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## INSIDE



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# Supreme Court Signals Possible End to Abortion Rights Under *Roe v. Wade*

*Texas decision provides foreshadowing*

Access to safe and legal abortion likely will end for half of America by this summer when the U.S. Supreme Court is expected to decide on Mississippi's 15-week abortion ban, according to reproductive healthcare providers, attorneys, and leaders.

Both the Mississippi case and the Texas six-week abortion ban — which the court allowed to continue in December 2021 — will potentially lead to abortion bans in dozens of states.

"Overall, we anticipate that 26 states could quickly move to ban abortion, whether by enacting new bans or implementing bans that are already on the books and that may have been blocked in court,"[1] says **Ianthe Metzger**, director of state media campaigns at Planned Parenthood Federation of America in Washington, D.C. "Twelve states have trigger bans that are intended to take effect as soon as the U.S. Supreme Court overturns *Roe v. Wade*, nine states have pre-*Roe* abortion bans that could be enforced, and some states even have both. Additionally, post-*Roe* bans that have been blocked by lower courts could be allowed to take effect. For example, federal courts have

> THE SUPREME COURT'S DECISION MAKES IT CLEAR ABORTION IN TEXAS HAS NOT BEEN RESTORED, AND THERE IS NO FULL RELIEF THAT CAN COME FROM PURSUING LEGAL CHALLENGES.



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already taken up appeals on currently enjoined gestational age bans in Missouri and Tennessee, and we anticipate that more court cases could follow ahead of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* [JWHO]." *(See story in this issue on the risks of banning abortion.)*

Mississippi's 15-week abortion ban is a direct challenge to *Roe v. Wade*. Both the Mississippi solicitor general and five Supreme Court justices — a solid majority — made statements suggesting a decision on Mississippi's bill would end nearly five decades of abortion rights under the 1973 landmark case. *(See story on what justices said about Mississippi's case in this issue.)*

## Supreme Court Declined to Halt Ban

The Supreme Court's decision to allow Texas to ban abortions after six weeks through a scheme that gives any citizen financial incentives to sue anyone they believe assisted in an abortion has effectively ended abortion rights for most Texans of reproductive age. Texas women who seek an abortion after six weeks of pregnancy must access medical care in another state or through non-legal means. For many women, this means they are forced to continue with an unwanted pregnancy because they cannot afford the time, travel, and expense of accessing an abortion out of state.

"The Supreme Court could have blocked the Texas ban, but instead closed most paths for challenging the law," says **Chelsea Tejada**, JD, staff attorney for the American Civil Liberties Union (ACLU) Reproductive Freedom Project. "They blocked us from being able to take the easiest path to challenging the law and, more specifically, from challenging the law before it goes into effect to secure statewide relief so abortion access could continue. They left open suing some state officials who have licensing authority over nurses, providers, and clinics because those officials have collateral enforcement power."

For instance, if a doctor or nurse is sued under Texas Senate Bill 8 (SB 8), then those state officials in the licensing area could issue licensing penalties, such as suspending the practitioner's license.

"The narrow path means we have litigation to pursue," Tejada says.

## EXECUTIVE SUMMARY

This year, the U.S. Supreme Court will decide whether Mississippi's 15-week abortion ban is constitutional. The decision is expected to end national legal protection for abortion care and allow states to enforce laws that prohibit abortion.

- Following arguments about the Mississippi anti-abortion rights case, the Supreme Court issued a decision that allowed Texas to continue with its six-week abortion ban and bounty-hunting scheme.
- Abortion rights advocates say the Supreme Court allowing the Texas ban to continue indicates the justices are ready to overturn *Roe v. Wade*.
- States already have filed copycat anti-abortion rights laws in the wake of the Texas bill.

"We'll continue trying to get relief against those licensing officials, trying to get a declaration that the law is unconstitutional and block them from revoking licenses."

But even if these lawsuits are successful, they do not stop people from suing anyone involved in a person's abortion and collecting a minimum of $10,000 per case.

"The threat of those lawsuits remains in effect," Tejada explains. "Even if there were providers who were willing to be sued, people are chilled from accessing care. It makes people fearful."

The Supreme Court's decision makes it clear abortion in Texas has not been restored, and there is no full relief that can come from the ACLU and others pursuing legal challenges.

"The messages we're getting out of the Supreme Court seem to suggest they're poised to overturn *Roe v. Wade*," says **Mimi Zieman**, MD, author of *Managing Contraception* and president of SageMed LLC in Atlanta. "If the court wasn't stacked the way it was, and if the justices seemed to adhere to what they said in their nominating testimony that they all considered [settled] law is important, then we wouldn't worry as much," Zieman says. "But listening to the arguments on the Mississippi abortion case signals they are ready to overturn *Roe v. Wade*."

## Copycat Legislation in the Works

Reproductive health advocates expect states will not wait for the Supreme Court's decision in *Dobbs v. JWHO,* since the court allowed the Texas ban to remain in place. For example, a Missouri legislator filed a bill on Dec. 16, 2021, that mirrors Texas' SB 8.[2]

"The Supreme Court has given states the green light to circumvent the Constitution through copycat laws by using this bounty-hunting scheme, all while allowing a blatantly unconstitutional law to stand," Metzger says.

Access to legal, safe abortions is at a crisis point. "We don't need to wait for the Supreme Court to decide on the Mississippi 15-week ban case because the court gave the green light for these schemes to go ahead," Tejada says. "In Texas, abortion has not been accessible since August."

## FDA OKs Telemedicine Mifepristone

In a move in the opposite direction, the Food and Drug Administration (FDA) decided in December 2021 to make medication abortion available via telemedicine. *(See story about FDA decision and telehealth abortion medication study in this issue.)* But this will not help women in states that ban abortions and mail-order mifepristone prescriptions. Many states have enacted bans that prevent medication abortion from being provided through the mail, Tejada says.

Even with the FDA's decision to make mifepristone available through pharmacies and by mail, not all people will have access to this convenience. Some states enacted laws that require patients to see a provider in person for counseling, ultrasounds, or other services before receiving abortion care.

"Providers have to comply with their state laws, and anyone who breaks those laws could be liable under state law," Tejada says.

The end of *Roe v. Wade* will harm many Americans, says **Robert A. Hatcher**, MD, MPH, professor emeritus in gynecology and obstetrics at Emory University and chairman of the *Contraceptive Technology Update* editorial board. Hatcher also was a co-plaintiff in the 1973 *Doe v. Bolton* case that challenged Georgia's prohibition on abortions.

"There will be a lot of tragic consequences for this," Hatcher says. "There will be many people who will have their lives adversely affected by an unintended pregnancy."

Hatcher also predicts a backlash to the end of *Roe*, suggesting that some states will ease their restrictions on abortions in response to tragedies of women dying from lack of access to safe abortion care. *(See Hatcher's predictions in this issue about what happens next if* Roe v. Wade *is overturned.)*

States passed hundreds of anti-abortion rights bills in the past few years that could take effect if *Roe* is overturned.

"I was in the state of Georgia chamber when the anti-abortion bill was passed, and it felt like a punch in the gut," Zieman says. "I couldn't believe we were returning to laws that infringed on the rights of women."

Zieman recalls OB/GYNs from her training pointing out the wards that used to be filled with women who were sick or dying from illegal abortions.

"That was common every day — to have many patients they were taking care of," she says. "They saw women die from sepsis. To force women to have unsafe care and less optimal care is shocking."

On Dec. 10, 2021, plaintiffs and attorneys in the case challenging SB 8 spoke about the Supreme Court's failure to block the bill. In a media conference call, they noted the court's decision would lead to states banning other fundamental rights recognized by the Supreme Court.[3]

"This is a dark day for abortion patients and providers," said Virginia Attorney General **Mark Herring**, JD, who was among those who argued for the court to block Texas from enforcing the law. "It is also a dark day for anyone who cares about constitutional rights. The implication of [this] decision will be profound and will reverberate for years to come."

SB 8 was not blocked immediately, as were other states' abortion bans, because it was designed to prevent federal lawsuit challenges.

The Supreme Court's 5-4 decision to allow SB 8 to continues means any state can prohibit the exercise of any constitutional right within that state's borders if it allows the prohibition to be enforced by private lawsuits, Herring argued.

"Today, it is abortion rights under attack. Tomorrow, I have no doubt we will see copycat abortion laws in other states," Herring said. "After that, any other fundamental right recognized by the Supreme Court can come under attack, and federal courts will be handcuffed from doing anything to stop it." ■

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# Key Takeaways from *Dobbs v. Jackson Women's Health*

*Justices discuss Mississippi's abortion ban*

In nearly two hours of oral arguments on Dec. 1, 2021, U.S. Supreme Court justices, petitioners, and attorneys discussed the dismantling of *Roe v. Wade* and national access to safe and legal abortion before fetal viability.

The following are key comments and questions from the Supreme Court's transcript[1] of that case:

• **Mississippi Solicitor General Scott G. Stewart, Esq:** "For 50 years, they've kept this court at the center of a political battle that it can never resolve. And 50 years on, they stand alone. Nowhere else does this court recognize a right to end a human life."

• **Justice Stephen Breyer:** In quoting *Planned Parenthood of Southeastern Pennsylvania v. Casey*: "Only the most convincing justification under accepted standards of precedent could suffice to demonstrate that a later decision overruling the first was anything but a surrender to political pressure and an unjustified repudiation of the principle on which the court stakes its authority."[2]

• **Justice Sonia Sotomayor:** "Will this institution survive the stench that this creates in the public perception that the Constitution and its reading are just political acts? … How is your interest anything but a religious view? The issue of when life begins has been hotly debated by philosophers since the beginning of time."

• **Justice Elena Kagan:** "There's been 50 years of water under the bridge, 50 years of decisions saying that this is part of our law, that this is part of the fabric of women's existence in this country."

• **Respondent Julie Rikelman, Esq, litigation director of the Center for Reproductive Rights:** "Mississippi's ban on abortion two months before viability is flatly unconstitutional under decades of precedent. Mississippi asks the court to dismantle this precedent and allow states to force women to remain pregnant and give birth against their will."

• **Justice Clarence Thomas:** On women being prosecuted for taking drugs while pregnant: "If she had ingested cocaine pre-viability and had the same negative consequences to her child, do you think the state had an interest in enforcing that law against her?"

• **Chief Justice John Roberts:** "[I]f you think that the issue is one of choice, that women should have a choice to terminate their pregnancy, that supposes that there is a point at which they've had a fair choice, opportunity to choice, and why would 15 weeks be an inappropriate line?"

• **Justice Amy Coney Barrett:** "Why don't the safe haven laws take care of that problem? It seems to me

that it focuses the burden much more narrowly. There is, without question, an infringement on bodily autonomy, you know, which we have in other contexts, like vaccines. However, it doesn't seem to me to follow that pregnancy and then parenthood are all part of the same burden."

• **Justice Samuel Alito:** "The fetus has an interest in having a life, and that doesn't change, does it, from the point before viability to the point after viability?"

• **Justice Brett Kavanaugh:** "I think the other side would say that the core problem here is that the court has been forced by the position you're taking and by the cases to pick sides on the most contentious social debate in American life … and, they would say, therefore, it should be left to the people, to the states, or to Congress."

• **U.S. Department of Justice Solicitor General Elizabeth B. Prelogar, JD:** "The real-world effects of overruling *Roe* and *Casey* would be severe and swift. Nearly half of the states already have or are expected to enact bans on abortion at all stages of pregnancy, many without exceptions for rape or incest."

• **Justice Neil Gorsuch:** "If this court will reject the viability line, do you see any other intelligible principle that the court could choose?" ■

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# What Will Happen to Women's Healthcare if Abortions Are Banned?

When most people no longer can seek safe abortion care in their home regions and states, there will be an increase in maternal deaths and injuries, both from unsafe abortions and from unsafe pregnancies that should have been ended because they risked the woman's health, several reproductive health advocates and researchers say.

"It's clear in countries where abortion is illegal or criminalized that women suffer more complications of pregnancy and higher mortality rates from unsafe abortions," says **Mimi Zieman**, MD, author of *Managing Contraception* and president of SageMed LLC in Atlanta. "In this country, the most unfortunate and unjust consequence of restricting abortion is that women of lower income and women of color will suffer more than women who have the means to travel to other states and countries to get care."

Abortions will continue in a post-*Roe* America, but women's safety will be jeopardized, says **Eva Lathrop**, MD, MPH, global medical director of Population Services International (PSI).

"It's crucial to provide safe abortion services," Lathrop says. "The global data show us that in highly restricted places, abortion does not go away."

When nations eliminate legal access, abortion numbers do not necessarily go down, but complications from abortions and deaths from abortions go up. "That's what we're looking at if abortion is overturned," Lathrop says.

A 2018 Guttmacher Institute report revealed that the abortion rate is 37 per 1,000 women in countries where abortion is prohibited or permitted only to save a pregnant woman's life. The rate is 34 per 1,000 women in countries where abortion is not as restricted.[1]

States have passed hundreds of abortion restrictions in recent decades, and access to safe and legal abortions already is limited for many people — particularly those from communities of color and indigenous communities.

"Removal of *Roe v. Wade* will make abortion care more challenging for everybody. It's devastating to think about," Lathrop says. "It's cruel and inhumane, and it's devastating for people who are carrying these pregnancies to term against their will. It's a complete violation of human rights to do that."

Vulnerable communities and people will suffer the most, says **Bhavik Kumar**, MD, staff physician at Planned Parenthood Center for Choice in Houston.

"Banning abortion uniquely harms the people who cannot travel out of state or find the means to end their pregnancies on their own," he says. "Disproportionately, those are the same communities who are already the most marginalized."

People of color, people in rural communities, and people who are

struggling to make ends meet and care for their families are the ones who will suffer most under state abortion bans because they usually are the ones who can least afford the cost and time of traveling out of state, Kumar adds.

States and nations that ban abortions also put pregnant women at risk, even with intended pregnancy. One consequence of abortion bans is that young OB/GYNs will choose not to practice in a state where they could suffer legal consequences if they perform an abortion to save a patient's life or health.

"What Texas did [with its six-week abortion ban] is make [it likely some] OB/GYNs will leave the state," Zieman says. "When we were fighting the six-week anti-abortion law in Georgia, we did a survey of new OB/GYNs and how the law would impact them. They said they wouldn't want to practice there."

Many reproductive health providers likely will avoid Texas because of its abortion ban. "They may not want to be in a position where someone is going to target them and take them to court, so they won't practice in that state at all," Zieman says. "That will affect all women because there will be a shortage of those providers."

The United States already has one of the highest maternal mortality rates in the industrialized world, and deaths during pregnancy likely will increase post-*Roe*.[1]

Recently, researchers found pregnancy-related deaths would increase by 7% soon after a nationwide abortion ban, and would increase by a further 21% in subsequent years. The researchers also noted pregnancy-related deaths would increase even if only some states banned abortions.[2]

Under the Texas abortion ban (SB 8), which began Sept. 1, 2021, women have been refused potentially life-saving care by practitioners in the state, according to media reports.

A woman in a rural area of south Texas called the National Abortion Federation (NAF) hotline after her doctor refused to help her end an ectopic pregnancy because of SB 8. NAF told the woman to go to the closest emergency department. But when the woman contacted the closest hospital, she was told she would have to go out of state to seek immediate medical care. The woman drove more than 12 hours to New Mexico to terminate her ectopic pregnancy.[3]

> ONE CONSEQUENCE OF THESE BANS IS THAT YOUNG OB/GYNS MIGHT CHOOSE NOT TO PRACTICE IN A STATE WHERE THEY COULD SUFFER LEGAL CONSEQUENCES IF THEY PERFORM AN ABORTION TO SAVE A PATIENT'S LIFE.

Ectopic pregnancies, which mainly occur in the fallopian tube, cannot be moved to the uterus. These pregnancies can cause a rupture with major internal bleeding, creating a life-threatening emergency that needs immediate surgery, according to the American College of Obstetricians and Gynecologists.[4]

"While some ectopic pregnancies end on their own, the vast majority are treated with medicine or surgery, which are necessary because it's life-threatening," Zieman says.

Laws that ban abortions, such as SB 8, force physicians and nurses to violate their medical practice and ethics. "They're not doing their best work, but they're doing what the state ordered them to do," Zieman says.

The United States is moving backward, Lathrop says. "We already have the highest maternal mortality rate among highly developed countries. That is shameful, and this will only increase it," she says.

Since SB 8 bans all abortions after six weeks, with no exception for rape or incest, this will have an immeasurable toll on women who become pregnant and are forced to continue the pregnancy.

Adolescents who become pregnant experience more complications in pregnancy and a higher risk for most complications, including preterm birth, pre-eclampsia, and risks from the physical trauma of carrying the pregnancy. They also could suffer from greater emotional trauma for being forced to become pregnant and bear the child of the person who assaulted them, Lathrop says.

States like California and New York, where state laws ensure abortion access, will see more people from out of state seeking abortion services. Early reports from late 2021 suggest that many Texans already have sought abortion care in other states.

"In California, abortion will be legal," says **Julie Rabinovitz**, MPH, president and chief executive officer of Essential Access Health in Berkeley, CA. "Governor Gavin Newsom has created the Future of Abortion Council."

The council will help the state prepare for an expected influx of out-of-state patients from Texas and also from other states in the event

the Supreme Court overturns *Roe v. Wade*. An estimated 1.4 million women — a nearly 3,000% increase — may travel to California for abortions if *Roe* ends, according to the council's December 2021 report.[5]

The Future of Abortion Council recommended that the state ensure cost is not a barrier to care and ensure timely reimbursement for abortion-related services, including an uncompensated care program that would provide abortion care reimbursement for out-of-state patients.

The report also recommends an expansion of abortion training and reproductive health education programs for primary care providers. The state should enact legal protections from civil and criminal liability for clinicians who provide abortions, including for patients from states with hostile abortion laws, the council noted.

"My hope is the government and legislature will adopt the recommendations and fully fund whatever is necessary to ensure access to people who want and need an abortion — not only in California, but also for those who come to California from other states where they do not have access," Rabinovitz says. ■

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# Planned Parenthood Federation of America Prepares for a Post-*Roe* Era

*Health outcomes expected to worsen*

**Ianthe Metzger**, director of state media campaigns at Planned Parenthood Federation of America (PPFA), spoke to *Contraceptive Technology Update* about the repercussions of an expected reversal of *Roe v. Wade*. The following interview has been lightly edited for length and clarity.

**CTU:** From a reproductive health perspective, what do you see as some of the most urgent repercussions in the event the U.S. Supreme Court sides with Mississippi's abortion ban?

**Metzger:** The Turnaway Study found that when women are denied abortions, their long-term well-being — and that of their children, if they have them — suffers.[1]

That burden falls mostly on Black and Latino communities, who, because of redlining and systemically white supremacist housing practices, are disproportionately living in low-income communities, and therefore more likely to struggle to access healthcare.[2]

Abortion is already often out of reach for these communities, and health outcomes will worsen should more states move to ban abortion if the U.S. Supreme Court overturns *Roe*. Currently, people have to not only find funds for an abortion, but take time off work, arrange childcare, and, increasingly, travel out of state for abortion care. Abortion restrictions create impossible hurdles that nobody should have to overcome in order to get essential healthcare. If more people are denied abortion, we can expect that more people will be forced to carry an unwanted pregnancy to term and possibly face great personal health risk.

Because of systemic racism in maternal healthcare in the United States, Black women in particular face disproportionate risks that could be deadly. Because of a lack of investment in social support to help Black birthing people thrive, they are three times more likely than white women to die or suffer severe complications during pregnancy, birth, and the postpartum period.

**CTU:** California's governor has created the Future of Abortion Council to look at how the state can prepare for increasing numbers of out-of-state patients of abortion services. In what ways are other

supportive states and PPFA clinics preparing for possible increases in abortion demands?

**Metzger:** California has long led the way on abortion access. [In December 2021], the California Future of Abortion Council released its report with recommendations on how to protect and expand abortion access in the state.[3]

Across the country, abortion providers in supportive states have been preparing for a surge in patients if other states ban abortion. We can also look to Illinois, where Reproductive Health Services (RHS) of Planned Parenthood of the St. Louis Region runs a health center just across the Illinois-Missouri border to serve people who are coming to Illinois. Already, 90% of patients who turn to RHS for abortion flee Missouri — where the state's abortion restrictions have put abortion out of reach for many people, especially Black and Latino Missourians, people with low incomes, and people who live in rural communities — to receive care in neighboring Illinois. [More information is available] in PPSLR's Future of Abortion Access in Illinois report.[4]

**CTU:** If the Mississippi abortion ban is upheld and other states end most abortion services as well, how can reproductive health providers encourage more people to be proactive with their contraception? For instance, could there be more of a push for women to stock emergency contraception, or could there be an increase in demand for intrauterine devices and other long-acting reversible contraceptives?

**Metzger:** Given what we've already seen in Texas, where abortion is now virtually inaccessible for many, we can expect to see a surge in the number of patients seeking emergency contraception and longer-term birth control options should other hostile states successfully ban abortion. To meet the demand, many of our Texas health centers have expanded access to birth control appointments, and even started distributing take-home empowerment kits, containing emergency contraception, early-detection pregnancy tests, condoms, and information about Texas's abortion ban, all available at no cost to all patients.[5]

These resources will, hopefully, help put some health information and assets directly back into patients' hands without political interference, given that their decision-making and access to the full range of options have been taken away. At the end of the day, Planned Parenthood will always stand up for its patients and will do everything possible to fight against laws that put politicians in control of people's healthcare decisions. ■

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# What Will 79% of OB/GYNs Do in Response to Supreme Court Abortion Decision?

*Expect a backlash when* Roe *ends*

**Robert A. Hatcher**, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board, discusses the history of *Roe v. Wade* and what could happen once the U.S. Supreme Court overturns it.

**CTU**: What is your history with abortion and *Roe v. Wade*?

**Hatcher:** I was a co-plaintiff in the *Doe v. Bolton* court case. *Roe v. Wade* and *Doe v. Bolton* were two cases about abortion that the U.S. Supreme Court heard together in 1973. The court decided in 1973 the laws regulating abortion in Texas and in Georgia were unconstitutional.[1]

I am a pediatrician. In the late 1960s, I went to the Centers for Disease Control and Prevention and said, "I want to work in family planning." They assigned me as an Epidemic Intelligence Service officer to the health department family planning program in Columbus, GA. When I got done with those two years, I'd put in many IUDs [intrauterine devices] and had seen people for a wide range of contraceptives. My next step was to join the department of gynecology and obstetrics at Emory University. My experience has been primarily in contraception.

I was never opposed to abortion, but I did not have strong feelings in favor of abortion until I started seeing patients in family planning who were using contraceptives and who became pregnant.

I'll give you one example from 1969 that altered my opinion about abortion. This woman came to me through our family planning program. She was the mother of five children. She had an IUD in place and was late for her period. I had to tell her that she was pregnant. Her life was looking up for her before this pregnancy. She had been living in an apartment that had rats in it, and they bit her children. This is what she awakened to find many times in the morning. She had found different public housing in Atlanta where rats were not a problem. But she could not move in if she had six children. I had to tell her that she was pregnant with what would be her sixth child. She was absolutely desperate.

> "IT'S GOING TO BE SO MUCH MORE DIFFICULT FOR YOUNG WOMEN, UNMARRIED WOMEN, AND WOMEN OF COLOR TO OBTAIN ABORTIONS."

I told her there was no law favoring abortion at this point. I didn't know how it would happen, but I told her I would help her obtain an abortion. There was group at Emory called the Emory Clergymen's Counseling Service. I knew that what they would require of her was about $300 to fly to Mexico to get the abortion in a place where they knew of doctors doing safe abortions. I asked two individuals if they would contribute $100 to this process, and decided I would do the same. That's how we came up with the $300. She flew down to Mexico, obtained a safe abortion, and from then on, I had put my foot into the water in terms of being a proponent of safe, legal abortions.

Then, in the summer of 1969, I was called by a woman who pulled together all the co-plaintiffs in the Supreme Court case in Georgia that would be argued with *Roe v. Wade,* the Texas case. *Doe v. Bolton* was the Georgia case. They asked if I would be a co-plaintiff in this case. Five years after the Supreme Court handed down their momentous decision, I found out that I was the first person called in Georgia because they wanted a doctor to sign up as the first co-plaintiff. I don't know what would have happened if there hadn't been four or five summer students sitting in the room with me when I got the call asking me to be a co-plaintiff. I said, "Of course, I'll do it." However, I was very nervous at that point because the chairman of the department for which I worked was listed as one of the co-defendants in *Doe v. Bolton*. I was a young, recently hired member of his GYN/OB faculty.

Ultimately, three people from our department became co-plaintiffs. The department chair was one of the people whom the case was filed against because his department had turned down Doe for an abortion. Eventually, his name was taken off the case.

I'd only been in the department for a year and a few months. Fortunately, most of the department wanted abortion to be available to people

in Georgia. Later on, Dr. John D. Thompson's name was taken off, and the case went to the Supreme Court. The case was filed against the attorney general of Georgia, the police chief of Atlanta, and the head of the hospital authority.

**CTU:** Did you ever think *Roe* would be overturned in your lifetime?

**Hatcher:** Most Americans wanted abortion available for women. That was the case in 1973 and it's still the case in 2022. I didn't think *Roe v. Wade* would be reversed, but I always thought it could be because it's such an emotional subject.

This raises the question: "How are women going to be able to get abortions in the United States?" It's going to be much more difficult for young women, unmarried women, poor women, economically disadvantaged women, and women of color to obtain abortions. Women who have money and who can go elsewhere will have safe abortions because there will be abortions available in many other places.

The mother of five I talked about is an example of what could happen again. Politically, the health concerns of poor, unmarried women of color are of less concern to many Americans although those are the very people who will not be able to get an abortion.

There are lots of people who know what their options are, but to have access to an abortion now in the face of the Supreme Court overturning *Roe*, safe access to abortion is going to be unlikely for a large segment of society. Abortions will cost a lot of money, and lack of access will hurt many people and their families.

**CTU:** If these bans occur, will doctors turn away women whose health depends on an abortion?

**Hatcher:** In many cases, the answer clearly will be yes. That's what happened in the past when hospitals turned away women for abortion even when pregnancy was dangerous.

This is a profound women's rights issue, and most physicians in obstetrics and gynecology now are women [79%].[2]

**CTU:** What will be the long-term repercussions of abortion bans?

**Hatcher:** Some physicians who are practicing in a state where abortions have been dramatically curtailed are going to fight and do things they're not supposed to do, and if they can hide it, they will do so. You just know that's going to happen. It's pretty straightforward how to do these procedures and how to do them safely. But you will also have back alley abortions, and they will sometimes be done incompetently. There are thousands of nurses and doctors in each state who know how to [perform] an abortion safely. It's not at all beyond the pale that some abortions will be available. It will be scary because the punishments are so ridiculous, but people will do them. I predict that some physicians in Texas, Florida, Mississippi, and Georgia will assist women desperate to end a pregnancy. I doubt that such physicians will go to jail or pay $10,000 fines. But we will see.

Imagine the young woman, who is raped, finding herself pregnant. She may know people who know someone who can perform abortions safely. She will put all sorts of pressure on her friends or family members to help her.

There will be a lot of tragic consequences from all these changes. I think it's safe to predict that eventually there will be a change back toward more availability of abortions in response to those tragedies. ■

## REFERENCES


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# FDA Approves Telemedicine Abortion; Canadian Study Demonstrates Safety

The FDA cleared the way for telehealth medication abortion after conducting a review of the Risk Evaluation and Mitigation Strategy (REMS) status of mifepristone on Dec. 16, 2021.[1]

The change to the abortion medication's REMS status will allow providers to dispense the pill via telehealth visits and allow certified pharmacies to dispense it. Patients can obtain the drug without an in-person clinic visit in states that do not prohibit mail-order mifepristone.

The FDA's change follows a trial period of mail-order distribution of mifepristone during the COVID-19 pandemic. The availability of mifepristone without the requirement of in-person visits proved successful.

Research shows that mifepristone can be treated as a normal prescription without compromising safety and risking complications. Researchers used population-based data from Ontario, Canada, to compare trends in abortion use,

safety, and effectiveness before mifepristone was readily available (January 2012 to December 2016), and after the medication was available without special regulatory restrictions (Nov. 7, 2017, to March 15, 2020).[2]

The researchers found that the proportion of medication abortions increased rapidly (from 2.2% to 31.4%) once mifepristone was available as a normal prescription. Overall, the abortion rate remained stable. Adverse events and complications did not increase after mifepristone became available when compared to before mifepristone was available.

"The big take-home message is that abortion services remain safe," says **Laura Schummers**, ScD, lead author of the study and a postdoctoral fellow at the University of British Columbia in Vancouver. "One of the advantages of our study is that we capture every single healthcare encounter that people in our study had, whether they go to a walk-in clinic, general practitioner, emergency room, or hospital. Because we have a single-payer provincial health system, we can link all of these different types of visits that let us know what happened with that pregnancy."

Schummers and colleagues studied the safety profile of medication abortion and looked at all abortion complications.

"We cast a wide net: Someone may have infection, bleeding, and things of that nature," Schummers says. "There was no change in incidence of those complications, comparing the period between January 2012 and December 2016, when 0.7% of abortions had complications."

After the medication abortion restrictions were lifted, the rate of complications remained at 0.7%.

"A more severe outcome would be a combination of abortion complication along with something indicating severe illness, like sepsis, an ICU [intensive care unit] admission," she says. "Those are very rare following any kind of abortion, and those did not change from before it was available and after all restrictions were removed."

The results show that the Canadian regulatory change in medication abortion had no effect on abortion safety in Canada, Schummers adds.

In Canada, abortion is regulated the same as any other medical procedure or medication. "It's up to the professional organizations to regulate how abortion is provided," Schummers explains. "There's nothing in the criminal code about abortion."

When Canada's regulatory agency lifted restrictions on mifepristone for medication abortion, investigators hypothesized that unencumbered access would result in an earlier shift in gestational age across all abortions because people would not have to travel so far to obtain an abortion. But this did not happen.

"We found no significant change in percentage of abortions provided in the second trimester after 14 weeks," Schummers adds.

A future question to study would be whether availability or accessibility of abortion services changed. "This is more nuanced, and it's something outside the scope of this paper," Schummers explains. "It's something we will look at in terms of access to primary care or populations that live outside Canada's major cities."

Researchers will study whether easier to access medication abortion means people obtained abortions closer to their homes and at primary care facilities rather than at abortion clinics.

"In Canada, with our geographically distributed population, it's a real challenge to make sure we have healthcare available in general," Schummers says.

The availability of mifepristone through pharmacies, primary care, and even telehealth would alleviate the burdens of traveling, arranging child care, and taking time off work.

The FDA's move to allow U.S. pharmacies to dispense mifepristone and providers to prescribe it via telehealth visits also will make medication abortion available for more people.

The pandemic continues to be a factor and may shift more abortion services to telehealth services, just as it has for other types of medical visits.

"How abortion services shifted in reaction to the pandemic is separate from the question of whether this is safe," Schummers says. "We stopped this study before the pandemic because those are separate questions." ■

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1. Food & Drug Administration. Questions and answers on Mifeprex. Updated Dec. 16, 2021. https://bit.ly/3zbzlqo
2. Schummers L, Darling EK, Dunn S, et al. Abortion safety and use with normally prescribed mifepristone in Canada. *N Engl J Med* 2022;386: 57-67.


## COMING IN FUTURE MONTHS

- Pharmacy-based model for contraceptive access
- Broad benefits to abortion training for OB/GYNs
- Adolescents follow contraceptive advice from mothers, social networks
- STD rates continue to rise

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# CME/CE QUESTIONS

1. **According to a study using Canadian health data, what was the effect of a regulatory change that made mifepristone available as a normal prescription?**

   a. There was a slight increase in complications and hospital visits after the change.
   b. There was a decrease in complications after the regulatory change.
   c. The study found no differences in complications and safety before and after the regulatory change.
   d. Fewer women sought medication abortions after the change.

2. **The California Future of Abortion Council made which recommendations in its December 2021 report?**

   a. The state should ensure cost is not a barrier to abortion care.
   b. California should sue states from which women travel to seek an abortion in California.
   c. The state should double its number of abortion centers near its borders by 2030.
   d. Providers should receive abortion care training at no cost.

3. **Planned Parenthood in Texas has taken which action to help patients affected by the state's six-week abortion ban?**

   a. They give patients information about abortion centers in other states.
   b. They distribute take-home kits of emergency contraception, early-detection pregnancy tests, condoms, and information about the abortion ban.
   c. They recommend intrauterine devices for all reproductive-age women.
   d. They provide people with information about abortion rights protests and marches.

4. **In December 2021, which medication did the FDA make available via telemedicine?**

   a. Hormonal birth control pills
   b. Contraceptive patches
   c. Medication abortion
   d. Vaginal ring