Preparing for a post-Roe world

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As the make-up of the Supreme Court shifts, with a new justice, and other seats potentially opening over the next few years, American women's access to safe abortion may become more tenuous than at any time since 1973, when Roe became the law of the land. If, with a new court, we enter a post-Roe world, decisions about abortion laws would devolve to the states. Indeed, in some states, there are already efforts to restrict access to legal abortion, and these state-level restrictions exemplify the challenges that will be faced when attempting to implement the strategies that we propose. Changes in access would particularly disadvantage women lacking the resources to travel to states that continue to permit abortion. While advocates on both sides of the abortion debate are mobilizing their adherents to frame the discussion, and to defend or dismantle Roe, providers of health care for women must start to consider their role and responsibility in what could soon become a post-Roe world. Whatever the ultimate legal denouement, providers must keep the health of reproductive-aged women as their lodestar. Some of the challenges that our discipline will face are discussed below.

Before the Supreme Court legalized abortion, several hundred to a thousand women died annually from unsafe abortions; in New York City in 1961, for example, it was estimated that 47% of maternal deaths were due to illegal abortions.[1,2] A repeal of Roe would compromise the health of more than just those women who resort to unsafe abortion. Women whose medical circumstances make pregnancy a life-threatening condition (eg, Eisenmenger's syndrome) and who lose the option of abortion will face medical jeopardy as well. Professional organizations will need to develop management guidelines for women who have those conditions and whose social situations preclude travel for safe terminations. Those same organizations will also have to create and disseminate guidelines for the treatment of septic abortion, uterine perforation, and other sequelae of self-induced abortions as well as abortions performed by nonprofessional individuals. Some women may find it easier, or perceive it to be safer, to use medical abortifacients than to travel to other states or to find local, unlicensed abortion providers. Providers must be prepared to deal with complications of inadequately supervised medical abortions as well.

Governmental and social service agencies will have to expand services for children with a variety of congenital disorders, ranging from Down syndrome through ultimately lethal malformations. It is estimated, as an example, that two-thirds of fetuses with Down syndrome are aborted.[3] Psychosocial support will be needed by families who had either planned pregnancies with serious fetal anomalies or unplanned pregnancies that they might otherwise have aborted. A common reason for termination of an unplanned pregnancy is financial and psychosocial hardship and the anticipated need to reduce resources for already-born children if the unplanned pregnancy is live born. The birth of that additional child may well put those families at risk, a risk that society should mitigate with the expenditure of necessary funds and support systems.

In addition, despite the fact that large geographic swaths of the United States may soon criminalize abortions, there will still be a need to train abortion providers. However, there will be new barriers to that training. Residency programs in states where abortion becomes illegal will not be able to provide training. Graduating residents from those programs, even if they begin their practice in states where abortion remains legal, will not be prepared to perform procedures safely. All of these problems are likely to have even greater impact on training for second trimester procedures in which serious fetal anomalies and life-threatening maternal diseases are identified. Therefore, several steps will need to be taken. The Residency Review Committee should make it easy for programs to send residents from states where abortion is illegal to states where abortion remains legal. Programs that offer training should offer rotations to trainees from other states. Post-residency training programs should be developed for physicians who were denied desired training during their residency but who wish to offer a full range of family planning services subsequently. Barriers to the training of care extenders such as midwives need to reconsidered and, ideally, removed. In New York State, for example, political disagreements in the upper house have thus far stymied efforts to allow practitioners other than physicians to perform early abortions. The possibility of a review of Roe in the Supreme Court adds urgency to a reconsideration of legislation that would allow the credentialing of qualified nonphysicians.

Strategies to maximize access to services by residents of states that criminalize abortions should also be developed and implemented. These efforts could include the opening of "border clinics" to reduce, to the greatest degree possible, the distance between women's homes and needed services. Ideally, those efforts would be coupled with funding, through philanthropy or from professional organizations, to help to defray the travel expenses of indigent women.

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Finally, in 2002 the ABIM Foundation, in conjunction with the ACP Foundation and the European Federation of Internal Medicine, jointly authored what they referred to as the Charter on Professionalism, which listed 3 tenets: primacy of patient welfare, autonomy, and social justice.[4] The last, writ small, speaks to the obligation of individual physicians to be guarantors of health equity in their practice. Writ large, we would submit, it speaks to the role of physicians as health experts to speak for the well-being of all peoples. In pursuit of that creed, physicians should use their expertise to advocate for the public health outside the footprints of their offices. They should be encouraged to speak to legislators about ways to lessen the deleterious health consequences that will be associated with any roll-back of Roe, and to track those consequences so that appropriate mitigation strategies can be adopted, and so that future debates about the effects of restricting abortion on the health of women can be fully informed.

Our mentor, Richard Schwarz, MD (1931−2017), was President of the American College of Obstetrics and Gynecology, The New York Obstetrical Society, and a founding member of the Infectious Disease Society of Obstetrics and Gynecology, and the Society of Perinatal Obstetricians (now the Society of Maternal Fetal Medicine). With all that, one of his proudest accomplishments was his text "Septic Abortion,"[5] published in 1968 in the days of "back alley" terminations. His acolytes looked at his tales of those dark pre-Roe days—the coat hangers, and knitting needles that often perforated the uterus and intestines, the ingestion of bleach and laundry detergent—the way our trainees look at the pre-HAART era of AIDS: times when needless deaths struck down people in the prime of their lives. That was a chapter in medical history that they assumed would never to be revisited in their professional lifetimes, and it is our hope that their assumptions will prove true. However, it would be Pollyannaish for women's health care providers to assume that if the Supreme Court reverses Roe there will be no adverse consequences. Accordingly, physicians acting in concert with all stakeholders need to take on a new and expanded role in view of this critical issue to women's health. In sum, the Supreme Court's decision to respect *stare decisis* or to void Roe v Wade will have more than legal consequence. The ruling will reverberate into the public health sphere. Unless physicians use this moment to plan, we will miss the opportunity to prevent some of the adverse events that will inevitably ensue. ■

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ABSTRACT

Preparing for a post-Roe world

Changes in the make-up of the Supreme Court make an overturn of the Roe v Wade decision a realistic possibility. In order to mitigate any adverse health consequences that could result from a change in the law, all stakeholders in women's health have to start to plan for that contingency. These stakeholders include physicians, nurse midwives, nurses, their professional organizations, health advocacy groups, health policy experts, and legislators. Among the tasks for physicians and their professional organization, we include education about the management of women injured by unsafe abortions, post-residency training for physicians with reduced access to residency training in abortion, and planning for the management of medically complicated pregnancies that currently are often terminated (eg, Eisenmenger's syndrome). In this piece, we argue for preparation for a potential post-Roe world.

Key words: abortion, Roe v Wade, septic abortion