BIOETHICS GUIDANCE FOR THE POST-*DOBBS* LANDSCAPE

June 28, 2022

The Association ofBioethics Program Directors (ABPD) comprises the leadership of nearly 100 academic bioethics programs at medical centers and universities across North America. Individual members, and the academic and health care institutions where they work, reflect multiple jurisdictions, cultures, and moral viewpoints.

Although we are a diverse group ofbioethics professionals, we share dismay that the healthcare landscape is being radically disrupted by the *Dobbs v. Jackson* decision with no accompanying policy structures to prevent widespread collateral harms. Nearly half of all U.S. pregnancies are unintended, while "nearly one in four women in the United States" have had an abortion by age 45. The APBD affinns a commitment to reproductive health care services in accordance with core healthcare ethics principles. The ABPD thus offers the following healthcare ethics guidelines for health care providers, budgets, and policymakers moving forward in a post-*Dobbs* landscape, cross-referenced with some of the relevant expected harms and patients' needs.

Previous research indicates that persons who seek and are denied access to abortion suffer a variety of negative consequences, including increased risks of poverty, staying in contact with physically abusive partners, and worsening health in general. Extrapolating from other countries that have banned abortion, we can also expect a surge in deaths from pregnancy complications.

1. The doctrine of informed consent obligates practitioners to counsel their prenatal patients about all available options within the medical standards of care' available in the United States, including all FDA-approved medications.
2. Professional ethics standards obligate practitioners to disclose any conflicts of interest, conflicts of commitment, or conscientious objections when treating prenatal patients, and to refer patients accordingly for the medical standard of care they cannot provide.
3. When the medical standard of care is not available in a particular jurisdiction or state, patients should be counseled about where such care is available[2], and unimpeded interstate travel for reproductive services should be supported by all jurisdictions without consequences to referring clinicians.
4. Affordable access to FDA-approved contraception should be ensured. The American College of Obstetricians and Gynecologists has backed proposals to make hormonal contraceptives available over-the-counter, which is one promising step toward increased access, though cost remains prohibitive for many.
5. The autonomous decisions of pregnant patients ought to be respected; patients who are constrained by state jurisdictions to involuntarily remain pregnant should be treated with respect and directed to other jurisdictions for care, including referral to mental health providers when appropriate.
6. Practitioners have a duty to care for their patients' welfare through well-earned trusting relationships. Physicians should avoid contributing to civil or criminal legal processes that serve to punish, threaten, or harass prenatal patients.
7. Scientifically and medically accurate sexual and reproductive health education should be provided to all patients, particularly adolescents [3].
8. Patients seeking fertility treatment should be referred to jurisdictions where full access to reproductive care is offered. Fertility practices in states where reproductive healthcare is limited or constrained should consider relocation to jurisdictions where the medical standard of care is available without constraints.
9. Clinicians should prepare for an increased need to identify and intervene in cases of intimate partner violence, child abuse, and suicidal ideation.

B) Pregnant persons in the US die of complications at nearly four times the rate of other wealthy countries; the rate of death from complications among non-Hispanic Black pregnant persons is even higher. Economic equity for the childbearing parent is weakly protected by U.S. policies because paid maternity leave is rare and childcare expectations tend to push postpartum parents out of the workforce. The cost of raising a child was approximately $13,000 per child each year before the recent inflation increased these figures.

1. All prenatal patients who present to hospitals or healthcare providers in labor require affordable access to obstetrical care, and informed consent for all medical options for safe labor and deliveries; obstetricians are obligated to respect the pregnant patient's autonomy, and to protect their life in catastrophic labors and/or deliveries.
2. Practitioners have a duty to advocate for legal changes that would advance the welfare of their patients.
3. Paid maternity leave should be offered for one year for any postpartum patient regardless of parental responsibilities, which is the international standard for wealthy countries.
4. Unwanted and/or abandoned neonates who become wards of the state must be provided with free healthcare for all their neonatal and future pediatric needs until/unless they are adopted or become adults at age 18.
5. Neonatal patients without parental representation require state-appointed guardians until/unless a parental authority can be designated.
6. All postpartum patients should be counseled about postpartum healthcare options and needs, and provided affordable access to mental health care, social services, and economic assistance; involuntary birthing patients should be provided with free legal services to opt out of parental responsibilities.
7. Expanded investment in childcare facilities, tax credits and other childcare support measures are essential for ensuring that children can thrive. This need is even more pressing if abortion restrictions force parenthood upon many.

C) Patients grieving over miscarriages may face the threat of criminal investigations from police and prosecutors. This problem will get worse and more widespread in the absence of legal protections. Patients seeking abortions outside their home jurisdictions will contend with a daunting and unclear legal landscape, with a patchwork of state regulations and laws and looming efforts to criminalize patients crossing jurisdictions to get care or to criminalize the efforts of others to help patients get the care they seek (including clinicians).

1. Confidentiality, in accordance with core bioethics principles, rights to privacy, and **HIP**AA, should be upheld in treating prenatal patients; state-imposed registries that make the names and personal health information of patients and their practitioners public for certain types of reproductive care contradict and violate basic healthcare ethics principles of confidentiality.
2. Practitioners seeing out-of-state patients for prenatal care banned in other states have a duty to treat them and to uphold confidentiality; such practitioners should consult their institutional legal counsel about their state's healthcare asylum policies for patients requiring it.
3. Prenatal patients in any state presenting with miscarriage should be treated with respect; confidentiality must be upheld.
4. Patient referral for healthcare services must remain legally protected. To classify such advice as "abetting" a crime would be catastrophic for the patient-caregiver relationship.

Notes:

1. The medical standard of care is detined by clinical practice guidelines, relevant medical associations, and evidence-based science and practice. Socio-economic and regional health disparities may intluence whether patients can access the standard of care, but do not change the standard of care.
2. if patients can more easily obtain the standard of care in Canada because it is closer, this should be considered; Canada otters prenatal asylum to any American patient requiring prenatal care.
3. lntormed consent ofthe parent or guardian is not required tor contraception; what detines adolescent patients is the age of onset of puberty, which may vary.