past well into menopause, when we don't worry about that, but we've got daughters and granddaughters, etc., that we're worried about it. So it's always it's always in our heads, you know, and I think for men and this is no, no, no criticism in men, they don't live with this reality the way we do. And so part of it, part of our obligation here politically is to share this with them, to share the fact that you need actually something that looks like abortion care when you have a miscarriage, and that, you know, and that there's all sorts of world of complications out there that fortunately, maybe they haven't encountered, good for them, but that are still

extremely important. And this law is really taking us way backwards in health care and everything else. Let any last comments and then we are at the end of our time. One last word.

BELL: I just want to piggyback on that comment, Elaine, and say, this is always really been about controlling women's and people with uteruses bodies. And abortion is, I think, really the the first issue and most pronounced issue that that, you know, policies are looking to infringe upon rights around that, but you can already see movement in the IVF space and towards restricting contraception. So, you know, I think abortion is one piece of many aspects of controlling, people's bodies and reproductive health care that we could see, movement towards in, in the coming years. So just putting a flag, there to, for people to recognize that.

KAMARCK: Well, thank you very much to Leah, who's right in the middle of the fight. To Louise, who is training people to be in the middle of the fight to Stephanie, was offered her legal advice and to Suzanne, who is studying such important issues around the world, thank you very much. And thank you everyone for listening.