

Law + Medicine After Dobbs CLE Outline

Presenters: Dr. Ingrid Skop, M.D., FACOG, and Katie Glenn Daniel, J.D.

One Sentence Summary: Learn about the changes to state laws post-Dobbs and how healthcare professionals navigate the legal landscape while still providing excellent patient care.

Background:

Why we are qualified to present on this subject:

Dr. Ingrid Skop¹ is the VP and Director of Medical Affairs for the Charlotte Lozier Institute, a 501(C)(3) research and education institute that leads the pro-life movement with groundbreaking scientific, statistical, and medical research.² Dr. Skop brings three decades of clinical experience as a board-certified ob/gyn to her research and her evaluation of the laws. Dr. Skop has extensive experience testifying before Congress, state legislatures, and state administrative agencies and as an expert witness in litigation. She is a member of the board of the American Association of Pro-Life Obstetricians & Gynecologists (AAPLOG), whose practice guidelines we will cite throughout this course and a member of the Texas Maternal Mortality Review Committee.

Katie Glenn Daniel³ is the Director of Legal Affairs and Policy Counsel for Susan B. Anthony Pro-Life America, an umbrella of organizations that combines politics with policy, investing heavily in voter education and issue advocacy, advancing pro-life laws through direct lobbying and grassroots campaigns.⁴ She has drafted, consulted on, or testified in support of all gestational protections enacted since *Dobbs*, as well as filing amicus briefs and participating in an AAPLOG continuing medical education course on this subject.⁵

Why we are passionate about this subject:

We care deeply about American women and girls receiving the best possible medical care and believe they deserve better than the information vacuum left by leading medical institutions, the media, and politicians who actively undermine pro-life laws by asserting that elective abortion is the only option in response to crisis. This attitude not only leads to worse health outcomes for women, but it is just plain untrue. We step into this void using our own voices and by activating pro-life lawmakers, healthcare professionals, and individuals to fight for accurate information about law and medicine.

Introduction:

The *Dobbs* decision gave elected officials the authority to fully regulate abortion for the first time in fifty years, and almost every state has altered its laws in some way since June 2022. Amid these changes, major medical organizations remained silent, allowing media misinformation to fester and leaving practitioners confused and searching for information elsewhere. Additionally, hospital attorneys and administrators have

¹ <https://lozierinstitute.org/team-member/ingrid-skop-m-d-facog/>

² <https://lozierinstitute.org/about/>

³ <https://sbaprofife.org/staff/katie-glenn-daniel>

⁴ <https://sbaprofife.org/about>

⁵ Practicing Obstetrics in States with Abortion Regulations: What Clinicians Need to Know, <https://meded.aaplog.org/>

often failed to provide support for physicians caring for pregnancy emergencies, leaving them fearful that a wrong interpretation of the law will leave them exposed to severe legal repercussions.

From 1973 until 2022, elective induced abortion⁶ was broadly available, at least as required by law, under the Supreme Court decisions in *Roe v. Wade*⁷ and *Planned Parenthood v. Casey*.⁸ These cases superseded longstanding state laws prohibiting abortion and prevented states from enacting meaningful regulations on the performance of abortions.

What is elective induced abortion?

The American Association of Pro-Life Obstetricians & Gynecologists (AAPLOG) states in its practice guideline *Concluding Pregnancy Ethically*: “All pregnancies end. While most pregnancies end in delivery of live offspring, a substantial minority end in delivery of nonviable products of conception. Rarely, pregnancies end at the time of maternal death, with either live birth or stillbirth of the fetus. Even if pregnancies end with the same outcome, the actions leading to those outcomes can be either ethical or unethical.”⁹

By its simplest medical terms, abortion is the end of a pregnancy before 20 weeks’ gestation. You may have seen “spontaneous abortion” in writing or even on a medical chart. We typically call this a miscarriage to prevent confusion on *how* the pregnancy ended. “Induced” signifies the intentionality of the action; an induced abortion ended the pregnancy on purpose rather than ending through a natural, unintentional loss. “Elective” describes the reason for the abortion (as opposed to a medical indication) – our colleagues at CLI found that more than 95% of abortions in the United States are performed for “elective or unspecified” reasons rather than a risk to the mother’s health, abnormality in the baby’s development, or rape/incest.¹⁰

When we say “elective induced abortion,” we are referring to the vast majority of abortions that are performed for non-medical reasons with the intent to deliver a deceased child. There is a developing area of policy around “self-managed abortion” versus abortions performed under the supervision of a healthcare professional, but we will not discuss that today.¹¹

Legal Background:

On the day it was handed down, *Roe* overturned laws in virtually every state, so perhaps it’s not surprising that there was an immediate and nationwide effort to carve out certain policy considerations.

- Example 1: Conscience Rights of Healthcare Professionals – Within 3 years of *Roe*, 40 states had enacted conscience rights to opt out of performing or referring for abortions. The first federal conscience protection was enacted just a few months after *Roe*, a rare example of Congress acting expediently.¹²

⁶ For expediency and reasons explained within, we will use “abortion” as a shorthand for “elective induced abortion,” or the intentional ending of a pregnancy that is induced by a medical professional for any purpose other than to treat a life-threatening medical emergency or delivering a live baby.

⁷ <https://supreme.justia.com/cases/federal/us/410/113/>

⁸ <https://supreme.justia.com/cases/federal/us/505/833/>

⁹ <https://aaplog.org/wp-content/uploads/2023/04/PG-10-Concluding-Pregnancy-Ethically-updated.pdf>

¹⁰ <https://lozierinstitute.org/fact-sheet-reasons-for-abortion/>

¹¹ To learn more, see <https://lozierinstitute.org/how-many-abortions-are-occurring-in-america-post-dobbs/>

¹² <https://fedsoc.org/fedsoc-review/what-will-settle-dobbs>; See Church Amendments

<https://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/ConscienceProtect/42usc300a7.pdf>

- Example 2: Physician Requirement – States quickly determined that not just anyone should be performing these inherently risky procedures. Most states (44) impose some requirements on who can perform abortions; in 31 states, a physician’s involvement is required.¹³
- Example 3: Taxpayer Funding for Abortion – By 1976, there was consensus that taxpayers should not be forced to participate in funding abortions, and Congress has enacted a version of the Hyde Amendment¹⁴ annually since it was upheld by the Supreme Court in *Harris v. McRae*.¹⁵ Just 17 states allow state Medicaid dollars to fund abortions, and several are forced to do so by court order.

For fifty years this was a heavily discussed and litigated area of law,¹⁶ so it should not surprise us to see activity today as elected officials finally regained broad authority in this space.¹⁷ Almost every state has enacted some change to its laws in the past three years, either broadening protections for the unborn through new laws or the revival of laws that were enjoined, or by “shielding” the abortion industry.¹⁸

There have been consistent themes in the pro-life laws that go back to pre-*Roe* and even pre-statehood. These laws, though short, were written with an exception to save the life of the mother.¹⁹ These exceptions are based on the ethical principle of “double effect,” which we follow when writing laws today.

In fact, every state with a pro-life law that imposes a gestational limit is written to allow physicians to intervene in a medical emergency.²⁰

So why do we hear so much to the contrary?

Major medical organizations have remained silent on these questions, or worse, actively confused their members by claiming they can’t practice quality medicine unless they’re in a state with few abortion limits. The media has dutifully echoed these claims, often without consulting OBs like Dr. Skop who regularly treat these women.

- Example 1: American College of Obstetricians and Gynecologists (ACOG): “A patchwork of state abortion bans, many written in nonmedical language, include vague and ambiguous exceptions, resulting in confusion for clinicians and patients. The resulting confusion leads to delayed and sometimes denied care, and the effects of these bans are seen across the spectrum of reproductive care. In addition to creating situations in which patients may fear legal prosecution for seeking care for early pregnancy loss and obstetric complications, legal restrictions hinder clinicians’ ability to make timely decisions in patient care. When clinicians have to consult lawyers and institutional boards, delaying needed care, the management of early pregnancy loss, ectopic pregnancy, and induced abortions required to save the life of the pregnant person all become more dangerous for the patient. The harms caused by abortion bans cannot be separated from the harms caused across the spectrum of reproductive care.”²¹

¹³ <https://lawatlas.org/datasets/abortion-provider-qualifications?g0=3094&g1=3100&g2=3101>

¹⁴ <https://www.congress.gov/crs-product/IF12167>

¹⁵ <https://supreme.justia.com/cases/federal/us/448/297/>

¹⁶ These are just some examples of major federal cases during the *Roe* era. There were dozens more filed in state courts. See <https://www.brennancenter.org/our-work/research-reports/roe-v-wade-and-supreme-court-abortion-cases>

¹⁷ See <https://aui.org/wp-content/uploads/2024/10/2024-Q3-Life-Litigation-Report.pdf>

¹⁸ See <https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html>

¹⁹ See *Dobbs* Appendix A, https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

²⁰ <https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/>

²¹ <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2025/abortion-training-and-education-in-a-post-dobbs-landscape>

- Example 2: ProPublica was recently awarded a Pulitzer Prize for its deceptive reporting on the deaths of women suffering pregnancy complications in Georgia and Texas, inappropriately placing blame on pro-life laws. The common denominator in all these tragic deaths is not abortion laws, which would have permitted care in every instance. The delayed and poor-quality care these women received may have resulted from medical malpractice. But it is also possible that the misperception of doctors and the public about the laws may have contributed.²²
 - Amber Thurman, a 28-year-old Georgia woman suffered retained pregnancy tissue after taking abortion drugs and developed sepsis. Doctors delayed performing a necessary D&C to remove the source of infection, resulting in her death.²³
 - Candi Miller died at home in Georgia after suffering from a failed medication abortion. Her autopsy revealed a lethal combination of painkillers, including fentanyl.²⁴
 - Nevaeh Crain, an 18-year-old Texas woman and her unborn child, died after being discharged from two hospitals, despite complaining of abdominal pain and showing signs of sepsis at six months' gestation, a gestational age when her child could have survived delivery.²⁵
 - Josseli Barnica presented to a Houston area hospital with an inevitable and incomplete miscarriage at 17 weeks' gestation. Her physicians failed to intervene for over 40 hours, waiting until her child died before inducing her labor, and she ultimately died from hemorrhage and sepsis.²⁶
 - Finally, Porsha Ngumezi, a 35-year-old Texas woman, died following complications of a miscarriage at 11 weeks' gestation. Despite heavy bleeding requiring blood transfusions, her physician did not perform a D&C, the minor surgical procedure that would have most quickly ended her obstetric emergency but instead gave her misoprostol. She was moved to a room with less nursing supervision, despite complaining of chest pain, where she subsequently died.²⁷

These cases demonstrate how important it is that healthcare professionals receive accurate information, especially from the attorneys helping them understand changes to the law.

Medical Considerations:

It is important to note that most obstetricians and gynecologists do not perform abortions.

- Only 7-14% of practicing obstetricians surveyed responded that they would perform an elective abortion if requested by their patient.²⁸
- In her testimony to the U.S. Senate HELP Committee, Dr. Christina Francis, CEO of the American Association of Pro-Life Obstetricians and Gynecologists stated, "As OB/GYN physicians, we care for two patients during pregnancy. Abortion guarantees the ending of the life of one of our patients

²² <https://lozierinstitute.org/breaking-study-uncovers-misconducting-crisis-in-er-visits-following-abortion-drugs/>

²³ <https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death>

²⁴ <https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia>

²⁵ <https://fox4beaumont.com/news/family-alleges-medical-negligence-in-death-of-vidor-teen-and-her-unborn-child>;

<https://www.propublica.org/article/nevaeh-crain-death-texas-abortion-ban-emptala>

²⁶ <https://www.propublica.org/article/josseli-barnica-death-miscarriage-texas-abortion-ban>

²⁷ <https://www.propublica.org/article/porsha-ngumezi-miscarriage-death-texas-abortion-ban>

²⁸ See 10.1016/j.contraception.2017.11.004; 10.1097/AOG.0b013e31822ad973

– and can severely threaten the life and health of the other. Science is clear that a new, distinct, and living human being comes into existence at the moment of fertilization.”²⁹

There are several principles that help physicians make ethical decisions:

- Hippocratic Medicine: The Hippocratic Oath originally included a prohibition on performing abortions;³⁰ this was removed in the “modern version.”³¹ However, this longstanding guiding principle never foreclosed the ability to intervene in a medical emergency.
- Double Effect: There is a long-standing principle in medical ethics of “double effect” which holds that it may be permissible to harm an individual while acting for the sake of a proportionate good, given that the harm is not an intended means to the good but merely a foreseen side-effect.³²
 - Reading the relevant state laws, and with the “principle of double effect” in mind, it is readily apparent that not all procedures which separate the mother and fetus are abortions in any meaningful ethical or legal sense.
 - This includes:
 - Implantation outside the normal location in the uterine cavity
 - When the embryo or fetus has died
 - Facilitating the completion of an inevitable miscarriage that is already in process, even if the fetus is still alive
 - Likewise, medical or surgical treatments for serious conditions, which may lead to miscarriage or fetal death as a complication or side effect (for example):
 - Appendectomy or other intraabdominal operation complicated by infection
 - Chemotherapy/radiotherapy, especially when affecting reproductive organs

Let’s compare the claims above from ACOG and ProPublica to the actual text of Texas’ law, considering “double effect.” Texas is a good case study for several reasons:

- Laws in other states use substantially similar language
- Dr. Skop practices medicine in Texas, so she has considered how these laws impact her practice
- The media has been very focused on Texas, so many of the headlines you might encounter come from Texas

It has been unfairly alleged that due to Texas’ pro-life laws deaths from self-managed abortions will increase, physicians can’t intervene in obstetric emergencies, overall maternal mortality will worsen, increased mental health disorders will lead to suicides in women, there will be a dramatic increase in births from rape-related pregnancies, infant mortality will increase, doctors will leave the state, worsening maternity care deserts, and Texas has failed to provide support for women who give birth. These are all blatantly false, as Dr. Skop has documented at length.³³ In all these cases, the main concern is for the maintaining the life of the mother or preventing permanent physical harm. The death of the fetus, though medically foreseeable or possible, is not intended.

²⁹ <https://www.help.senate.gov/imo/media/doc/80626e6a-a9e9-50e7-072a-95e7c2a059e3/Francis%20-%20Testimony.pdf>

³⁰ <https://www.congress.gov/117/meeting/house/114995/documents/HHRG-117-IF02-20220719-SD007.pdf>

³¹ https://www.pbs.org/wgbh/nova/doctors/oath_modern.html

³² <https://journalofethics.ama-assn.org/article/principle-double-effect-and-proportionate-reason/2007-05>

³³ <https://lozierinstitute.org/are-pro-life-laws-harming-women-and-children-an-examination-of-claims-against-texas/>

Legal Considerations:

How do physicians make decisions and how does the law govern whether they are right or wrong?

We must acknowledge that medical diagnosis is an imperfect science. Two physicians may arrive at different diagnoses, requiring different treatments. We recognize this in law, which is why laws governing practice of medicine leave room for the physician's expert judgment regarding what is "medically necessary." Our laws are written to presuppose good faith on the part of the physician.

- Good Faith Judgment – a subjective test based on whether the physician was acting in "good faith" where intent is key
- Reasonable Medical Judgment – an objective test based on the "reasonable person" standard, or was the physician acting reasonably based on the individual circumstances, where intent is subordinate to reasonableness

Groups like ACOG have argued in court that limiting abortion using the Texas language is confusing to physicians and leads to worse patient outcomes.³⁴ Their solution is permissive abortion laws in every state.

In fact, however, "reasonable medical judgment" is not a new term created by legislatures as part of these abortion restrictions. It has been a widely accepted legal concept since at least the 1960s, and medical professionals have operated for decades under this same standard across areas of medicine.³⁵

- Mental competence
- End-of-life decisions
- Medical malpractice
- Informed consent
- The Americans with Disabilities Act

Example: Texas Human Life Protection Act (implemented in August 2022)³⁶

"A person may not *knowingly* perform, induce, or attempt an abortion..."

But the law includes an exception if a "medical emergency" is present:

"[if] in the exercise of reasonable medical judgment, the pregnant female...has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced."

Furthermore, the Texas statute defining "abortion" specifically says that it shall not apply when these acts are done to:

"(A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion (miscarriage); or (C) remove an ectopic pregnancy."

³⁴ See <https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2023/11-21-2023-state-of-texas-v-amanda-zurawski.pdf?rev=ad926891b0df477a900a232e0e784187>

³⁵ <https://lozierinstitute.org/filed-brief-zurawski-v-texas-and-reasonable-medical-judgment>

³⁶ <https://www.legis.state.tx.us/tlodocs/87R/billtext/html/HB01280F.HTM>

How Law and Medicine Fit Together:

Case Study 1: PPROM

What is PPROM? Previabile, premature rupture of membranes occurs before the unborn child has developed enough to survive separation from his mother and before the onset of labor. No decision is required if labor is occurring or infection is diagnosed, but if labor has not begun, the obstetrician is faced with a decision on whether to intervene. The risks to the mother from continuing pregnancy and possibly developing infection are high, and the benefits to the unborn child may be low depending on the length of time until viability.

- What are the treatment options for PPROM? ACOG and AAPLOG acknowledge that both immediate delivery and expectant management (watchful waiting) are appropriate options in the absence of infection, with a mother's full informed consent. ACOG adds D&E abortion as an option, but the reality is that the intentional dismemberment of the unborn child is rarely necessary (unless separation is urgently needed, as in the case of substantial hemorrhage) and mothers usually prefer an intact child to grieve over, and thus almost always prefer induction if immediate delivery is chosen.
- What is the difference between "Maternal-Fetal Separation" and abortion?³⁷ The required treatment in an obstetric emergency may be ending the pregnancy through delivery, but intentionally ending the child's life through induced abortion is rarely, if ever, necessary. Most severe complications occur later in pregnancy when the child is likely to survive delivery if given quality medical care. In that circumstance, he does not need to be killed; he just needs to be delivered.

Case Study 2: Ectopic Pregnancy

- What is an ectopic pregnancy: A pregnancy implanted outside of the normal location in uterus can almost never reach a gestational age where the child can survive and may cause catastrophic hemorrhage threatening the mother's life if the pregnancy continues. All pro-life OB/Gyns are willing to treat an ectopic upon diagnosis, and it has never been considered an abortion. Some state laws actively exclude ectopic pregnancy from the definition of abortion.³⁸
- Importantly, the treatment of ectopic pregnancy and the performance of an elective abortion is DIFFERENT.³⁹

Many physicians have asked "how sick is sick enough"? No state law requires that a woman with a life-threatening complication be actively dying in order for a physician to intervene to end her pregnancy.⁴⁰

For doctors, it can be helpful to prompt them to think about a situation where they have had a patient with a complication like previable PROM who *did not want* interventions unless they were confident she had evidence of something life-threatening. What was the protocol or decision-making process like with her? I'm confident that the doctor didn't wait until she was septic and unstable before recommending delivery - they likely monitored her temperature and other vital signs closely, watched her white blood cell count

³⁷ <https://aaplog.org/wp-content/uploads/2023/04/PG-10-Concluding-Pregnancy-Ethically-updated.pdf>

³⁸ See Tex. Health & Safety Code § 245.002(1) <https://statutes.capitol.texas.gov/docs/HS/htm/HS.245.htm>

³⁹ <https://aaplog.org/wp-content/uploads/2023/01/PG-9-Ectopic-Pregnancy.pdf>

⁴⁰ Some state supreme courts such as Idaho, Oklahoma, and Texas have confirmed that a physician can act if a life-threatening event is foreseeable, she must not wait for escalation.

and did frequent abdominal exams as well as gave her warning signs - and then intervened if there was even the slightest evidence of infection. This is appropriate management, based on reasonable medical judgment - and it is perfectly legal in every state in this country.

Conclusion:

Women deserve the truth. Dr. Skop, alongside other pro-life OB-Gyns is speaking out, even garnering more than one million views on one X thread debunking these claims.⁴¹ Katie has worked with a dozen states on medical education, leading to state agencies and leaders communicating with licensed medical professionals to ensure that they understand how pro-life laws impact the practice of medicine in their state.⁴² Both of us testified and offered comments when the Texas Medical Board enacted rules concerning Exceptions to Abortion Ban (§165.7), Abortion Ban Exception Performance and Documentation (§ 165.8), and Complaints Regarding Abortions Performed (§ 165.9).⁴³

Few medical professionals perform elective induced abortions, and they are the ones whose practice is changed when states enact gestational limits because they simply cannot end unborn babies' lives in the same way they could under *Roe*. That is a policy decision of the state to promote life and protect unborn babies.

The vast majority of medical professionals won't change their practice at all because they can still intervene in a medical emergency, as they always have. These doctors are being actively misled for political reasons, and they deserve accurate information, which includes the reassurance that they can exercise their judgment and provide the best care for both patients, a mother and her baby.

Further Reading:

- <https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/>
- <https://lozierinstitute.org/filed-brief-zurawski-v-texas-and-reasonable-medical-judgment/>
- <https://aaplog.org/resources/practice-guidelines/>

⁴¹ <https://x.com/docskop/status/1853838189963718931>

⁴² <https://sbaprofife.org/latest-news/the-med-ed-efforts-in-fl-tx-and-beyond-to-protect-womens-lives>

⁴³ Skop: https://lozierinstitute.org/wp-content/uploads/2024/05/CLI-Comment-Texas-Medical-Board-Proposed-Ruhttps://sbaprofife.org/wp-content/uploads/2024/05/May-2024-SBA-Comment-TMB-Med-Ed.pdfle-4-30-2024.pdf?_hstc=42728442.303c044a587adfb2a34e963942f9aa84.1692629757160.1748428968893.1748439005102.281&_hssc=42728442.6.1748439005102&_hsfp=1623487770; Daniel: <https://sbaprofife.org/wp-content/uploads/2024/05/May-2024-SBA-Comment-TMB-Med-Ed.pdf>