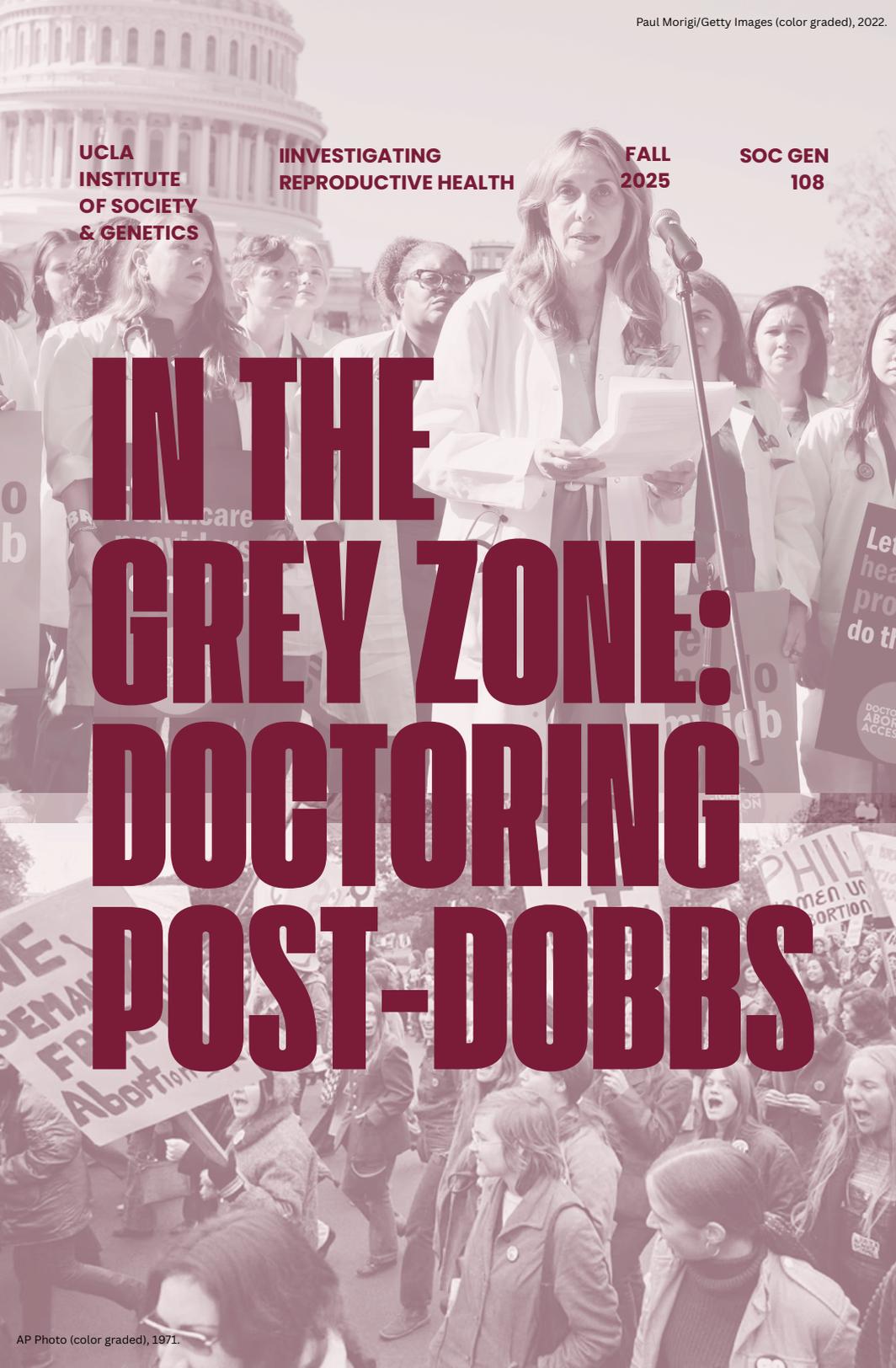


**UCLA  
INSTITUTE  
OF SOCIETY  
& GENETICS**

**INVESTIGATING  
REPRODUCTIVE HEALTH**

**FALL  
2025**

**SOC GEN  
108**



# **IN THE GREY ZONE: DOCTORING POST-DOBBS**

# NOTE FROM THE EDITORS



**Avantika  
Aggarwal**



**Saanvi  
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The landscape of reproductive health in the United States has long been contested and remains ever-changing. Since the 2022 *Dobbs v. Jackson Women’s Health Organization* decision overturned *Roe v. Wade*, clinicians across the United States have been faced with difficult decisions that require a reconciliation of clinical obligation and legal restriction. More specifically, healthcare providers are facing heightened legal ambiguity when treating pregnancy-related issues. Situations such as ectopic pregnancies, premature rupture of membranes, or septic miscarriages demand rapid, biologically informed decisions to save a patient’s life. However, new state laws that criminalize or severely restrict abortion force clinicians to delay or deny evidence-based care until a patient’s condition worsens enough to meet vague legal thresholds. When paired with informed clinical intervention, these vague legal thresholds cause a clash between law and medical practice, often leaving clinicians to navigate tricky situations with little guidance. Examining the implications of legal ambiguity in a Post-*Dobbs* landscape becomes imperative in order to understand the federal and state-specific shift that has occurred since 2022, and how this is impacting clinician decisions, policymaker work, and community experiences alike.

Our project focuses specifically on investigating this issue from the perspective of healthcare providers in states that have some of the most restrictive reproductive health landscapes in the country. With a specific emphasis on Georgia, we strive to understand how clinicians at teaching institutions, such as Emory, evaluate and care for pregnancy-related emergencies amidst restrictive policies. Our work incorporates a variety of interviews to provide a holistic understanding of the stakeholders involved, from the policy makers to those in academia, medical students, impacted communities, and finally, clinicians who have worked in Obstetrics and Gynecology and witnessed changing practices over the last decade. These complexities leave us with a critical set of questions we hope to explore: How do clinicians provide timely, evidence-based care when legal ambiguity shapes decisions? How do these constraints alter the learning environment for medical students and residents? And how do these compounded pressures manifest among policymakers, health systems, and the communities most affected?

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# ABORTION THROUGH THE YEARS

1821: Connecticut passes the first U.S. law banning any abortions after “quickening” or fetal movement.

1965: *Griswold v. Connecticut* strikes down Connecticut’s contraception ban for married couples and recognizes a right to marital privacy.

1973: *Roe v. Wade* legalizes abortion as a constitutional right nationwide, using a trimester viability framework.

1986: A federal law, EMTALA, passes requiring hospitals to provide stabilizing emergency care regardless of a patient’s ability to pay.

1999: FDA approves the first “morning-after pill” and Plan B emergency contraception follows and becomes OTC for 18+ in 2006.

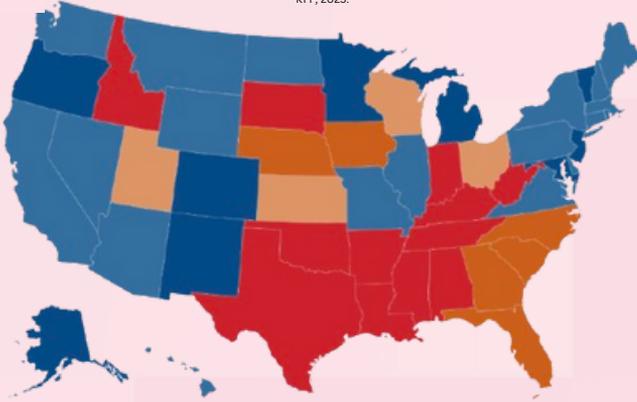
2022: *Dobbs v. Jackson Women’s Health Organization* overturns *Roe*, ending the federal constitutional right to abortion and returning control to the states.

# POLICY HAS A BODY COUNT

The first map outlines state-specific gestational limits — a legal restriction on the maximum number of weeks of pregnancy for which an abortion can be performed — while the second map depicts trends in maternal mortality rates across the country. Placed side by side, there is an overall trend suggesting that states imposing the harshest limits on abortion overwhelmingly have the worst maternal mortality rates.

## GESTATIONAL LIMITS BY STATE

KFF, 2025.



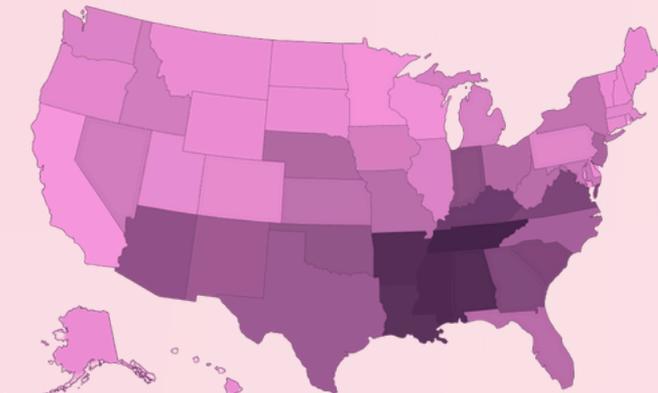
### Status of Abortion Bans in the United States as of June 2, 2025

Hover over state for more details

- Abortion Banned (12 states)
- Gestational limit between 6 and 12 weeks LMP (6 states)
- Gestational limit between 18 and 22 weeks LMP (4 states)
- Gestational limit at or near viability (19 states)
- No gestational limits (9 states & DC)

## MATERNAL MORTALITY BY STATE

Eugene Declercq and Laurie C. Zephyrin, Commonwealth Fund, 2025.



Maternal Mortality Rate (2018-2022) (per 100k Births)

- 10.0
- 15.0
- 20.0
- 25.0
- 30.0
- 35.0
- 40.0
- 45.0

# LEGAL AMBIGUITY

Legal ambiguity in abortion law is a grave hazard that reshapes how clinicians practice medicine. The Post-*Dobbs* system is set up in a way such that clinicians around the country face different legal risks for identical clinical scenarios. Pregnancy-related emergencies present a unique subset of cases, typically requiring rapid decision-making and evidence-based intervention. It is these very cases, however, that are most severely implicated by legally ambiguous language. Physicians must interpret vague terms such as “medical emergency,” “viability,” “fetal age,” or even “personhood,” often with legal consequences attached.

Certain emergencies, like an active hemorrhage, call for clear clinical action. Other, less explicit warning signs leave far more room for interpretation, forcing physicians to hesitate and further endanger the life of the patient. In cases like ectopic pregnancy, for example, the law is unclear.

So how, then, are physicians expected to make rational decisions, especially when their careers, reputations, and livelihoods are on the line? Policies differ by hospital and interpretation of the same law differs across institutions, ultimately creating more confusion among doctors and lawyers alike. These uncertainties now intersect with the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA creates a federal obligation to stabilize patients in emergencies, even when that stabilization requires pregnancy termination.



Gemunu Amarasinghe/AP Photo, 2022.

EMTALA is in legal conflict with several state bans, further blurring the lines between legally justifiable and criminal. Sepsis cases are rising, even though this is a preventable part of maternal deaths (Plante). Abortion laws are not consistent in their language, design, or implementation. There are no standard measures of fetal age or emergency thresholds (KFF). There are no medically grounded criteria for personhood, both biological and legal. When these policies are drafted without clear clinical standards, physicians are forced into a tricky position - are they practicing medicine, or law?

# CASE STUDIES

## ADRIANA SMITH, GA



A 30-year-old woman in Georgia who had been declared brain-dead during pregnancy was kept on life support against her family's wishes. Under Georgia's restrictive abortion laws, the presence of cardiac activity legally qualified the fetus as a "person," prohibiting withdrawal of life support even when fetal viability was low and doctors anticipated fatal birth defects. This situation highlighted how rigid legal definitions can override medical judgment and family autonomy. It also demonstrates how post-*Dobbs* laws can create ethically confusing scenarios where patients' bodies are treated as incubators (PBS News).



## KAT CAMMACK, FL

Florida representative Cammack revealed that she suffered a life-threatening ectopic pregnancy, but her doctors were hesitant to administer methotrexate, a drug used to inhibit cell growth, due to uncertainty about Florida's six-week abortion ban. This delay illustrates how clinicians, out of fear, may wait until a patient is sicker before intervening. Previously, Cammack, who voted in favor of H.R. 21, which imposes criminal penalties on healthcare providers who fail to comply strictly with abortion restrictions, fell victim to her own legislation (Feminist Majority Foundation).

## AMBER THURMANN, FL



Amber Nicole Thurman was a young black mother in Georgia who developed a treatable complication after a medical abortion but died when doctors delayed intervening. Her pregnancy passed the six-week mark on July 20th, 2022, the day Georgia's LIFE Act went into effect (Georgia General Assembly). She ended up travelling to North Carolina and was given mifepristone, instead of getting a D&C (dilation and curettage) because she was late. However, Thurman was one of the rare cases in which the pill did not ensure a complete abortion. Days later, she went to a Georgia hospital with signs of infection, but doctors waited hours before performing a uterine evacuation because her case was not a clear enough "emergency" (Surana). Her infection got so bad that she ended up having to get her bowel removed, and when she was finally taken into the operating room, her heart stopped, leaving her 6 year old son without a mother (Surana). At the heart of this case is an ethical problem that goes beyond a single medical mistake: should fear of violating a six-week abortion ban ever outweigh a patient's urgent need for life-saving care?

# A LOOK AT THE NUMBERS

**70%**

of physicians report symptoms of anxiety and depression as a result of *Dobbs*

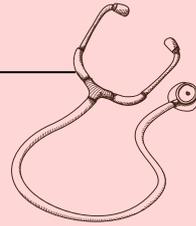


**58%**

of prospective doctors are unlikely to apply to a residency program in a state with abortion restrictions

**11%**

of physicians report moving their practices to states with stronger abortion protections post-*Dobbs*



**56%**

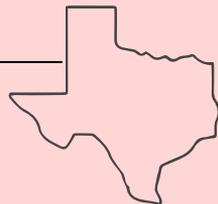
rise in maternal mortality in Texas following the state's abortion ban

**87%**

of providers from a survey reported worries about practicing in an uncertain legal climate post-*Dobbs*

**155%**

higher risk of maternal death in Texas than in California





# IN CLINICIANS' WORDS

as quoted in surveys by Boston College published in JAMA (2024)

“It used to be that any day you were going to work, you could get sued. And now, any day you go to work, you could get sued or you could be charged with a felony. And that additional anxiety just weighs on me.”

“I trained for the stress of treating an unstable...ectopic pregnancy. I did not train for, I am not ready for thinking about, ‘Is this the case that’s going to make me a felon?’”

“I feel like there’s a politician in the room with me with patients...just waiting to send me to jail, to make an example out of me if I say the wrong thing.”

“How frustrating is it that somebody has to drive hours somewhere to get a medically recommended therapy, when the physician in the office [is] telling you, ‘I can take care of you but the law says I can’t?’ Let’s say she had a bad outcome, let’s say she labored or started bleeding in the car...[how] frustrating it is that we’re limited in what we can and can’t do just to take care of people?”

# ZOOMING INTO GEORGIA

The state of Georgia has long pioneered the push for restrictive reproductive laws. Long before *Dobbs*, the Peach State was laying the groundwork for aggressive limitations on abortion and other forms of obstetric care. House Bill 481 (HB 481), enacted in 2019, bans most abortions upon detection of fetal cardiac activity – typically six weeks into pregnancy (GA. H.B. 481 2019). Though the bill only became legally enforceable in 2022 following the *Dobbs* decision, it has already turned reproductive care on its head. Its obscure “six-week” deadline functions less as a clinically-supported guideline and more as a political boundary that most patients cannot realistically meet.

Perhaps more concerning, HB 481 includes an exception for “medical emergencies,” but fails to explicitly define what exactly constitutes a legally viable “emergency.” Instead, it leaves interpretation entirely up to the physician’s discretion. This obscurity presents unfathomable challenges, particularly for physicians making time-sensitive clinical decisions. These physicians are now tasked with assessing both symptoms and potential legal consequences, all in the same breath. In fact, HB 481 makes it clear that physicians can face criminal action in the form of license suspension, felony charges, and even prison time if an intervention is found to be “unwarranted.” Consequently, physicians are incentivized to delay evidence-based care until a patient’s condition reaches the point of uncontestable medical instability. To meet these undefined legal thresholds, patients are often left to worsen to the point of infection, cardiovascular instability, and even significant hemorrhage – only then is



evidence-based care legally defensible.

In a report published by Georgia Senator Jon Ossoff’s office in collaboration with the American College of Obstetrics and Gynecology (ACOG), doctors report having to send women home to wait for infections to set in before carrying out abortions (Ossoff et al. 2025). In one case, after waiting for serious complications to develop, physicians had to perform an emergency hysterectomy on a patient, leaving her permanently sterilized.

Standard of care used to be straightforward and clear. Now, many Georgia hospitals and OB-GYN departments report increased ethics consults, legal reviews, and delays in care post-*Dobbs*. “Risk management” assessments are the new norm, and instead of doing their jobs, physicians are forced to anticipate the “worst-case-scenario” and navigate a bill that was written to be as vague as it is restrictive. Georgia thus presents an incredibly interesting case study: how do physicians navigate legal ambiguity? How does policy language, or the lack thereof, reshape physician decision-making? We hope to answer these questions through our investigation of Georgia’s post-*Dobbs* clinical landscape and the ways in which it shapes real-time medical decision-making.

# HB-481 UP CLOSE: WHEN LAWMAKERS CONTROL MEDICINE



## 1 "DETECTABLE HUMAN HEARTBEAT ..."

**means embryonic or cardiac activity or the steady and repetitive rhythmic contraction of the heart within the gestational sac.** There is no medical standard for "steady" or "repetitive," and the bill makes no mention of acceptable methods of cardiac measurement. Is cellular activity necessarily indicative of a fully functioning heart? Is a beating heart equal to personhood?

1

2

## "MEDICALLY FUTILE MEANS..."

**that, in reasonable medical judgement, an unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth.** The bill offers no diagnostic list or criteria of "qualifying" fetal anomalies. Does "sustaining life" refer only to physical survival, or does it take into account quality of life?



## 3 "MEDICAL EMERGENCY MEANS..."

**a condition in which an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function.** What constitutes "substantial" damage? What counts as a "major bodily function," and what is "necessary?" These words are vague and largely undefined.

3



## "A PHYSICIAN DETERMINES..."

**"in reasonable medical judgment, that a medical emergency exists."** What is "reasonable" to one may not be reasonable to another, especially if judged retrospectively in court (by someone with little to no clinical expertise). Again, we are left to wonder what constitutes a medical emergency. The bill fails to provide specific parameters, like vital-sign thresholds or infection markers, leaving legal lines blurry.



5

4



## "AN ABORTION MAY BE PERFORMED IF..."

**the probable gestational age of the unborn child is 20 weeks or less and an official police report has been filed alleging the offense of rape or incest.** 'Probable gestational age' is medically imprecise. Ultrasound dating has a margin of error of up to a few weeks, and gestational age isn't a medically reliable measure of fetal age.



Bob Andres/Atlanta Journal-Constitution/Associated Press, 2019.

# THE STATE OF AFFAIRS

## INSIGHT INTO THE LEGISLATIVE LANDSCAPE IN GEORGIA

### POLICY-MAKING + STAKEHOLDERS

It is no secret that the post-*Dobbs* landscape in Georgia is grim, marked by widespread confusion, uncertainty, and restriction. In Atlanta, however, some lawmakers are working to move policy in a new direction.

Representative Nikema Williams of Georgia's 5<sup>th</sup> Congressional District has recently emerged as a leading voice in Atlanta and beyond. Her office focuses on protecting access to abortion and reproductive healthcare and addressing Georgia's broader maternal-health disparities.

A staffer in her office told us that policymaking in this space hinges on strategic engagement with stakeholders, including national advocacy organizations like Planned Parenthood, and "on-the-ground" physicians.



Nathan Posner/Anadolu via Getty Images, 2025.

Conversations with clinicians, the staffer noted, are often marked by fear. Providers regularly struggle to balance their responsibility to care for their patients with their responsibility to follow the law. For many physicians, these duties are starting to conflict with one another.

The staffer spoke candidly about the political dynamics surrounding abortion. In a state where bipartisan support is virtually non-existent, the legislative "waiting periods" in Congress serve as strategic leverage. To prepare for "prime

time," as the staffer put it, these bills are constantly refined and tested so that they're ready to advance the moment a political window opens.

Unfortunately, it remains difficult to reach across the aisle when discussing abortion. Framing it in the context of broader maternal health issues, the staffer said, can help appeal to the other side.

It is unclear whether this change in delivery will initiate real policy change, but in what is effectively a political stalemate, it may be the most promising path forward.

### CONFUSION BY DESIGN

House Bill 481, put forth by Representative Ed Hurtz (R), is notably vague in its language. Interestingly enough, the staffer we spoke with was unfamiliar with this bill, despite working in Georgia's reproductive health policy space themselves. Still, the staffer conceded that this ambiguity is deliberate. In fact, confusion seems to be part of the goal for Republicans in Georgia and beyond. According to the staffer we spoke with,

this uncertainty further discourages clinicians from providing abortion-related care, whether consciously or not. If physicians are unsure about their legal standing, the staffer noted, they are more likely to err on the side of caution, which usually means denying pregnant patients the care they need - care that is often medically recommended. Vagueness, it seems, functions as a mechanism of control. It does what explicit bans alone cannot, creating barriers from within and leaving pregnant patients to bear the consequences.

# EMORY UNIVERSITY: GEORGIA'S REPRODUCTIVE HUB

How do physicians provide robust reproductive care in one of the most restrictive states in the country? Based on our conversations with faculty members, institutional support is key. Located in metropolitan Atlanta, Emory University has established itself as one of Georgia's most comprehensive and critical anchors for reproductive care. In 2024 alone, clinicians within the Department of Gynecology and Obstetrics engaged in over 492,000 patient encounters across up to ten clinical sites (Emory University School of Medicine 2025).

Within this system, the Division of Complex Family Planning offers critical pre- and post-natal support, including contraception, medication and surgical abortion, and management of early pregnancy loss – services that are increasingly inaccessible in other areas of the state.

The physicians we spoke to within Emory recognize its status as a major referral center for the region, particularly where abortion care is concerned. A clinician within the university system described a very deliberate institutional strategy for navigating the post-*Dobbs* landscape. In fact, Emory had already begun developing protocols and preparing for the enforcement of HB 481 long before the *Dobbs* decision was finalized. This particular doctor expressed satisfaction with the institution's handling of these legal challenges. They, like some others within the department, feel well-supported by Emory and report little difficulty making abortion-related care decisions. This institutional backing is of course helped by the fact that Emory has a massive legal team at its disposal.



John E. Davidson/Getty Images, 2022.

According to this same physician, the “dos” and “dont’s” of reproductive care seem pretty explicit, and it doesn’t feel as if they have a responsibility to evaluate legal justifiability for themselves. Instead, they feel confident that their decisions will be protected by Emory’s extensive legal team, particularly when they are supported by precedent.

If a pregnant patient arrived hemorrhaging, for example, this physician assured us that clinicians would be able to move quickly, knowing the institution would stand behind, and defend, their decision to treat. According to the doctors we spoke with, the university health system does not provide physicians with any formal legal training. Rather, they learn these legal precedents on the ground and as they practice. According to one doctor we spoke with, the emergency cases are usually pretty clear-cut: if a pregnancy puts a patient in a life-threatening situation, an abortion may be performed. But every case is not so cut and dry. In the case of a novel scenario, Emory faculty typically consult with legal before moving forward. If a particular condition or case is seen several times, Emory’s legal team will work with physicians to



Emory University School of Medicine, n.d.

## TRAINING THE FUTURE

In the midst of this tricky legal landscape, Emory is trying to hold their training pipeline together. In a letter to prospective applicants post-*Dobbs*, the Division Director of the Complex Family Planning Fellowship assured readers that the department would remain operational. Since *Dobbs*, however, the program has been forced to adopt out-of-state clinical rotations. For many trainees, these travel rotations are their only exposure to certain reproductive procedures, including second trimester abortions. The restrictions introduced by HB 481 limit what can be seen and taught by physicians in Georgia, even at a healthcare giant like Emory. The Complex Family Planning Fellowship in particular attracts doctors who felt their residency training did not provide adequate exposure to abortion care – unfortunately, the post-*Dobbs* landscape continues to shield them from valuable training opportunities. One clinician we spoke with trained at a religiously affiliated institution where reproductive care was not a primary focus – one of the reasons they sought specialized training at Emory afterward. They describe having to leave the state for six weeks at a time for additional training. They reflect positively on the experience, but recognize that these workarounds place undue strain on both trainees and the institution.

establish an appropriate protocol. Rather than leaving individual OB-GYNs to guess where the legal line sits, Emory uses multidisciplinary review to define, in advance, which scenarios constitute “substantial and irreversible” risk under HB 481. This requires interdisciplinary conversations with maternal-fetal medicine, neonatology, oncology, complex family planning, and of course, legal. The physicians we spoke to reiterated the fact that, compared to other health systems in Georgia and the greater post-*Dobbs* south, Emory interprets the law more consistently and less conservatively. In this way, it very much represents the “ideal” in Georgia, rather than the norm.

Still, this support allows physician-affiliates of the university to practice medicine with less fear than many of their counterparts in other smaller institutions. While the clinicians we spoke with all recognize and appreciate the structural support they receive from Emory, they expressed varying degrees of satisfaction with hospital reproductive care policies a whole. One doctor we spoke with felt their practice was not very affected by *Dobbs*, due in part to Emory’s institution-specific policies. This view does not necessarily represent the majority. In fact, this physician conceded that while OB-GYNs across Georgia share the same medical knowledge, they do not necessarily share the same legal protection or administrative support. Physicians in smaller-scale institutions, for example, receive less legal direction. Where there may be an established protocol for hemorrhaging patients at Emory, there may still be confusion at an independent, rural hospital in Jackson, Georgia.

Ultimately, reproductive care remains precarious. A patient’s outcomes are heavily dependent on where, and with whom, they receive care. Emory may represent what is possible under restrictive laws, but it is not immune to the challenges posed by *Dobbs*.



DR. ENRIQUE SOSA, PhD.

# DR. ENRIQUE SOSA

We spoke with Dr. Enrique Sosa, a biologist who studies human development and teaches about pregnancy and reproduction. He began with something that sounds simple but shapes every abortion law on the books: how we measure time in pregnancy, and how we determine fetal age.

“Gestational age is just really one of those things that is easier to find out,” he explained. Embryonic age, by contrast, starts at fertilization and is what developmental biologists use when they talk about stages and organs. That two-week gap sounds small, but in early pregnancy, it is a lot. As Dr. Sosa told us, “If we are talking about the embryo or the fetus, we are talking about certain developmental time points that have to be achieved,” and a difference of two weeks can mean a very different stage of development.

This mismatch becomes critical in so-called heartbeat laws. Legally, six weeks almost always means six weeks gestational, which is only about four weeks after fertilization. At that point, the cells that will become the heart have started to organize and send electrical signals, but most organ systems are still in very early formation. “The heart gets all this attention,” Sosa said, “but you need a lot more than just a heartbeat to make a person.” Focusing on a heartbeat, he argued, is a political choice, not a biologically meaningful line. When we asked about viability, Sosa was blunt. A fetus “isn’t viable up until week 22,” he said. Before that, organs like the lungs cannot support life outside the uterus. Even at 22 weeks, survival depends on intensive care, ventilators, and highly specialized neonatology teams. Without that kind of intervention, “it would not survive.”

Dr. Sosa also walked us through the basic biology of pregnancy tests and abortion care. Early pregnancy detection relies on hCG, a hormone produced after implantation. Other hormones, like progesterone, help support the uterine lining, and AMH is more used as a marker of ovarian reserve than pregnancy itself. He distinguished between medical abortion and surgical abortion as forms of termination. Pills offer a less invasive option, but involve more bleeding, cramping, and a risk of incomplete abortion. Surgical procedures are fast and highly effective but require anesthesia and a clinical setting. From a strict biological angle, he told us, “Fertilization is the beginning of the human life cycle.”

But he drew a sharp line between life and personhood. Personhood, he said, involves questions of consciousness, viability, and how society assigns moral and legal status. “Trying to prosecute people or put them in jail based on this very poorly understood timing,” he added, “is an injustice. That has nothing to do with personhood at all.”

# IN CONVERSATION

## WITH ELIZABETH THAYER



DR. ELIZABETH THAYER, MD

### INSIDE THE MIND OF AN OB-GYN IN GEORGIA

Dr. Elizabeth Thayer, a gynecologic oncologist at Emory in Atlanta, has seen firsthand what happens when patients are denied life-saving abortion care. Thayer never felt a true calling towards OB/GYN, until the night of the 2016 election. She was on call, in a hospital in a “place that was very pro-Trump.” When the results came in, Thayer thought to herself: “Well, we’ll be doing OB/GYN regardless, because we’ve got to have good people in the field... advocating for choice.”

Thayer trained at Penn State, and then UMass. She remembers being “at an institution with faculty that were incredibly supportive.” “It was just standard that you got full spectrum abortion care training,” she said.

Then she graduated from residency and everything changed. “I moved to Georgia, and the Dobbs decision actually came down the day I graduated from residency, which really put a damper on that day,” Thayer shared. Shortly after she arrived, Georgia enacted HB 481, the most restrictive abortion ban in the country.

As a gynecologic oncologist, Dr. Thayer is not usually the person making the initial abortion decision – but she does see the fallout when care is delayed or denied. She described at least two encounters with patients who presented with life-threatening complications. Both were denied abortions.

One arrived hemorrhaging and required a hysterectomy. Another had uterine anatomy complications and was denied termination care. “Essentially, her whole uterus got infected and died, and we had to take it out,” said Thayer. One of those patients, she told us, “had originally been happy to be pregnant and now will never be, because she couldn’t get the care that she needed.”

Inside Emory, there is at least an infrastructure for navigating bad laws. According to Thayer, committees and legal teams offer advice surrounding abortion cases that may be particularly tricky. “[Emory’s Complex Family Planning Division] does a pretty good job of having clear guidelines and keeping the department updated,” said Thayer. “If there’s a hard case, it’s pretty clear how to activate the whole process,” she added.

**Physicians did not write the law, and lawyers, for the most part, don’t have any idea what the medical scenarios actually are.**

This includes knowing who to call, how to bring in risk management, what to document to protect clinicians.

What scares her most is imagining the same scenarios without Emory’s safety net. “I can’t even imagine having to try to make those legal decisions if you’re just in an ER out in the middle of nowhere,” she said. “Emory has a whole legal department and a committee to tell you what to do – if you’re just seeing a patient and you have to figure that out on your own, I can’t imagine what they’re having to deal with,” she added.

Physicians depend on this institutional support, particularly when rapid decisions need to be made. “If there are no clear guidelines, you have to make a decision about what you could theoretically defend in court. And understandably, most people are going to take a more cautious stance [in saying cases] don’t meet those criteria [for intervention]” said Thayer.

She’s also thinking about the next generation of doctors. At Emory, Complex Family Planning fellows can still get clinical experience by rotating out of state. Residents may not necessarily be afforded the same opportunities.

She worries what will happen if the legal landscape flips again. “If we ever get to a point where *Dobbs* gets reversed, are we going to now have a generation of OB-GYNs who are not able to do those procedures?”

In a medical education space that largely ignores abortion, these effects are compounded. “If abortion care even gets mentioned, you’re already doing better than most med schools,” said Thayer. Ultimately, the situation remains grim. “It’s awful,” said Thayer. “It is awful to know that I cannot provide the care that I am trained to provide and that women deserve.”

# TRAINING THE NEXT GENERATION: KY'TAVIA STAFFORD CARREKER



UCLA School of Medicine Newsroom, 2023.

As a coordinator of UCLA's chapter of Medical Students for Choice, Ky'Tavia provided critical insight regarding the current state of teaching programs at UCLA and various institutions nationally. She emphasized that UCLA's curriculum has taught students to understand 'abortion' as a broad medical term for pregnancy loss (including spontaneous and threatened abortions). While she noted that the UCLA medical training curriculum has thus far provided a generally holistic and adequate overview of how to navigate reproductive cases, an issue she highlighted, is the lack of mandated reproductive education in clinical training programs nationwide. More specifically, Ky'Tavia explained a key issue in training: while certain training programs related to disciplines that are deemed mandatory competencies, such as Intensive Care or Critical care, are required, trainings pertaining to medical and surgical abortions, remain on an opt-in basis. The irony here, is that abortion care comprises a large amount of critical and emergency care cases; why then, is it treated as optional rather than essential?

Ky'Tavia elaborates on these ironies, emphasizing her own experience. After witnessing a vacuum abortion in medical school, she described it as a "sobering" experience confronting this reality. But ultimately, it fueled her commitment to her patients emphasizing that "[clinicians] should know how to perform a manual [vacuum aspiration]. But if [they] can't, [they] should at least know how to diagnose it. If [they] don't learn it, then [they] can't diagnose it." As Ky'Tavia has been confronted with changes in health equity curriculums and the realities of what education may look like for her in the near future, training in certain states is a concern for her now as she may not experience "full scope of care." She underscores how confusing it feels that trainees cannot opt out of learning life saving skills like "inserting a line or managing sepsis" yet can opt out of abortion care even though patients often "come in dying from hemorrhage, infection, or incomplete miscarriage." Together, these reflections reveal the inconsistencies she finds most troubling and that are widespread in curriculums and training nationwide.



# “ROE WAS THE FLOOR:” TYLA ADAMS

Tyla Adams, a Reproductive Justice Program Manager with Black Women for Wellness in Los Angeles, walked us through what abortion policy actually looks like on the ground. Tyla describes Roe as “quite literally the floor... the bottom of the barrel,” especially for Black and Indigenous communities, who “never had equal access to begin with.” She notes that the dismantling of Roe forced people to confront the fragility of rights that had been considered secure: “So a critical, critical measure for Roe has been gone. What does that mean for reproductive health?” Adams also described a surprising shift in the aftermath - a space to imagine more. “The loss of Roe has allowed people to reimagine what could be,” she explained, suggesting that the overturn has opened the door to envisioning something far more.

However, policy since *Dobbs*, in her view, is designed to exhaust people. Tyla discussed the flood of executive orders and legal attacks on abortion as a deliberate strategy: “They’re trying to wear us down with all of those executive orders...The confusion is intentional... they thrive in the chaos.” Every time the community scrambles to understand a new rule or defend a shrinking protection, that’s time and energy stolen from building long-term power.

*“The confusion is intentional... they thrive in the chaos.”*



Via Black Women for Wellness, Meet Our Team.

Tyla pushed back on the idea of California as a safe, progressive bubble, asking: “Is California truly that progressive, or is everyone else so far behind us?” She pointed out that “California is not immune to racist policy,” and that a “fascist, authoritative regime right now in the White House” shapes what is possible everywhere. Being in a “sanctuary” state means constantly holding local officials accountable so they don’t quietly trade away protections while pointing at places like Mississippi as the real problem.

At the same time that laws are tightening, the systems meant to track harm are disappearing. Tyla mentioned that maternal mortality review committees and similar oversight bodies have been gutted: “They’ve completely cut and shut down all those review committees, so we’re not getting this lifetime feedback...they’ve all been defunded. So we’re having to investigate it on our own, because they don’t care.” This helps explain why it is so hard to get official answers about deaths like Amber Nicole Thurman’s, and why community organizations end up doing their own research, without the data or resources the state used to provide.

# FINAL THOUGHTS

When we began this project, we thought we were studying a single issue: abortion law after *Dobbs*. What we actually found was a web. Abortion is tied to hospital legal committees, residency accreditation, Medicaid rules, state legislatures, federal agencies, religious directives, and grassroots organizers. Every story we encountered—Amber Nicole Thurman, Adriana Smith, the patients at Emory—sat at the intersection of medicine, law, and geography. You can't pull on just one thread without feeling all the others move.

Our interviews forced us to ask: how far should we expect doctors to stretch beyond their training? At what point does “knowing the law” become an impossible burden that actively undermines their ability to practice medicine safely and compassionately? The project also pushed us to think about what future medical education should look like. As Dr. Thayer pointed out, abortion care is barely present in many curricula, and yet trainees are graduating in a landscape where every decision about pregnancy can carry civil or criminal risk. Many of the doctors we spoke with were trained in settings where full-spectrum abortion care was either standard or almost completely absent. Now, residents may never see a routine abortion, but are expected to manage septic miscarriages, hemorrhage, pre-viable membrane rupture, and fetal anomalies

under legal threat. If the law swings the other way, what does this mean for the next generation of OB-GYNs? Doing this work changed the way we think about responsibility. We came in asking what doctors should do under restrictive laws. We left thinking more about what the rest of us owe to them and to their patients. Legislators choose vague language. Courts reinterpret precedent. Hospital systems design policies that can either back clinicians or leave them exposed. Community organizers, lawyers, journalists, and voters all have roles to play in closing the gap between what the law allows and what patients actually need. If there is one thing this project taught us, it is that protecting reproductive health cannot be left to clinicians alone. They are already carrying enough.

AP Photo/Jacquelyn Martin, 2022



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## SOURCES

