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Losing Lives Despite "Lifesaving" Exceptions: Examining the Fatal Flaws of Vague Abortion Bans and the Spectrum of Medical Decisionmaking in Cancer Care

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NOTE

Losing Lives Despite "Lifesaving" Exceptions: Examining the Fatal Flaws of Vague Abortion Bans and the Spectrum of Medical Decisionmaking in Cancer Care

On June 24, 2022, the Supreme Court upended decades of precedent pertaining to reproductive health when it held that abortion fell outside the purview of constitutionally protected rights. Since then, conservative states have raced to institute stringent abortion bans, with many lacking explicit exceptions for pregnant individuals enduring medical emergencies that necessitate care. Ambiguous statutory language has induced a chilling effect in the medical arena, where providers risk criminal and civil liabilities by performing requested and medically recommended abortions for emergent patients when fetal development would risk the life of the pregnant individual. Seized in the crossfire of hyperpolarized politics, cryptic laws, and medical ethics, many healthcare providers hesitate to furnish assistance to their patients, invoking risk assessments to gauge whether the patient's condition falls within the categories of statutorily warranted care. This murky landscape is especially nuanced in an area of medicine that is commonly overlooked by lawmakers: pregnancy-associated cancer. This Note reviews the downstream effects of Dobbs *on pregnant cancer patients seeking abortions while simultaneously pursuing oncological treatment plans. First, to provide a foundatinal framework, this Note traces the history of health-related exceptions in anti-abortion states. The Note then turns to the modern status of reproductive health restrictions and its consequences for cancer patients. Next, the various approaches promulgated to resolve the fatal ambiguity of state abortion bans will be juxtaposed. Finally, this Note proposes a two-prong solution involving the decriminalization of abortion care under the void-for-vagueness doctrine and promulgation of standards of care that incorporates abortion into recognized cancer treatment plans. This solution aims to ameliorate* Dobbs*-induced paralysis and augment patients' chances of receiving necessary care.*

INTRODUCTION

In June 2022, a thirty-seven-year-old patient with stage III melanoma wept inconsolably in her clinician's office after providers detected a fetal heartbeat.[1] Despite the medical reality that her late-stage cancer required immediate medical attention, doctors had refused to provide care until she terminated the pregnancy, observing the governing ethical norms concerning fetal harm.[2] Unfortunately, the patient had arrived at the medical center in Dayton just three days late: Ohio's abortion ban had already gone into effect.[3] Left to physically deteriorate, the patient had to weigh her only viable options—travel out of state to receive an abortion or risk her chances of survival by delaying

1. Affidavit of Aeran Trick in Support of Plaintiffs' Motion for Temporary Restraining Order Followed by Preliminary Injunction at 3, Preterm-Cleveland v. Yost, No. A2203203, 2022 WL 4279758 (Ohio Ct. C.P. 2022) [hereinafter Trick Affidavit].

2. *Id.* Typically, the medical treatment options for late-stage melanoma include lymph node dissection, chemotherapy, radiation therapy, and immunotherapy. *Stage III Melanoma*, MOUNT SINAI: KIMBERLY & ERIC J. WALDMAN MELANOMA & SKIN CANCER CTR., https://www.mountsinai.org/locations/waldman-melanoma-center/what-is/stage-3-melanoma (last visited Sept. 17, 2024) [https://perma.cc/DHA8-MRFU].

3. Trick Affidavit, *supra* note 1, at 3.

treatment until she miscarried or delivered.[4] This patient was one of numerous emergent pregnant individuals suffering the consequences of delayed and deficient treatment in abortion-restrictive states.[5]

Since the U.S. Supreme Court overruled *Roe v. Wade* and *Planned Parenthood v. Casey* on June 24, 2022, over twenty-five states have reduced or eliminated access to reproductive healthcare by criminalizing abortion services through legislation.[6] State restrictions impose varied limits, including restrictions on the stage of fetal development (referred to as "gestational bans"),[7] the medical methods employed during the abortion procedure,[8] permissible reasons for

4. *Id.*

5. *Id.*; Andrea MacDonald, Hayley B. Gershengorn & Deepshikha Charan Ashana, *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, 328 JAMA 1691, 1691–92 (Nov. 1, 2022), https://jamanetwork-com.proxy.library.vanderbilt.edu/journals/jama/fullarticle/2797866 [https://perma.cc/XGU8-4VMD]. For additional stories concerning pregnant cancer patients seeking care after *Dobbs*, see Shannon Firth, *How the Dobbs Decision Can Affect Cancer Patients*, MEDPAGE TODAY (Sept. 5, 2023), https://www.medpagetoday.com/obgyn/abortion/106182 [https://perma.cc/G9XZ-4CA8] (sharing one provider's experience treating a patient with aggressive, metastatic cancer who was fourteen months pregnant).

6. Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022); Roe v. Wade, 410 U.S. 113 (1973), *overruled by Dobbs*, 597 U.S. 215; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992), *overruled by Dobbs*, 597 U.S. 215. For an up-to-date database featuring live updates of states' legislative and judicial shifts in the post-*Dobbs* climate, see *Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INST., https://states.guttmacher.org/policies/minnesota/abortion-statistics (last updated July 24, 2024) [https://perma.cc/ML7P-WMVW] [hereinafter GUTTMACHER INST., *Interactive Map*].

7. Gestational age is calculated in weeks from the start of the most recent menstrual cycle. Max Mongelli & Jason O. Gardosi, *Evaluation of Gestation*, MEDSCAPE, https://emedicine.medscape.com/article/259269-overview (last updated Oct. 19, 2021) [https://perma.cc/5JSN-AFTY]. From this date, an average pregnancy lasts approximately forty weeks. *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions (last updated June 1, 2024) [https://perma.cc/HW7M-SCUW].

8. "Method bans" refer to statutes prohibiting a specific method of abortion care, including dilation and extraction procedures and dilation and evacuation procedures, medically safe procedures that constitute the majority of second-trimester abortions in the United States. Megan K. Donovan, *D&E Abortion Bans: The Implications of Banning the Most Common Second-Trimester Procedure*, GUTTMACHER INST. (Feb. 21, 2017), https://www.guttmacher.org/gpr/2017/02/de-abortion-bans-implications-banning-most-common-second-trimester-procedure [https://perma.cc/2Y8K-NE3T].

terminating the pregnancy,[9] and the termination's setting.[10] Fourteen states have enacted near-total bans, outlawing abortions in almost all circumstances.[11]

This Note will specifically examine various abortion bans' medical exceptions, which allow abortions for patients experiencing certain complications during pregnancy.[12] If a patient's medical condition does not clearly fit within one of the state's statutory exemptions, physicians frequently risk imprisonment, monetary penalties, or license revocation for providing an abortion or aiding and abetting the induction of one.[13] Thus, in determining whether to provide care, physicians are forced to consider a jury's likelihood to agree with their medical evaluation of the urgency or gravity of the patient's condition.[14] Since abortion bans often fail to delineate which conditions qualify for exemption, statuses that seem "unequivocal from a medical perspective" are not obviously insulated from prosecution.[15] Given the

9. "Reason bans" prohibit abortions sought or potentially sought for one of the stipulated reasons, typically pertaining to sex-selective and race-based procedures, as well as termination due to fetal abnormalities. *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly (last updated Aug. 31, 2023) [https://perma.cc/34YZ-X3VR]. Eleven states include abortion bans for sex-based selection—these include Arizona, Arkansas, Kansas, Mississippi, Missouri, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Dakota, and Tennessee. *Id*. Five states have prohibited abortions sought out for racial purposes—Arizona, Mississippi, Missouri, North Carolina, and Tennessee. *Id.* Lastly, eight states ban abortions for genetic anomalies—Mississippi, Missouri, North Carolina, North Dakota, Ohio, South Dakota, Tennessee, and Utah. *Id.*

10. This includes abortions managed outside clinics or hospitals. Within this category, a handful of states—Nevada, Oklahoma, and South Carolina—criminalize "self-managed abortions," which refer to terminations undertaken outside of a healthcare setting. *After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RTS., https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited Sept. 17, 2024) [https://perma.cc/C58T-K46A]. Despite the limited number of statutes explicitly outlawing self-managed terminations, from 2000–2023, investigations occurred in twenty-six states. Laura Huss, *Self-Managed Abortion Is Not Illegal in Most of the Country, but Criminalization Happens Anyway*, IF/WHEN/HOW: LAWYERING FOR REPROD. JUST. (Aug. 9, 2022), https://www.ifwhenhow.org/news/self-managed-abortion-is-not-illegal-in-most-of-the-country-but-criminalization-happens-anyway/ [https://perma.cc/9YBC-5CP6]. One report recorded sixty-one cases in which individuals have been "criminally investigated or arrested for self-managing their own abortion or helping someone else do so." *Id.*

11. *Tracking Abortion Bans Across the Country*, N.Y. TIMES, https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (last updated July 1, 2024, 1:26 PM) [https://perma.cc/V3HA-YXTL] (reporting that these states include Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia). This Note refers to these bans as "total bans."

12. *See infra* Table One.

13. Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortions Bans: Implications for the Provision of Abortion Services*, KFF, https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ (last updated June 6, 2024) [https://perma.cc/39CK-VTS4].

14. *Id.*

15. *Id.*

confusion resulting from this ambiguity, many doctors would rather err on the side of caution than risk legal action against them; this dilemma ultimately impedes physicians' ability to provide comprehensive care and threatens the well-being of patients who require emergency assistance.[16]

These medical, legal, and ethical considerations arise in the context of pregnancy-associated cancers, which include melanoma, breast cancer, cervical cancer, lymphoma, and leukemia.[17] Given the necessity of diagnosing and treating cancer using procedures that may render the fetus unviable,[18] medical practitioners frequently require or advise patients to terminate their pregnancies before initiating cancer treatment.[19]

Forced risk assessments lie at the intersection of law and medicine in the post-*Dobbs* landscape and implicate several acute questions for cancer care providers: Which health risks qualify under lifesaving exceptions?[20] Must the threat to life be imminent or impact long-term survival?[21] Does pregnancy in the setting of cancer inherently constitute a threat to life?[22] If physicians prepare a numerical risk assessment, is there a bright-line threshold for receiving care?[23] Would a twenty percent risk of death qualify, or would that be too remote?[24]

16. MacDonald et al., *supra* note 5, at 1691.

17. Kriti Mittal, Melanie Sheen, Megan Wheelden, Rawan Faramand, Eleonora Teplinsky & Monika Joshi, Dobbs v Jackson-*Rewriting Women's Autonomy in Cancer Care*, 19 JCO ONCOLOGY PRAC. 157, 157 (Jan. 18, 2023), https://ascopubs.org/doi/full/10.1200/OP.22.00610?role=tab [https://perma.cc/TG3M-66RH].

18. For a description of pregnancy loss during and after cancer treatment, see *How Cancer and Cancer Treatment Can Affect Fertility in Females*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/managing-cancer/side-effects/fertility-and-sexual-side-effects/fertility-and-women-with-cancer/how-cancer-treatments-affect-fertility.html (last updated Feb. 6, 2020) [https://perma.cc/S76B-DNKA].

19. Jordyn Silverstein & Katherine Van Loon, *The Implications of the Supreme Court Decision to Overturn* Roe v Wade *for Women with Pregnancy-Associated Cancers*, 8 JAMA ONCOLOGY 1394, 1394 (2022) ("[A] discovery of cell-free DNA that is discordant from the fetal karyotype is associated with a diagnosis of maternal cancer in 18% of cases.").

20. *See* Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of* Roe v. Wade, 386 NEW ENG. J. MED. 2061, 2061 (2022).

21. *Id.*

22. *Id.*

23. *Id.*

24. *See id.* ("What does the risk of death have to be, and how imminent must it be? Might abortion be permissible in a patient with pulmonary hypertension, for whom we cite a 30-to-50% chance of dying with ongoing pregnancy? Or must it be 100%?").

Who determines whether a proposed risk qualifies for care?[25] What happens when doctors disagree about the magnitude of the harm?[26]

This Note addresses the impact of ambiguous statutory language on the quality of cancer care by examining the various health exemptions to abortion bans to promote legal frameworks that enhance medical services for pregnant cancer patients. To underscore physicians' pivotal role in navigating patient care, this Note also acknowledges the necessary facets of medical decisionmaking required to achieve this objective. Part I addresses (1) the background of abortion regulation and the role of lifesaving exceptions in historical anti-abortion laws, (2) the wave of post-*Dobbs* statutes governing abortion access, and (3) the implications of restrictive bans for pregnant individuals with cancer diagnoses.[27] Part II explores the various frameworks developed by legal and medical scholars to combat the ambiguities pervading the current state legislative regimes.[28] Finally, Part III presents a two-prong approach to rectify the issues of the current legal framework: the first prong urges the judiciary to decriminalize abortion care under the void-for-vagueness doctrine; the second prong proposes uniform educational regimes that foster nationalized standards of care.[29]

I. BACKGROUND

A. Lifesaving Exceptions in Historical Anti-abortion Law

Among ancient depictions of reproductive healthcare, abortion was neither morally nor legally troubling until quickening—that is, when the woman felt fetal movement.[30] Terminations within the first trimester were largely considered unproblematic during the eighteenth

25. *See, e.g.*, Laurie Sobel, Mabel Felix & Alina Salganicoff, *Who Decides When a Patient Qualifies for an Abortion Ban Exception? Doctors vs. the Courts*, KFF (Dec. 14, 2023), https://www.kff.org/policy-watch/who-decides-when-patient-qualifies-for-abortion-ban-exception/ [https://perma.cc/RLA5-BCBU] (discussing the tension between courts and physicians in the sphere of medical decisionmaking).

26. *See generally* David J. Casarett, Commentary, *When Doctors Disagree*, 8 AM. MED. ASS'N J. ETHICS 571, 572–74 (2006) (discussing the overall ethical quandary implicated when doctors diverge on sound medical diagnoses or treatment options for patients).

27. *Infra* Part I.

28. *Infra* Part II.

29. *Infra* Part III.

30. *See* Commonwealth v. Bangs, 9 Mass. (9 Tyng) 387 (Mass. 1812) (providing an example of an early abortion dispute that discusses the historical lineage of the "quickening" threshold); KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 14–15 (1984); JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY 4–5 (1978). Interestingly, the Bible refers to "quick and the dead" as a way to distinguish life. 1 *Peter* 4:5; 2 *Timothy* 4:1.

and early nineteenth centuries.[31] In the following years, physicians began shaping the dialogue surrounding life at conception by framing fetal development as a process as opposed to a set of definitive stages.[32] In response to physicians' anti-abortion rhetoric, states raced to criminalize abortion.[33] Between 1860 and 1880, state legislatures enacted at least forty bills to this end. Almost all of these new laws explicitly exempted "therapeutic" abortions, meaning those conducted by doctors.[34] By the turn of the century, all but six states had enacted therapeutic exceptions.[35]

After a few decades of relative calmness in the anti-abortion movement, two distinct legal frameworks emerged in the anti-abortion movement in the 1960s.[36] The first model reflected nineteenth-century discourse.[37] Exemplified by a 1961 statute, the Texas legislature imposed criminal liability on any individual who "knowingly procure[d] to be administered with her consent any drug or medicine, or [ ] use[d] toward her any violence or means whatsoever externally or internally applied, and thereby procure[d] an abortion."[38] This sweeping ban, however, included a "medical advice" exception, which shielded providers if they deemed the procedure necessary to save the life of the mother.[39]

The second legal framework emerged from a 1960s Georgia law that provided more leeway to providers of abortion services.[40] Georgia's 1968 statute carved out exceptions if a licensed surgeon determined that "a continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health."[41] Notably, compared to Texas's 1960s abortion statute—which created an exception only for saving the lives of pregnant individuals—Georgia's law expanded the scope of permissible health-related abortions by tacking on the injury-to-health exception.[42] The statute

31. MOHR, *supra* note 30, at 4–5.

32. Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protections*, 44 STAN. L. REV. 261, 282–87 (1992); Horatio R. Storer, *Report on Criminal Abortion*, 12 TRANSACTIONS AM. MED. ASS'N 75 (1859).

33. MELISSA MURRAY & KRISTIN LUKER, CASES ON REPRODUCTIVE RIGHTS AND JUSTICE 694 (2023) (citing MOHR, *supra* note 30, at 4–5).

34. *Id.* at 1027; LUKER, *supra* note 30, at 32–33.

35. MURRAY & LUKER, *supra* note 33, at 1027.

36. *Id.*

37. *Id.*

38. TEX. CRIM. STAT. 2A, arts. 1191, 1196 (1961) (punishable by two- to five-year penitentiary sentences).

39. *Id.*

40. GA. CRIM. CODE §§ 26-1201, 26-1203 (1968).

41. *Id.*

42. CRIM. STAT. 2A, arts. 1191, 1196; CRIM. CODE §§ 26-1201, 26-1203.

imposed several procedural hurdles on patients seeking abortion care, including certification of state residency, written declaration of at least three physicians that abortion was necessary, and prior approval of the procedure by a committee containing the hospital's medical staff.[43]

Although the Georgia statute may seem austere, it reflected a growing trend to liberalize abortion and defer to providers' judgments, drawing on principles featured in the Model Penal Code's reform provision.[44] Section 274 of the Model Penal Code allowed a physician to perform "justifiable abortions" when "he believe[ed] there [was] substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect."[45] Several states adopted section 274, emphasizing the importance of providing abortion care when "necessary to preserve" the patient's life.[46] In 1967, for example, California's legislature extended protections under its Therapeutic Abortion Act to include cases in which there was "substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother."[47]

California's more tolerant attitude toward abortion signaled a broader legislative trend toward greater deference to the professional expertise of providers.[48] Throughout the decade preceding *Roe v. Wade*, numerous states repealed and liberalized abortion regulation through judicial review, legislation, and public referenda.[49] Four states even passed statutes repealing criminal abortion statutes.[50] As states continued to deregulate and clarify the circumstances under which providers could administer abortions, medical professionals embraced the reform, which rendered abortion a "relatively uncontroversial" issue by the time the Supreme Court decided *Roe* in 1973.[51]

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43. CRIM. CODE §§ 26-1201, 26-1203 (1968).

44. MODEL PENAL CODE § 230.3 (AM. L. INST. 1962).

45. *Id.*

46. *Id.*

47. The Therapeutic Abortion Act was passed in a response to an outbreak of rubella, which caused fetal harm and heightened the chance of disability. MURRAY & LUKER, *supra* note 33, at 707. This statutory regime changed when the Supreme Court released *Roe*. *See* Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

48. MURRAY & LUKER, *supra* note 33, at 707.

49. *See* Ruth Roemer, *Abortion Law Reform and Repeal: Legislative and Judicial Developments*, 61 AM. J. PUB. HEALTH 500, 500 (1971).

50. *Id.* These states included New York, Hawaii, Alaska, and Washington. *Id.*; *see also* MURRAY & LUKER, *supra* note 33, at 708 (describing this wave of statutory dissemination).

51. MURRAY & LUKER, *supra* note 33, at 708.

*B. Post-*Dobbs *Statutes and Governing Medical Exemptions*

On June 24, 2022, the Supreme Court released its final decision in *Dobbs v. Jackson Women's Health,*[52] upholding Mississippi's fifteen-week abortion ban and overruling *Roe v. Wade*[53] and *Planned Parenthood v. Casey*.[54] Reasoning that abortion is not a right "deeply rooted in [our] history and tradition" or "essential to our Nation's 'scheme of ordered liberty,' " Justice Samuel Alito, writing for the six-justice majority, found that reproductive health falls outside the scope of substantive rights protected under Due Process Clause jurisprudence.[55] The Constitution, the Court held, does not confer a right to abortion.[56]

In extinguishing nearly five decades of precedent, the Court upended the long-established legal, medical, and political landscapes discussed above.[57] *Dobbs* automatically "triggered" statutes in thirteen states that banned abortion in anticipation of *Roe*'s eventual downfall.[58] These trigger bans fell into three categories: (1) laws that automatically went into effect without any further action; (2) bans with a thirty-day waiting period; and (3) statutes requiring additional steps before implementation.[59] All thirteen trigger laws criminalized abortion and included allowances only when necessary to save the life of the pregnant patient.[60]

In addition to the three categories of trigger bans, dormant bans issued during the *Roe* era (from 1973 to 2022) posed a new threat.[61] Before *Dobbs*, courts immediately blocked these bans due to direct conflict with *Roe*.[62] Now, without *Roe*'s shield, these dormant bans can

52. 597 U.S. 215 (2022).

53. 410 U.S. 113, *overruled by Dobbs*, 597 U.S. 215.

54. 505 U.S. 833 (1992), *overruled by Dobbs*, 597 U.S. 215.

55. *Dobbs*, 597 U.S. at 237, 240.

56. *Id.* at 240.

57. *Id.*

58. MURRAY & LUKER, *supra* note 33, at 1026. These states included Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming. *Id.* (citing Elizabeth Nash & Isabel Guarnieri, *13 States Have Abortion Trigger Bans—Here's What Happens When* Roe *Is Overturned*, GUTTMACHER INST. (June 6, 2022), https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned [https://perma.cc/3TXS-P9C7]).

59. MURRAY & LUKER, *supra* note 33, at 1027. An example of the third category is certification of *Roe*'s overruling. *Id.*

60. *Id.* Only four trigger ban states included exceptions for rape and incest. *Id.*

61. *Id.*

62. *Id.*

also be enforced because judicial reasoning is vulnerable to futurechallenges.[63]

Lastly, several states had enacted "zombie bans" before *Roe*'s ruling in 1973.[64] Although these zombie bans remained unenforced before *Dobbs*, they were never repealed and can now be resurrected by state attorneys general.[65]

Collectively, the abortion-regulation terrain has been the setting of perpetual transformation, increased fragmentation, and heightened polarization.[66] Twenty-one states have enforced restrictions after *Dobbs*.[67] Of these, fourteen states have issued "total bans" that outlaw abortions in almost all circumstances.[68] These laws have a far-reaching impact: fifty-eight percent of women live in a state that is hostile to abortion rights.[69] In the most restrictive states, abortion is authorized only when necessary to save the patient's life, reflecting a legislative regression reminiscent of Texas's 1960s pre-*Roe* ban.[70] The standard of risk remains unclear because policymakers fail to define the qualifications that would warrant "lifesaving" care.[71] It is often difficult to discern when a patient will die without provision of a certain procedure, and conditioning care on certainty-of-death analyses places doctors in an ethically murky territory.[72]

Table One illustrates the intricate composition of abortion regulations.[73] As depicted by the Table, medical exceptions to state

63. *Id.*

64. *Id.*

65. *Id.;* Leonard M. Fleck, *Abortion and "Zombie" Laws: Who Is Accountable?*, 32 CAMBRIDGE Q. HEALTHCARE ETHICS 307, 307 (2023) (noting that the phenomenon of "zombie" bans and the revival of decades-old laws directly contradict Justice Alito's promise in *Dobbs* that "the authority to regulate abortion is returned to the people and their elected representatives").

66. GUTTMACHER INST., *Interactive Map*, *supra* note 6.

67. N.Y. TIMES, *supra* note 11.

68. *Id.*

69. *State Policies on Abortion*, GUTTMACHER INST., https://www.guttmacher.org/united-states/abortion/state-policies-abortion (last visited Sept. 17, 2024) [https://perma.cc/U2TM-6CMX] (solely considering women between ages thirteen and forty-four).

70. GUTTMACHER INST., *Interactive Map*, *supra* note 6*; see supra* note 38 and accompanying text.

71. Harris, *supra* note 20, at 2061.

72. MacDonald et al., *supra* note 5, at 1691; Brietta R. Clark, *Protecting Health After* Dobbs, 56 HASTINGS CTR. REP. 6, 6 (2022), https://catalog.library.vanderbilt.edu/permalink/01VAN_INST/11nigse/cdi_proquest_miscellaneous_2756124812 [https://perma.cc/4LPN-Q3X2]; Monica Rakesh Saxena, Esther K. Choo & Sara Andrabi, *Reworking Emergency Medicine Resident Education Post*-Dobbs v. Jackson Women's Health Organization, 15 J. GRAD. MED. EDUC. 283, 283 (2023).

73. *See infra* Table One (displaying sixteen states that have different medical exceptions and term limits).

abortion bans fall into four general categories:[74] abortions (1) to prevent the death of the pregnant individual,[75] which Table One classifies as the "life exception"; (2) to allow aid during medical emergencies associated with a risk of death; (3) to avoid "substantial irreversible impairment" or irreversible damage to a "life-sustaining organ"; and (4) to avert irreversible physical impairment of a "major bodily function."[76]

Notably, every state includes the life exception, allowing provision of abortion services when doing so is necessary to save the patient's life.[77] In six states, the total bans provide no additional health exceptions.[78] As shown by Table One's fourth column, however, most states include some variation of an exception for grave health risks, such as exemptions for "serious health risks," "medical emergencies," or "risks of death."[79] Only two states further exempt abortions provided to "prevent serious, permanent impairment of a life-sustaining organ."[80] Nine states currently exempt abortions provided to prevent "impairment of a major bodily function,"[81] yet only one state actually defines "major bodily functions."[82] Other states employing this phrase not only fail to define both "major bodily functions" but also leave "substantial impairment" undefined.[83]

With underinclusive or nonexistent definitions, this vague terminology places providers in a challenging position when patients with jeopardizing health conditions require an abortion as an integral step of their treatment. Ultimately, it is up to the hospital's lawyers to determine whether an abortion is legally permissible care.[84] Ohio's law, for example, lists "pre-eclampsia, inevitable abortion, and premature rupture of the membranes" as medically diagnosed conditions

74. Because this Note solely examines medical exceptions, exemptions for rape, incest, and lethal fetal anomalies fall outside the scope of this discussion. For more information on these exceptions, see Felix et al., *supra* note 13.

75. This Note employs the gender-neutral term "pregnant individuals," to reflect the fact that intersex individuals and people of various gender identities—including transgender and nonbinary individuals—may become pregnant and seek reproductive healthcare. For more information pertaining to the role of gender-neutral language in different fields of research, see NAT'L ACAD. OF SCIS., BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE 16 (Susan C. Scrimshaw & Emily P. Backes, eds., 2020).

76. *See infra* Table One.

77. *See infra* Table One.

78. *Infra* Table One.

79. *Infra* Table One.

80. *Infra* Table One.

81. *Infra* Table One.

82. ARIZ. REV. STAT. ANN. § 36-2321 (2022).

83. *Infra* Table One.

84. Felix et al., *supra* note 13.

constituting "serious risk of the substantial and irreversible impairment of a major bodily function."[85] This underinclusive list poses a challenge for physicians in discerning whether a significant health issue would qualify as an exception.[86] Moreover, the bans afford doctors a limited (if not entirely absent) level of deference, which compounds the difficulties in ascertaining the legal status of care.[87]

85. OHIO REV. CODE. ANN. § 2919.20 (West 2017).

86. Felix et al., *supra* note 13.

87. *Id.*

TABLE ONE: MEDICAL EXCEPTIONS TO STATE ABORTION BANS[88]

State	Ban Length	Life Exception	Risk	Organ Injury	Major Bodily Function	Ectopic Pregnancy
Alabama[89]	*	x	x			x
Arizona[90]	***	x	x		x	x
Arkansas[91]	*	x				x
Florida[92]	**/***	x			x	
Georgia[93]	**	x	x		x	x
Idaho[94]	*/**	x	x			
Iowa	**	x	x		x	
Indiana[95]	*	x	x		x	
Ketucky[96]	*/**/***	x	x	x		

Note: Total bans are represented by *, six-week bans by **, fifteen-week bans by ***, and twenty-week bans by ****. Statutory variations falling within the fourth column include "serious health risk," "medical emergency," and "risk of death." Statutes in the fifth column have employed "permanent impairment of a life-sustaining organ" language to delineate injuries to organs.

88. Examination of mental illness exceeds the scope of this Note, which will primarily focus on physical health. It is important to highlight, however, that virtually all abortion bans lack mental health exceptions, despite recent studies indicating that mental health conditions account for 22.7% pregnancy-related deaths. Susanna Trost, Jennifer Beauregard, Gyan Chandra, Fanny Njie, Jasmine Berry, Alyssa Harvey & David A. Goodman, *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019*, CTRS. DISEASE CONTROL & PREVENTION (Sept. 19, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html#t4-1 [https://perma.cc/YCA9-B5TB]; *see also* Felix et al., *supra* note 13 (reporting that most states limit health exemptions to physical conditions, with several explicitly precluding mental health conditions).

89. ALA. CODE § 26-23H-4 (2019); *see also* ALA. CODE § 13A-13-7 (2024) (inducing abortion is subject to criminal liability unless necessary to preserve the mother's life or health).

90. ARIZ. REV. STAT. ANN. § 13-3603 (1978), *repealed by* 2024 Ariz. Legis. Serv. Ch. 181 (West); Planned Parenthood Ariz., Inc. v. Brnovich, 524 P.3d 262 (Ariz. Ct. App. 2022) (blocking enforcement of stricter bans on abortion issued in 1864), *vacated*, Planned Parenthood Ariz., Inc. v. Mayes, 545 P.3d 892 (Ariz. 2024); ARIZ. REV. STAT. ANN. § 36-2322 (2022); ARIZ. REV. STAT. ANN. § 36-2151 (2021).

91. ARK. CODE ANN. § 5-61-304 (2022); ARK. CODE ANN. § 5-61-403 (2021).

92. 2023 Fla. Sess. Law Serv. Ch. 2023-21 (West); *see* Advisory Opinion to the Attorney General Re: Limiting Government Interference with Abortion, 384 So.3d 122 (Apr. 1, 2024) (No. SC2023-1392) (Florida Supreme Court upholding Florida's abortion ban and the six-week abortion ban went into effect in May 2024).

93. GA. CODE ANN. § 16-12-141 (West 2020).

94. IDAHO CODE ANN. § 18-622 (West 2023) (total ban); IDAHO CODE ANN. § 18-8804 (West 2022) (six-week ban).

95. IND. CODE ANN. § 16-34-2-1 (West 2022); IND. CODE ANN. § 16-18-2-327.9 (West 2022).

96. KY. REV. STAT. ANN. § 311.772 (West 2019).

State	Ban Length	Life Exception	Risk	Organ Injury	Major Bodily Function	Ectopic Pregnancy
Louisiana[97]	*/***	x	x	x		
Mississippi[98]	*	x	x		x	x
Missouri[99]	*	x	x			
North Dakota[100]	*	x	x			x
Oklahoma[101]	*/**	x				
South Dakota[102]	*	x				
Tennessee[103]	*/**	x	x		x	x
Texas[104]	*	x	x		x	x
Utah[105]		x	x		x	x
West Virginia[106]	*	x	x			x
Wisconsin[107]		x				
Wyoming[108]	*	x	x		x	x

Note: Total bans are represented by *, six-week bans by **, fifteen-week bans by ***, and twenty-week bans by ****. Statutory variations falling within the fourth column include "serious health risk," "medical emergency," and "risk of death." Statutes in the fifth column have employed "permanent impairment of a life-sustaining organ" language to delineate injuries to organs.

While some states provide conditional exceptions to the bans, others diverge by erecting an affirmative defense in judicial

97. LA. STAT. ANN. § 40:1061 (2022); LA. STAT. ANN. § 14:87.7 (2022).

98. MISS. CODE ANN. § 41-41-45 (West 2007) (total ban); MISS. CODE ANN. § 41-41-34.1 (West 2019) (six-week ban); MISS. CODE ANN. § 41-41-191 (West 2018) (fifteen-week ban).

99. MO. ANN. STAT. § 188.017 (West 2019) (total ban); MO. ANN. STAT. § 188.056 (West 2019) (eight-week ban); MO. ANN. STAT. § 188.057 (West 2019) (fourteen-week ban).

100. N.D. CENT. CODE ANN. § 12.1-19.1-01 (West 2023); N.D. CENT. CODE ANN § 12.1-19.1-03 (West 2023).

101. OKLA. STAT. ANN. tit. 21, § 861 (West 1999) (total ban).

102. S.D. CODIFIED LAWS § 22-17-5.1 (2005).

103. TENN. CODE ANN. § 39-15-213 (West 2023).

104. TEX. HEALTH & SAFETY CODE ANN. §§ 170A.001-007 (West 2022); TEX. HEALTH & SAFETY CODE ANN. § 245.002 (West 2017).

105. UTAH CODE ANN. § 76-7a-101 (West 2023); UTAH CODE ANN. § 76-7a-201 (West 2023)

106. W. VA. CODE ANN. § 16-2R-3 (West 2022).

107. WIS. STAT. ANN. § 940.04 (West 2024).

108. WYO. STAT. ANN. § 35-6-102 (West 2023). Wyoming's trigger ban and total ban have been enjoined. Johnson v. State, No. 18732 (Wy. Dist. Ct. of Teton Cnty. Aug. 10, 2022) (order granting preliminary injunction); *see also* Mead Gruver, *Judge Blocks Wyoming's 1st-in-the-Nation Abortion Pill Ban While Court Decides Lawsuit*, AP NEWS (Jun. 22, 2023), https://apnews.com/article/wyoming-abortion-pill-ban-lawsuit-429266bcea6bf5ded1b9c9892ee5578b [https://perma.cc/KQ9D-UN77].

proceedings.[109] Although an affirmative defense enables a defendant to introduce evidence that may negate criminal or civil liability, it places the burden of proof on defendants.[110] In the context of abortion care, an affirmative defense requires the provider to establish that medical care fell within the stipulated defenses.[111] Put simply, affirmative defenses in this setting are harmful because providers are considered guilty unless they can provide a defense.[112] Consequently, physicians are left vulnerable to criminal convictions, thereby disincentivizing risk-averse providers from assisting patients in cases where the life or health of the pregnant person is endangered.[113] Overall, when legal interpretations of exceptions—or lack thereof—conflict with recommended medical interventions, physicians are left facing uncertainties that hinder patient care in emergency situations.[114]

C. Effects of Vague Medical Exemptions on Cancer Care

Pregnant individuals who are diagnosed with cancer face a unique set of challenges in states with vague exceptions to abortion bans.[115] Cancer currently affects one in every one thousand pregnant individuals, but experts project that diagnoses will rise with the improvement of detection measures.[116] To determine whether termination is necessary in such cases, providers often employ the following multidisciplinary factors: "(1) the mother's diagnosis, stage, and prognosis; (2) the gestational age of the embryo or fetus; (3) the recommended therapeutic plan; and (4) the mother's personal values and beliefs."[117] This decisionmaking process reflects the tension between fetal and maternal health. When medical therapy poses a threat to the fetus, medical practitioners are commonly unwilling to provide treatment unless the patient terminates the pregnancy, causing nearly thirty percent of pregnant cancer patients to receive

109. *Affirmative Defense*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/affirmative_defense (last visited Sept. 17, 2024) [https://perma.cc/L7R4-E98X].

110. *Id.*

111. Felix et al., *supra* note 13.

112. LEGAL INFO. INST., *supra* note 109.

113. *Id.*

114. *Id.*

115. *See* Adriana Hepner, Daniel Negrini, Eliane Azeka Hase, Pedro Exman, Laura Testa, Angela F Trinconi, Jose Roberto Filassi, Rossana Pulcineli Vieira Francisco, Marcelo Zugaib, Tracey L. O'Connor & Michael Gary Martin, *Cancer During Pregnancy: The Oncologist Overview*, 10 WORLD J. ONCOLOGY 28, 28 (2019); Silverstein & Van Loon, *supra* note 19, at 1394.

116. Hepner et al., *supra* note 115, at 28; Silverstein & Van Loon, *supra* note 19, at 1394.

117. Silverstein & Van Loon, *supra* note 19, at 1394.

abortions.[118] Importantly, factors accompanying pregnancy, such as suppressed immunity and pregnancy hormones, may accelerate disease progression, further intensifying the need for immediate therapy.[119]

Abortion bans, however, pervert this nuanced evaluation by invading the privacy of the examination room and injecting legal standards into the determination of whether care is appropriate for the pregnant person.[120] In an amicus curiae brief to the Supreme Court in *Dobbs*, more than twenty medical organizations highlighted this ethical reality.[121] The brief asserted, "[L]egislation that substitutes lay lawmakers' views for a physician's expert medical judgment impermissibly interferes with the patient-physician relationship and poses grave dangers to patient well-being."[122] Thus, doctors treating cancer patients, already being required to make highly intricate decisions, are unduly burdened with an additional consideration: weighing possible criminal liability against patients' well-being and potential malpractice liability.[123]

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118. *See supra* note 116 and accompanying text. This range stems from contrasting results of various studies. *Compare* Mathilde Barrois, Olivia Anselem, Jean Yves Pierga, François Goldwasser, Didier Bouscary, Vivien Alessandrini, François Goffinet & Vassilis Tsatsaris, *Cancer During Pregnancy: Factors Associated with Termination of Pregnancy and Perinatal Outcomes*, 261 EUR. J. OBSTETRICS & GYNECOLOGY & REPROD. BIOLOGY 110, 113 (2021) ("Cancer diagnosed during pregnancy is . . . associated with a high rate of termination of pregnancy, 28.2 % in the present study. . . . [I]n studies reporting such data the rate of terminations ranges between 5 and 72 %."), *with* Jorine de Haan, et al., *Oncological Management and Obstetric and Neonatal Outcomes for Women Diagnosed with Cancer During Pregnancy: A 20-Year International Cohort Study of 1170 Patients*, 19 LANCET ONCOLOGY 337, 341 (2018) (finding that, of 1,142 pregnancies among cancer patients, only nine percent ended in termination).

119. Silverstein & Van Loon, *supra* note 19, at 1395 (noting that "initiation of treatment may be deferred until after delivery" in cases of latent malignant conditions).

120. Selena Simmons-Duffin, *For Doctors, Abortion Restrictions Create an 'Impossible Choice' When Providing Care*, NPR (June 24, 2022, 4:26 PM), https://www.npr.org/sections/health-shots/2022/06/24/1107316711/doctors-ethical-bind-abortion [https://perma.cc/M65K-MB5X]. One Kentucky-based gynecologic oncologist, Dr. Monica Vetter, recently reported that she provided substandard treatment to her cervical cancer patient who was twenty-one weeks pregnant after a hospital panel found the case to be outside the scope of the state's medical exceptions. Jeannie Baumann, *Abortion Restrictions Weakening Cancer Care, Other Treatments*, BLOOMBERG L. (Aug. 14, 2023, 4:04 AM), https://news.bloomberglaw.com/pharma-and-life-sciences/abortion-restrictions-weakening-cancer-care-other-treatments [https://perma.cc/RK5K-KTN3]:

> [The patient] couldn't receive what Vetter described as the "tried and true" curative treatment for locally advanced cervical cancer while she was pregnant. Instead, she first received what's called neoadjuvant chemotherapy, a treatment Vetter said hasn't been rigorously tested for this cancer. . . . "I was potentially forced to give her a treatment that is likely inferior to the standard of care treatment," Vetter said.

121. Brief for American College of Obstetricians et al. as Amici Curiae Supporting Respondents, Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

122. *Id.* at 27.

123. Silverstein & Van Loon, *supra* note 19, at 1394; Harris, *supra* note 20, at 2061.

Figure One depicts the spectrum of risk assessment that doctors are forced to undertake in states with abortion bans.[124] While this scale is not exhaustive, it illustrates a potential assessment that doctors may conduct to evaluate whether an abortion is legal under a medical exception.[125] First, and most remotely, the doctor's assessment might ask: if a patient tests positive for a genetic predisposition to cancer while pregnant or before getting pregnant, would the risk of developing cancer qualify under the medical exceptions? Medical studies indicate that breast cancer ("BRCA") gene variant carriers are at a significantly higher risk for developing breast and ovarian cancer.[126] When patients test positive for BRCA gene mutations, prophylactic treatment includes a bilateral risk-reducing mastectomy[127] or an oophorectomy.[128] Since risk-reducing surgery is associated with a significant reduction of cancer cells, doctors may struggle in deciding whether provision of care in anticipation of cancer development constitutes lifesaving treatment.[129] In the most restrictive states, this preemptive treatment is likely too far removed to plausibly qualify as lifesaving care.[130]

The following category is relevant when a pregnant patient is diagnosed with curable cancer while pregnant.[131] Generally, the risk of mortality increases when cancer treatment is delayed.[132] A study of over 1.2 million cancer patients revealed that each month of delayed treatment was associated with a possible thirteen percent increase in

124. *Infra* Figure One.

125. *Infra* Figure One.

126. *BRCA Gene Mutations: Cancer Risk and Genetic Testing*, NIH: NAT'L CANCER INST., https://www.cancer.gov/about-cancer/causes-prevention/genetics/brca-fact-sheet (last updated Nov. 19, 2020) [https://perma.cc/TEY7-62UJ]. While all women have BRCA1 and BRCA2 genes, mutations of those genes cause cells to rapidly divide, which raise cancer risks. *Id.* Studies find that fifty-five percent to seventy-two percent of BRCA1 gene variant carriers and forty-five to sixty-nine percent of BRCA2 mutation carriers will develop breast cancer. *BRCA Gene Mutations*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/cancer/breast/young_women/bringyourbrave/hereditary_breast_cancer/brca_gene_mutations.htm#:~:text=Print-,BRCA%20Gene%20Mutations,have%20mutations%20in %20those%20genes. (last updated Mar. 21, 2023) [https://perma.cc/T33A-XCD9] [hereinafter CTRS. FOR DISEASE CONTROL & PREVENTION, *BRCA*]. Thirty-nine percent to forty-four percent of BRCA1 variant carriers and eleven to seventeen percent of patients who inherit a harmful BRCA2 mutation, will develop ovarian cancer. *Id.*

127. This procedure comprises removal of both breasts. CTRS. FOR DISEASE CONTROL & PREVENTION, *BRCA*, *supra* note 126.

128. *Id.* Oophorectomy requires removal of the ovaries. *Id.*

129. *Id.*

130. *See, e.g.*, Baumann, *supra* note 120.

131. *Infra* Figure One.

132. Baumann, *supra* note 120.

mortality risk.[133] Accordingly, acting quickly to treat curable cancer is imperative. For instance, surgery can cure stage I or II cervical cancer, but left untreated, the cancer may develop into stage III or IV, at which point chemotherapy and radiation are typically required.[134] When a pregnant individual's cancer is curable but rapidly progressing, immediate therapy is warranted and strongly recommended.[135] As the Chief Medical Officer of the American Society of Clinical Oncology explained, "For people diagnosed with cancer during pregnancy or who become pregnant during treatment, abortion is part of evidence-based care."[136]

The third risk assessment category involves cancer diagnoses that are fast acting and may not be curable. For example, timely chemotherapy and radiation are the only viable options for patients with leukemia or lymphoma.[137] Since these forms of cancer are life threatening in the short term, patients could die within three months if they cannot obtain treatment.[138] It is not apparent whether this hypothetical three-month period would constitute imminent harm under state abortion bans.[139]

The fourth assessment grapples with ambiguity when determining whether terminally ill cancer patients may qualify for lifesaving care, especially if the patient is prognosed to live past the pregnancy.[140] The prospect of forcing a pregnant individual to carry to term and deliver despite the reality that the individual will not survive to raise the child is "unfathomable."[141]

Finally, the fifth category considers whether cancer patients are entitled to an abortion mere breaths away from losing their lives. With the fear of prosecution lingering in the examination room, doctors may

133. Melissa Suran, *Treating Cancer in Pregnant Patients After* Roe v Wade *Overturned*, 328 JAMA NETWORK 1674, 1674 (Sept. 29, 2022), https://jamanetwork.com/journals/jama/fullarticle/2797062#:~:text=Generally%2C%20the%20longer%20the%20time,13%25%20increase%20in%20mortality%20risk [https://perma.cc/N7UR-UDV9].

134. *Id.* at 1675. Note that surgery may itself compromise a pregnancy, but it is typically a preferred treatment when eliminating localized cancer cells and preventing the spread of tumors. *Id.* Chemotherapy is likely to harm a fetus, especially in early stages of pregnancy, and cause adverse side effects. Kathy Katella, *Do You Still Need Chemo for Breast Cancer?*, YALE MED. (Oct. 4, 2022), https://www.yalemedicine.org/news/chemo-for-breast-cancer [https://perma.cc/R7ZC-LXCW].

135. Suran, *supra* note 133, at 1674.

136. *Id.*

137. *Id.* at 1675.

138. *Id.*

139. *See supra* Table One.

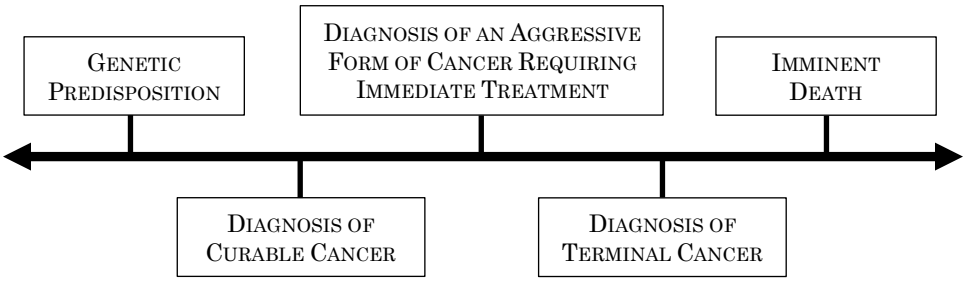
140. Silverstein & Van Loon, *supra* note 19, at 1394.

141. *Id.*

decide to withhold medical assistance until the patient is "basically dead."[142]

The spectrum depicted in Figure One aims to expose the dangers of risk assessments that impair the quality of medical care. Patients are increasingly traveling out of state in dire medical conditions to receive abortive treatment when providers refuse to offer care, risking aggravating their condition.[143] Studies estimate that at least fifteen hundred pregnant women will be diagnosed with cancer in states that impose abortion restrictions and that between 135 and 420 women will suffer from inferior cancer care and loss of life.[144] Consequentially, these forced risk assessments are inherently dangerous.

FIGURE ONE: RISK ASSESSMENT SCALE



II. ANALYSIS

As shown in Part I, ambiguous medical exceptions have positioned cancer patients and their providers in a uniquely distressing setting: the chilling effect associated with risk assessments has disturbed traditional oncological treatment options for pregnant patients.[145] To address deficiencies in the post-*Dobbs* landscape[146] and

142. Shefali Luthra, *State Abortion Bans are Preventing Cancer Patients from Getting Chemotherapy*, THE 19TH (Oct. 7, 2022, 6:00 AM), https://19thnews.org/2022/10/state-abortion-bans-prevent-cancer-patients-chemotherapy/ [https://perma.cc/G8VX-7KLU] (interviewing Dr. Leilah Zahedi-Spung, a maternal fetal medicine physician in Tennessee).

143. *See, e.g.*, Laura Ungar & Heather Hollingsworth, *Despite Dangerous Pregnancy Complications, Abortions Denied*, AP NEWS (Nov. 20, 2022, 8:43 AM), https://apnews.com/article/abortion-science-health-business-890e813d855b57cf8e92ff799580e7e8 [https://perma.cc/B74G-CXGA] (reporting that patients with life-threatening diagnoses have been forced to seek out-of-state abortions to begin chemotherapy or radiation treatment, including one Texas patient whose cancer relapsed "aggressively after she became pregnant with her second child. She sought an abortion to resume the cancer treatment that promised to keep her alive for her toddler.").

144. *Id.*

145. *See supra* Part I.

146. *See supra* Table One.

contextualize the proposal offered in Part III, this Part analyzes several approaches to challenging ambiguous medical exemptions to abortion bans and highlights the advantages and deficiencies of each approach.

Specifically, Section II.A will examine the void-for-vagueness doctrine, a constitutional argument which has been raised in the context of abortion restrictions that trigger criminal penalties.[147] Emphasizing the former successes of vagueness challenges to abortion restrictions and medical constraints, proponents of this approach argue that bans imposing criminal liability implicate notice obligations under the Due Process Clause. Section II.B will then survey several approaches in post-*Dobbs* legal academia, including reliance on uniform implementation of federal protections.

A. Void-for-Vagueness Doctrine

Historically, challenges to abortion bans have invoked the void-for-vagueness doctrine, which derives from the Fourteenth Amendment's Due Process Clause notice requirements.[148] To survive a void-for-vagueness claim, a law must provide "relatively clear guidelines" pertaining to the outlawed conduct.[149] Because everyone is entitled to information related to state-imposed requirements and restrictions, a statute that is "so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law."[150] This Section first presents a successful challenge to a pre-*Roe* abortion statute to highlight the strengths of the void-for-vagueness doctrine and then explores recent scholarship and post-*Dobbs* cases.

In the 1969 case *People v. Belous*, the California Supreme Court drew on the well-established vagueness principle to overturn the conviction of a local surgeon who referred a distraught patient to a skilled but unlicensed abortion provider after the patient threatened to attain an illegal abortion elsewhere.[151] To prevent "butchery in Tijuana[,] or self-mutilation[,]" and imminent health risks associated with such unskilled procedures, the provider determined that referral to a safe facility could save her life.[152] Reasoning that criminal laws are

147. *See* People v. Belous, 458 P.2d 194, 197 (Cal. 1969).

148. *See* U.S. CONST. amend. XIV, § 1.

149. Posters 'N' Things, Ltd. v. United States, 511 U.S. 513, 525 (1994); Mary Claire Bartlett, *Physician Mens Rea: Applying* United States v. Ruan *to State Abortion Statutes*, 123 COLUM. L. REV. 1699, 1730 (2023).

150. *Belous*, 458 P.2d at 197.

151. *Id.* at 196.

152. *Id.*

required to guarantee a reasonable degree of certainty concerning illegal conduct, the *Belous* court found that the Model Penal Code's phrase, "necessary to preserve" the pregnant individual's life, was unconstitutionally vague.[153] Specifically, "necessary to preserve" lacked a dictionary definition, and the words failed to independently provide a clear meaning.[154] Further, the court rejected an interpretation that conflated "necessary to preserve" with certainty or immediacy of death, highlighting that insomnia, anxiety, and suicidal tendencies had sufficiently justified reversal of criminal abortion convictions in previous cases.[155] A demonstration of "immediacy or certainty of death" was not essential to satisfy the "necessary to preserve" test.[156]

Although *Belous* does not bind the federal judiciary or other state courts, the California Supreme Court's holding provides persuasive reasoning pertinent to the void-for-vagueness doctrine.[157] Scrambling to regain constitutional footing in the wake of *Dobbs*, theorists increasingly support efforts to invoke the void-for-vagueness doctrine in the context of abortion care.[158] Legal scholar Alan Morrison, for example, argues that the medical exceptions to abortion bans undeniably violate the void-for-vagueness doctrine.[159] Morrison writes that when the legality of the care hinges on the arbitrary determination of a jury, all medical personnel involved with the treatment blindly risk liability.[160] Though not explicitly examining long-term solutions, Morrison offers a short-term proposal to ameliorate the chilling effect that is spreading through medical centers, urging providers to

153. *Id.* at 197:

> Section 274 of the Penal Code, when the conduct herein involved occurred, read: "Every person who provides, supplies, or administers to any woman . . . with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life, is punishable by imprisonment in the State prison not less than two nor more than five years."

154. *Id.* at 198.

155. *Id.* at 199 (citing People v. Ballard, 167 Cal. App. 2d 803, 813 (Cal. Dist. Ct. App. 1959)); People v. Abarbanel, 48 Cal. Rptr. 336, 337 (Cal. Dist. Ct. App. 1965)).

156. *Belous*, 458 P.2d at 199.

157. *See, e.g.*, Preliminary Injunction Order at 13, Preterm-Cleveland v. Yost, No. A2203203 (Ct. C.P. Hamilton Cnty. Oct. 12, 2022) [hereinafter Yost Preliminary Injunction Order]; Plaintiffs' First Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction at 54, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023) [hereinafter Zurawski Injunction Petition].

158. *See* Alan Morrison, *Abortion Ban Exceptions and the Problem of Vagueness*, NAT'L L.J. (2022), https://plus.lexis.com/api/permalink/16b3f1a8-5f2d-4c5e-8869-42c0d328c1be/?context=1530671 [https://perma.cc/88US-GC2X]; Bartlett, *supra* note 149, at 1730–34 (discussing vague standards for mens rea).

159. Morrison, *supra* note 158.

160. *Id.*

immediately file suit in federal court to halt the enforcement of abortion bans that violate the vagueness doctrine.[161]

Morrison's tactic for addressing abortion restrictions optimistically assumes that courts will be amenable to striking down entire statutes.[162] Pragmatically, it is unlikely that courts, especially those in the most conservative states, will strike down entire statutes without assurance that at least some restrictions will remain in place.[163] Realistically, some plaintiffs fear a loss under the void-for-vagueness will create bad precedent.[164] Due to this fear, they have avoided the argument altogether.[165]

Plaintiffs' arguments in post-*Dobbs* litigation reflect this concern with the void-for-vagueness doctrine.[166] In *Zurawski v. Texas*, Plaintiffs challenged Texas's abortion ban, seeking clarification regarding the scope of the term "medical emergency."[167] In the complaint, Plaintiffs argued medical complications commonly escalate into emergent conditions when treatment is considered unsafe during pregnancy, which includes "certain cancers requiring radiation, chemotherapy, or major surgery."[168] The complaint featured descriptions of patients directly affected by Texas's abortion restrictions,[169] including the widely publicized story of Kristina Cruickshank, whose doctors refused to provide abortion care after diagnosing her with partial molar pregnancy, a condition that can cause cancer.[170]

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161. *Id.* (citing Johnson v. United States, 576 U.S. 591, 595 (2015)).

162. *Id.*

163. *See, e.g.*, Seila L. v. Consumer Fin. Prot. Bureau, 591 U.S. 197, 237 (2020) (declaring that "Congress would prefer that we use a scalpel rather than a bulldozer in curing the constitutional defect[s]"). The doctrine of judicial restraint reflects courts' reluctance to encroach on congressional policymaking and maintain the separation of powers. For a general description of this doctrine, see RICHARD A. POSNER, THE FEDERAL COURTS: CHALLENGE AND REFORM 304–34 (1996).

164. *See, e.g.*, Yost Preliminary Injunction Order, *supra* note 157, at 19; Zurawski Injunction Petition, *supra* note 157, at 54.

165. *See, e.g.*, Yost Preliminary Injunction Order, *supra* note 157, at 19; Zurawski Injunction Petition, *supra* note 157, at 54.

166. *See, e.g.*, Yost Preliminary Injunction Order, *supra* note 157, at 19; Zurawski Injunction Petition, *supra* note 157, at 54.

167. Zurawski Injunction Petition, *supra* note 157, at ¶¶ 5, 316–17, 320–24.

168. *Id.* at ¶ 282; *see also id.* at ¶ 285 ("Some fetal conditions present particularly acute risks to the pregnant person. For example, partial molar pregnancy is a condition where the placenta transforms into an invasive cancer, thus creating an emergency for the pregnant person.").

169. See *supra* Table One for further information on the Texas ban.

170. Zurawski Injunction Petition, *supra* note 157, at ¶ 368. In June 2022, while fifteen weeks pregnant, Texas resident Kristina Cruickshank received a diagnosis of a partial molar pregnancy, an emergent condition that may trigger severe health complications, including the development of invasive cancer. *Id.* Despite the medical reality that the fetus was not viable, multiple ethics committees refused to provide abortion care because doctors detected the fetus's cardiac activity.

On August 4, 2023, the district court granted an injunction in *Zurawski*, blocking enforcement of Texas's abortion ban in cases of dangerous pregnancy complications and erecting a "good faith judgment" standard for physicians in cases of severe medical emergencies.[171] Shortly thereafter, the state appealed, halting invocation of the injunction while the case waited for the Texas Supreme Court's review.[172]

Notably, the Plaintiffs have not explicitly invoked the void-for-vagueness doctrine.[173] During oral arguments in November 2023, the Texas justices directly questioned Plaintiffs' counsel on their failure to raise a vagueness challenge in their suit.[174] This choice, counsel insinuated, reflected a strategic concession: rather than pursuing a facial claim of unconstitutionality under the void-for-vagueness doctrine—which, if successful, would result in striking down the entire statute—the Plaintiffs submitted a more modest request to the court, asking that the justices only define the meaning of the medical exception under as-applied relief.[175]

Like the plaintiffs in *Zurawski*, Ohioan Plaintiffs avoided vagueness claims in their injunction motion.[176] After the six-week ban in Ohio went into effect, physicians refused to provide cancer treatment to one pregnant patient with stage III melanoma until she terminated her pregnancy, despite the lack of abortion access in the state.[177] In *Preterm-Cleveland v. Yost*, Plaintiffs sued on behalf of such pregnant, medically at-risk individuals.[178] The *Yost* court granted the Plaintiffs' preliminary injunction motion, reasoning that the "vague and

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Id. Over the span of three days, Kristina "la[id] in agony" while her obstetrician searched for a hospital willing to accept her case. *Id.* Although Kristina eventually received critical treatment, the physical and emotional impact of her pregnancy manifested in lingering symptoms, including rapid heart rate, shortness of breath, and anxiety. *Id.*

171. Temporary Injunction Order at 5, Zurawski v. Texas, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. Aug. 4, 2023).

172. *Id.*

173. Zurawski Injunction Petition, *supra* note 157, at ¶¶ 463–64; 471–72; 479–80. Rather, the plaintiffs turned to three provisions in Texas's constitution: article I, section 3 (granting equal rights to "all freemen"), 3a (prohibiting denial of equality "because of sex, race, color, creed, or national origin"), and 19 (barring deprivation of "life, liberty, property" except by "due course of the law"). *Id.* at ¶¶ 463–64 (citing TEX. CONST. art. I, § 3), 471–72 (citing TEX. CONST. art. I, § 3a), 479–80 (citing TEX. CONST. art. I, § 19).

174. Oral Argument at 20:27, Zurawski v. Texas, (Tex. Nov. 28, 2023) (No. 23-0629), https://www.youtube.com/watch?v=Ult-iWTMNl4 [https://perma.cc/9NBS-ELY8].

175. *Id.* at 20:50.

176. *See* Yost Preliminary Injunction Order, *supra* note 157, at 26 n.5.

177. Relators' Memorandum in Opposition to Respondents' Motion to Dismiss at 15, State *ex rel.* Preterm-Cleveland v. Yost, No. 2022-0803 (Ohio Aug. 1, 2022); *see supra* notes 1–5 and accompanying text.

178. Yost Preliminary Injunction Order, *supra* note 157, at 9.

imprecise" exceptions in the Ohio abortion ban failed to cover numerous pregnancy-associated health issues, including cancer.[179] The court drew on the testimony of one doctor, who shared that her clinic could not "provide abortion care to [the abovementioned cancer] patient because they could not confirm whether exceptions in [state abortion laws] applied."[180]

Yet, despite repeatedly highlighting the ambiguous language of the ban and referring to its unconstitutional vagueness, the court mentioned in a footnote that Plaintiffs failed to actually invoke a void-for-vagueness claim in their injunction motion.[181] While *Yost* traveled through the state's appeals process, voters passed a state constitutional amendment, enshrining the right to abortion care.[182] In December 2023, Ohio's Supreme Court dismissed the case sua sponte to reflect the change in law.[183] Because this case was dismissed, the Ohio Supreme Court ultimately failed to address the validity of the vagueness argument.[184]

As *Zurawski* and *Yost* demonstrate, plaintiffs have refrained from drawing on the void-for-vagueness doctrine when moving for injunctions, perhaps recognizing the likelihood of adverse judicial outcomes.[185] In other words, apprehensive that wholesale facial challenges will perturb judicially modest courts, plaintiffs have opted out of invoking vagueness arguments.[186] Notably, plaintiffs' fears concerning the inevitable failure of vagueness challenges may be well founded: the vagueness approach has not always been an effective tool for striking down abortion bans.[187]

In *Gonzales v. Carhart*, for example, the Supreme Court rejected a void-for-vagueness challenge raised in response to the Partial-Birth Abortion Ban Act of 2003 ("the Act").[188] The law prohibited the facilitation of partial-birth abortions, commonly known as intact dilation and extraction, while also outlawing certain abortive

179. *Id.* at 17.

180. *Id.* at 19.

181. *Id.* at 26 n.5.

182. Jo Ingles & Jahd Khalil, *Abortion Rights Win in Ohio and Virginia Election*, NPR (Nov. 11, 2023, 6:10 PM), https://www.npr.org/2023/11/11/1212502213/abortion-rights-win-in-ohio-and-virginia-elections [https://perma.cc/HFP8-N2HA].

183. Preterm-Cleveland v. Yost, No. 2023-Ohio-4570, 2023 WL 8663888 (Ohio Dec. 15, 2023).

184. *Id.*

185. *See, e.g.*, Yost Preliminary Injunction Order, *supra* note 157, at 26 n.5; Zurawski Injunction Petition, *supra* note 157 (not mentioning vagueness).

186. *See* Yost Preliminary Injunction Order, *supra* note 157, at 26 n.5.

187. *See* Gonzales v. Carhart, 550 U.S. 124, 144–57 (2007).

188. *See id.*

procedures based on fetal positioning.[189] Finding that the Act required doctors to deliberately deliver a fetus to "an anatomical landmark" in order for liability to attach, the Court determined that providers would not face criminal liability for mistakenly delivering a fetus beyond the prohibited point.[190] In other words, the Act was not sufficiently ambiguous to satisfy a vagueness challenge.[191] To defeat a vagueness challenge, then, states may simply point to bright-line preexisting rules within exemptions, such as Ohio's list of conditions that qualify for care, described in Section I.B.[192] These rules are often underinclusive, which means physicians may refuse to provide necessary care to patients with unenumerated emergency conditions.[193] This is especially true in the context of oncology. Since cancer is virtually absent from current state medical exemptions, deferring to statutory lists may prevent even the most debilitated cancer patients from receiving treatment.[194] Further, since cancer is rarer than other pregnancy-related illnesses,[195] it is unclear whether policymakers will expand medical exemptions to include such cases.

Further, state policymakers may remedy vagueness concerns by further restricting abortion allowances through blanket bans that do not allow for emergent patients, which would invalidate medical and lifesaving exemptions.[196] Several state constitutions explicitly warrant

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189. *Id.*; Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531(b):

> [T]he term "partial-birth abortion" means an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the mother's body, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

190. *Gonzales*, 550 U.S. at 148.

191. *Id.*

192. *See supra* Section I.B.

193. *See, e.g.*, *supra* notes 85–86 and accompanying text (providing Ohio statute as an example of underinclusive list); *see also supra* Table One (highlighting the lack of unenumerated conditions, as well as the vague categories of qualifying care).

194. *See supra* Table One (lacking cancer as a qualifier for medical exceptions).

195. For example, preeclampsia is significantly more common than cancer-associated pregnancy, occurring in about one in twenty-five pregnancies. *High Blood Pressure During Pregnancy*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/high-blood-pressure/about/high-blood-pressure-during-pregnancy.html?CDC_AAref_Val=https://www.cdc.gov/bloodpressure/pregnancy.htm (last updated June 6, 2024) [https://perma.cc/A2LF-HUJ5]; Hepner et al., *supra* note 115, at 28 (reporting that cancers occurs in one in every one thousand pregnancies).

196. *See, e.g.*, Mary Ziegler, *Why Exceptions for the Life of the Mother Have Disappeared*, ATLANTIC (Aug. 22, 2022, 5:35 PM), https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582/ [https://perma.cc/MYH7-F7X4] (discussing groups in Wisconsin, Idaho, and Michigan that combat lifesaving exceptions).

such extreme bans, including Tennessee's, which stipulates that it does not protect the right to abortion and gives elected officials the right to "enact, amend, or repeal statutes regarding abortion, including . . . when necessary to save the life of the mother."[197]

Mary Claire Bartlett has offered a different proposition pertaining to vagueness in the abortion context. Bartlett suggests a subjective mens rea requirement should be included in the vaguess doctrine.[198] When establishing the elements of a crime, there are important evidentiary implications depending on whether an objective or subjective mens rea standard is applied.[199] Objective mens rea would require a defendant provider to establish that the abortion would *generally* be considered a reasonable medical judgment, invoking an analysis of general practices in the physician community.[200] Alternatively, subjective mens rea would require a physician to establish that they exercised their *personal* medical judgment to evaluate whether the abortion was necessary.[201] According to Bartlett, an objective mens rea provision subjects providers' decisions to arbitrary evaluations by jurors who typically lack medical expertise.[202] Conversely, Bartlett notes, a subjective mens rea requirement would allow doctors to evade criminal charges for performing emergency abortions unless they "*knowingly, intentionally, deliberately* (or whatever subjective standard the statute employs) contravene[d] reasonable medical judgment."[203]

Bartlett's contention, like Morrison's proposal, suffers from several salient deficiencies. Most importantly, a subjective mens rea potentially forces providers to speak to their own good faith on the stand and makes criminal charges contingent on the jury's interpretation of an individual's risk assessment, state of mind, and decisionmaking.[204] Worse yet, the jury's determination of a doctor's credibility and likeability, despite jury instructions to the contrary, may influence

197. TENN. CONST. art. I, § 36. *Cf. supra* Table One.

198. Bartlett, *supra* note 149, at 1724–34.

199. *Id.* at 1715–16.

200. *Id.* at 1726 (citing ALA. CODE § 26-23H-3(6) (2023)).

201. *Id.* (discussing the role of subject intent in the context of medical suits).

202. *Id.* at 1729–30.

203. *Id.* at 1734.

204. *See* Jonathan L. Hood, *What Is Reasonable Cause To Believe?: The Mens Rea Required For Conviction Under 21 U.S.C. § 841*, 30 PACE L. REV. 1360, 1365–68 (2010) (finding that objective mens rea is preferable when defendant is charged with serious criminal offenses). *See generally* Michael A. Foster, CONG. RSCH. SERV., R46836, *MENS REA*: AN OVERVIEW OF STATE-OF-MIND REQUIREMENTS FOR FEDERAL CRIMINAL OFFENSES 18–29 (2021) (examining the subjective mens rea framework in the context of criminal cases).

criminal charges.[205] Commentators like Bartlett have countered that subjective requirements prevent a "war of the experts" in medical suits, wherein anti-choice doctors give testimony that refutes other testimony that supports provision of abortion care.[206] Under an objective mens rea standard, however, instead of testifying on their own behalf in front of captious juries, providers can offer industry standards and the testimony of other clinicians to establish the bounds of reasonable medical judgment.[207]

Overall, although *Belous* indicates that courts may defer to medical practitioners who provide care under ambiguous statutory regimes, the merits of vagueness challenges may not remedy the flaws. These flaws include (1) plaintiffs' fear of creating bad precedent; (2) the possibility that vague abortion bans will be replaced with over- and underinclusive lists; (3) elimination of medical exemptions altogether; and (4) the misguided implementation of subjective mens rea requirements that force doctors to take the stand.

B. Nationalization of Abortion Policy Through Federal Preemption

In addition to the void-for-vagueness doctrine, legal scholars have turned to the federal government to nationalize abortion care, implicating preemption arguments.[208]

Scholars David S. Cohen, Greer Donley, and Rachel Rebouché examine the interjurisdictional dilemma posed by *Dobbs*, arguing that federal preemption provides "a novel and untested argument for chipping away at state abortion bans."[209] The scholars examine the Emergency Medical Treatment and Active Labor Act ("EMTALA"), a federal statute requiring all Medicare-participating hospitals with emergency rooms to provide emergent patients with stabilizing

205. For a discussion regarding the ineffectiveness of jury instructions on limiting jurors' consideration factors that are not offered for a legally acceptable purpose (such as the physician's character), see Shari Seidman Diamond & Neil Vidmar, *Jury Room Ruminations on Forbidden Topics*, 87 VA. L. REV. 1857 (2001).

206. *See* Bartlett, *supra* note 149, at 1715. ("Another organization, Physicians Against Abuse, argued that the objective standard simply created a 'war of experts,' in which criminal liability depends on who hired the 'more believable, more charismatic' expert.").

207. *See* Foster, *supra* note 204 (explaining mens rea requirements).

208. *See* David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 52 (2023) (examining the new legal battles likely to take place after *Dobbs*).

209. *Id.* at 1, 7, 99 (highlighting opportunities of the federal government to nationalize abortion rights, including "shielding abortion providers in abortion-supportive states from out-of-state investigations, lawsuits, or prosecutions; preempting state laws that contradict federal laws and regulations; providing abortion services on federal land; further loosening federal restrictions on medication abortion; and advancing telabortion through licensure and telemedicine infrastructure").

treatment.[210] In the context of emergent care, the scholars assert that EMTALA may preempt state abortion laws lacking medical exceptions, as well as bans with exceptions that are more inhibitory than those in EMTALA.[211] Following Texas's enactment of S.B. 8 in 2021, the United States Secretary of Health and Human Services ("HHS") sent a memorandum to hospitals that reinforced the notion that physicians' duty to provide emergency treatment "preempts any directly conflicting state law."[212] This guaranty, the memorandum emphasized, extends to pregnant individuals.[213]

Shortly after the *Dobbs* decision, President Biden promoted EMTALA as a vehicle through which providers in abortion-restrictive states could intervene during medical emergencies in Executive Order 14,076.[214] Further, the White House issued a press release that reiterated the President's devotion to securing access to "emergency medical care" under EMTALA.[215]

Drawing on these sources, Cohen, Donley, and Rebouché urge HHS to target specific hospitals for failure to comply with EMTALA.[216] As the authors point out, patients would be required to file complaints with the agency in enforcement actions before the agency could initiate responsive action.[217] To increase the number of complaints against noncompliant hospitals, the scholars urge HHS to continue spreading awareness of EMTALA and ensure that the agency implements user-friendly filing systems which facilitate compliance and enforcement.[218]

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210. *Id.*; 42 U.S.C. § 1395dd(a), (b), (e).

211. 42 U.S.C. § 1395dd(a), (b), (e):

> The term "emergency medical condition" means (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

212. Memorandum from Karen L. Tritz, Dir., Surv. & Operations Grp. & David R. Wright, Dir., Quality, Safety & Oversight Grp., on the Reinforcement of EMTALA Obligations Specific to Patients who Are Pregnant or Are Experiencing Pregnancy Loss to State Surv. Agency Dirs. (Sept. 17, 2021).

213. *Id.*

214. Exec. Order No. 14,076, 87 Fed. Reg. 42053, 42054 (July 8, 2022) (requiring that pregnant patients "receive the full protections for emergency medical care afforded under the law, including by considering updates to current guidance on obligations specific to emergency conditions and stabilizing care under the Emergency Medical Treatment and Labor Act").

215. THE WHITE HOUSE BRIEFING ROOM, FACT SHEET: PRESIDENT BIDEN TO SIGN EXECUTIVE ORDER PROTECTING ACCESS TO REPRODUCTIVE HEALTH CARE SERVICES (2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/08/fact-sheet-president-biden-to-sign-executive-order-protecting-access-to-reproductive-health-care-services/ [https://perma.cc/55LU-FX3S].

216. Cohen et al., *supra* note 208, at 77.

217. *Id.*

218. *Id.*

Notwithstanding its utility, Cohen, Donley, and Rebouché's proposal fails to account for the low probability that patients will endure the procedural hurdles of collectively filing an agency compliant.[219] Moreover, the authors' proposal emphasizes retrospective chastisement of noncompliant hospitals rather than proactive mitigation of dangerous outcomes, meaning the expected enforcement of the scholars' proposal is primarily reactive.[220] Most importantly, federal preemption arguments have generally been futile, failing in both Texas and Idaho.[221] Texas has nullified HHS guidance, finding EMTALA "protects both mothers and unborn children."[222] In the same vein, the Supreme Court has permitted Idaho to enforce its total ban, overriding the district court's determination that EMTALA preempted the state's strict abortion ban in emergency circumstances.[223]

Federal preemption arguments suffer serious shortcomings, as indicated by several problems.[224] First, it is unclear whether EMTALA *directly* conflicts with state abortion bans.[225] Several federal courts of appeals have already described EMTALA as failing to preempt state medical standards.[226] Second, as the appellants in *Moyle v. Idaho* highlighted, EMTALA defines a medical emergency as a complication which places "the health of the woman or *her unborn child* in serious

219. *See id.* ("HHS should also enforce the statute against specific hospitals that are accused of delaying care. Those enforcement actions, however, require patients to file complaints with the agency before the agency can act.").

220. *See id.* ("At the time of writing, the first EMTALA investigation against a hospital in Missouri that denied a patient emergency abortion care made headlines.").

221. Texas v. Becerra, 623 F. Supp. 3d 696, 704–05 (N.D. Tex. 2022); United States v. Idaho, 623 F. Supp. 3d 1096, 1109 (D. Idaho 2022), *cert. granted sub nom*. Moyle v. United States, 144 S. Ct. 540 (2024).

222. *Becerra*, 623 F. Supp. 3d at 704.

223. *Idaho*, 623 F. Supp. 3d at 1109, *cert. granted sub nom*. Moyle v. United States, 144 S. Ct. 540.

224. *See* Application for Stay of the Preliminary Injunction Issued by the United States District Court for the District of Idaho, United States v. Moyle, 144 S. Ct. 540 (2024) (No. 23-726), 2023 WL 8237583, at *15–21 (pointing out "EMTALA is governed by two non-preemption clauses," and arguing it does not preempt Idaho's abortion legislation).

225. 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").

226. Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1258 (9th Cir. 1995) ("Congress enacted the EMTALA not to improve the overall standard of medical care, but to ensure that hospitals do not refuse essential emergency care because of a patient's inability to pay."); Hardy v. N.Y.C. Health & Hosp. Corp., 164 F.3d 789, 795 (2d Cir. 1999) ("[O]ne of Congress's objectives was that EMTALA would peacefully coexist with applicable state 'requirements' "); Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996) ("[T]he legal adequacy of that [emergency] care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt.").

jeopardy."[227] It takes little stretch of the imagination to anticipate judicial emphasis on EMTALA's concern for the "unborn child." Further, in the context of cancer care, raising EMTALA challenges in court likely will not prove sufficient because numerous cancer diagnoses may not implicate the same level of immediate urgency to qualify for stabilizing care, as discussed above.[228] Finally, since cancer care may require a multifaceted, elongated treatment plan, a court is unlikely to categorize an abortion as "stabilizing" because termination of pregnancy may be perceived as a pretreatment requirement rather than part of the treatment procedure.[229]

Although EMTALA has emerged as a potential avenue for the restoration of abortion rights for emergent patients, this strategy is unlikely to survive for three reasons. Most importantly, circuit courts have established robust precedent pertaining to preemption of medical care standards.[230] Moreover, EMTALA's requirement that the "unborn child['s]" health must be included when determining whether patients qualify for care makes this strategy unlikely to survive.[231] Relatedly, even if EMTALA prevails as a legal approach to obtain some abortion rights, EMTALA's protection likely does not extend to cancer patients for whom abortion is seen as a prerequisite to treatment and not necessarily part of treatment itself.[232]

III. SOLUTION

As pregnant individuals continue to endure the lingering effects of providers' *Dobbs*-induced paralysis, cancer patients are at the crux of the medical and legal debates concerning the applicability of medical exceptions to abortion bans.[233] Accordingly, a comprehensive legal remedy that addreses widespread informational gaps is needed to cure healthcare system deficiencies and liberate access to evidence-based cancer care, including termination of pregnancy.[234]

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227. Application for Stay of the Preliminary Injunction Issued by the United States District Court for the District of Idaho, United States v. Moyle, 144 S. Ct. 540 (2024) (No. 23-726), 2023 WL 8237583, at *21.

228. *Id.*

229. *See supra* Section I.C (discussing how cancer care is administered).

230. *See supra* note 226 and accompanying text (providing several circuit court opinions finding no preemption).

231. 42 U.S.C. § 1395dd(c), (f).

232. *See, e.g.*, Silverstein & Van Loon, *supra* note 19, at 1394–95 (providing an overview of the factors contributing to shared decisionmaking in cancer cases).

233. *See supra* Part II (discussing the legal landscape and its effect on cancer care for pregnant women).

234. *See supra* Section I.C (unpacking cancer risk assessments and the potential for *Dobbs* to interfere with critical treatment).

To be sure, the ideal legal solution for emergent cancer patients would include the full restoration of reproductive rights, reversal of *Dobbs*, and recognition that the nuanced treatment process requires insulation from hyperpolarized state intervention.[235] Achieving these goals, however, is virtually impossible in the short term, especially considering the conservative composition of the Supreme Court and the hesitancy of Congress to enact necessary legislation.[236] Even so, there are several alternatives that may, at least in part, clarify the chaotic matrix of vague health exceptions shown in Table One and ultimately dismantle barriers to care.[237]

This Note offers a two-pronged approach that begins to resolve the legal and informational deficiencies pervading the abortion legal landscape. The first prong aims to decriminalize abortion care using severability and vagueness theories that centralize provider-patient relationships in cancer cases.[238] While opponents litigate constitutional arguments under the first prong, the second prong focuses on education—a pragmatic approach regularizing standards of care and employing educational trainings that address the immediate deficiencies in the current legal regime adversely affecting emergent patients.[239]

A. Prong One: Decriminalizing Abortion Care

Abortion care must be decriminalized. As highlighted in Section II.C, the lingering threat of criminal penalties has paralyzed providers.[240] State legislatures have forced physicians to consider their own interests as a factor in determining a patient's treatment plan by including criminal charges in abortion statutes.[241] This chilling effect

235. *See* Silverstein & Van Loon, *supra* note 19, at 1394–95 (providing an overview of the factors contributing to shared decisionmaking in cancer cases).

236. For discussions pertaining to the prospect of overturning *Dobbs*, see David S. Cohen, Greer Donley & Rachel Rebouché, *We Need to Talk About Overturning the* Dobbs *Decision*, N.Y. TIMES (June 24, 2023), https://www.nytimes.com/2023/06/24/opinion/dobbs-overturn-strategy-abortion.html [https://perma.cc/4CL5-8THZ] ("Developing a strategy now to overrule Dobbs is necessary to move closer to that desired reality. It won't be easy, and it likely won't be quick."); *see also* Ed Kilgore, *Could* Dobbs *Be Reversed Like* Roe *Was?*, N.Y. MAG. (July 2, 2023), https://nymag.com/intelligencer/article/dobbs-reversed-like-roe-abortion-rights.html [https://perma.cc/2FRP-CL44] ("[I]t would take a net change of two justices before the Court could even begin to reverse *Dobbs*. . . . Democratic senators are famously slow to embrace 'radical' institutional reforms"); Cohen et al., *supra* note 208, at 77.

237. *See supra* Table One.

238. *See infra* Section III.A.

239. *See supra* Figure One (highlighting the lack uniform approach to risk assessments).

240. *See supra* Section II.C.

241. *See supra* Section II.C; *see also* Table One (highlighting the web of vague statutory qualifications that shape medical treatment plans).

culminates in substandard care which severely impairs the well-being of cancer patients and, in some cases, leads to otherwise preventable death.[242] The first prong of this framework urges providers and patients to challenge provisions of abortion bans that implicate criminal penalties under the void-for-vagueness doctrine. By specifically asking the Court to sever criminal aspects of abortion bans while leaving the remainder of the statute intact, litigants may reduce the stakes associated with liability.[243]

This is especially important since vagueness concerns are intensified where a statute imposes criminal penalties,[244] so laws must be sufficiently explicit to inform regulated individuals of the conduct that will trigger penalties.[245] The Supreme Court has acknowledged such vagueness concerns, applying stringent analyses to invalidate laws that create tension between the medical duty owed to the patient and the physician's self-interest in avoiding prosecution.[246] The Court noted that "where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions."[247]

Considering the Court's heightened standard of review for vague criminal statutes, plaintiffs are more likely to prevail under vagueness

242. *See* Ungar & Hollingsworth, *supra* note 143 ("Some doctors in states with restrictive abortion laws say they've referred or suggested more patients go elsewhere than ever. Some women are facing harmful, potentially deadly delays.").

243. *See supra* Section III.A. As of January 2024, fourteen states have criminalized abortion: Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia. CTR. FOR REPROD. RTS., *supra* note 10.

244. *See* Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc., 455 U.S. 489, 498–99 (1982) ("The Court has . . . expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe."); Sessions v. Dimaya, 548 U.S. 148, 155–57 (2018) (reiterating the principle that criminal penalties implicate a higher level of judicial scrutiny); *see also* N.Y. State Rifle & Pistol Ass'n v. Cuomo, 804 F.3d 242, 265 (2d Cir. 2015) ("Statutes carrying criminal penalties or implicating the exercise of constitutional rights . . . are subject to a 'more stringent' vagueness standard than are civil or economic regulations.").

245. *See Hoffman Ests.*, 455 U.S. at 498–99 ("[W]e insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning." (quoting Grayned v. City of Rockford, 408 U.S. 104, 108–09 (1972))); *Sessions*, 548 U.S. at 155–57 ("The void-for-vagueness doctrine, as we have called it, guarantees that ordinary people have 'fair notice' of the conduct a statute proscribes." (quoting Papachristou v. City of Jacksonville, 405 U.S. 156, 162 (1972))); *N.Y. State Rifle & Pistol Ass'n*, 804 F.3d at 252 ("The doctrine requires that 'a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement.' " (quoting Kolender v. Lawson, 461 U.S. 352, 357 (1983))).

246. *See* Colautti v. Franklin, 439 U.S. 379, 390 (1979) (finding a statute requiring providers to assess fetal viability before abortion procedures void for vagueness when criminal sanctions attached).

247. *Id.* at 400–01.

claims if their challenges focus solely on statutory provisions pertaining to criminal liability.[248] This approach would require a reviewing court to sever the challenged statute.[249] To determine whether a statute is severable, the Court has looked at the following two factors: (1) whether the legislature would have enacted the valid provisions of the act, notwithstanding the severable portion; and (2) whether the undisturbed provisions of the statute are "fully operative as a law" and can function independently of the invalid provision.[250] State abortion laws satisfy both severability elements even though they lack severability clauses.[251] The Court decided such an absence is not dispositive because it is evident that states would have enacted abortion bans with civil penalties independently of criminal penalties.[252] Every abortion ban with criminal liability also includes civil penalty provisions, which suggests that states intended the laws to be severable.[253] Further, most state abortion bans can still operate without their attendant criminal penalty provisions.[254]

As explored in Section II.A, void-for-vagueness arguments require delicate precision.[255] A nuanced, curated manifestation of the vagueness theory is required to address prospective plaintiffs' concerns that facial challenges will fail and establish bad precedent.[256] Morrison's faulty disregard of plaintiffs' hesitations can be remedied by

248. *See id.* ("[W]here conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions."); Alaska Airlines v. Brock, 480 U.S. 678 (1987) (holding a legislative veto provision severable from an otherwise permissible statute).

249. *See Colautti*, 439 U.S. at 384, 401 ("[The lower court] declared the Act to be severable, upheld certain of its provisions, and held other provisions unconstitutional. . . . The judgment of the District Court is affirmed."); *Brock*, 480 U.S. 678, 684–87 (discussing severability); *see also Tenth Amendment — Constitutional Remedies — Severability* — Murphy v. National Collegiate Athletic Association, 132 HARV. L. REV. 387, 387 n.4 (2018) [hereinafter *Tenth Amendment*] ("[T]he act of severing inludes separating an invalid portion of a statute from the valid portions and continuing to maintain those remaining portions as an enforceable scheme.").

250. *Brock*, 480 U.S. at 680–81, 684; *see also* Tennessee v. Garner, 471 U.S. 1 (1985) (invalidating an unconstitutional provision from the remaining constitutional provisions after severing).

251. *Brock*, 480 U.S. at 686.

252. *See supra* note 249 and accompanying text (highlighting states' civil and criminal bans of abortion).

253. *See* GUTTMACHER INST., *Interactive Map*, *supra* note 6; *supra* Table One.

254. *See Tenth Amendment*, *supra* note 249, at 390; *see also* Becca Damante & Kierra B. Jones, *A Year After the Supreme Court Overturned* Roe v. Wade, *Trends in State Abortion Laws Have Emerged*, AM. PROGRESS (June 15, 2023), https://www.americanprogress.org/article/a-year-after-the-supreme-court-overturned-roe-v-wade-trends-in-state-abortion-laws-have-emerged/ [https://perma.cc/3WJC-8ESN] (examining the execution and enforcement of various bans).

255. *See supra* Section II.A.

256. *See supra* Section II.A.

severing the criminal and civil provisions in abortion bans.[257] Such a suit may stem, for example, from providers who (1) have been charged with criminal penalties[258] or (2) will testify to the chilling effect resulting from the fear of prosecution.[259]

This framework provides an avenue to presenting a facial challenge to abortion bans and increases the odds of such challenges surviving in court.[260] Most importantly, this solution recognizes providers' denouncement of distressing risk assessments.[261] This litigation strategy will also minimize litigants' hesitations to invoke the void-for-vagueness doctrine, while improving the likelihood of favorable judicial outcomes.[262] Additionally, this model will minimize providers' risks to ensure patients' interests are prioritized.[263]

B. Prong Two: Establishing and Implementing National Standards of Care

In the wake of *Dobbs*, providers need comprehensive, uniform guidelines in order to understand the circumstances wherein patients, especially those seeking cancer care, qualify for abortion procedures.[264] The second prong of this proposal, which focuses on shifting informational regimes, aims to resolve providers' confusion, mitigate doctors' unwillingness to provide care, and address their paralyzing fears of penalties or delicensing.[265] To do so, this prong first requires cooperation among multidisciplinary organizations in formulating flexible, comprehensive guidelines concerning qualifications for abortion care, such as cancer. Second, this prong encourages hospitals to disseminate compiled standards of care and educational training programs capable of implementing these policies.[266]

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257. *See supra* Section II.A; *see also* John C. Nagle, *Severability*, 72 N.C. L. REV. 203, 207 (1994) (describing the elements of severability arguments).

258. For an example of a successful severed vagueness claim, see Belle Maer Harbor v. Charter Twp. of Harrison, 170 F.3d 553, 559 (6th Cir. 1999) (finding only one clause void under the vagueness doctrine).

259. *See* Felix et al., *supra* note 13.

260. *See, e.g.*, Morrison, *supra* note 158.

261. *See supra* Section I.C.

262. *Cf.* Yost Preliminary Injunction Order, *supra* note 157, at 19; Zurawski Injunction Petition, *supra* note 157, at 54 (recognizing plaintiffs' reluctance to bring facial challenges).

263. *See* Suran, *supra* note 133, at 1674 (explaining that cancer care protocols pose nuanced issues).

264. MacDonald et al., *supra* note 5, at 1691; Clark, *supra* note 72, at 6; Saxena et al., *supra* note 72, at 283–85.

265. This prong aims to mitigate the sorts of risk analyses seen in Figure One.

266. *See supra* notes 120–123 and accompanying text.

1. Organizational Collaboration and Drafting Standards of Care

First, medical experts from each state should convene to compile comprehensive, uniform guidelines to nationalize standards of care in pregnancy-associated cancer cases.[267] This step would benefit from collaboration among national organizations, including the Society for Maternal Fetal Medicine ("SMFM"),[268] American College of Obstetricians and Gynecologists ("ACOG"),[269] and Society of Family Planning ("SFP").[270] As noted above, cancer care for pregnant patients involves a multidisciplinary approach to treatment.[271] Developing cohesive guidance among SMFM, ACOG, and SFP would reflect pervasive medical customs, as well as legitimize those customs if questioned.[272] Promulgating care standards that expressly adopt abortion as a form of pregnancy-associated cancer treatment will allow preeminent national organizations to establish the foundation necessary to bolster future claims regarding the legitimacy of such treatment within evidence-based decisionmaking paradigms.[273] Moreover, since these organizations inherently have specialized medical expertise, this approach effectively reassigns decisionmaking authority from policymakers and judges to those possessing the most pertinent medical background and knowledge.[274] In so doing, this approach aims to prioritize patient wellbeing and clinical efficacy.

Uniform care standards will also have a downstream effect on the strategies of medical personnel and abortion providers. Consider, for instance, a pregnant lymphoma patient in Tennessee who discovers they are pregnant after receiving a cancer diagnosis. Fearing that their condition will worsen if they delay treatment, they immediately seek to initiate radiation therapy by imploring their physician to provide abortion care and formulate a treatment plan. The doctor may do so

267. Pertinent professional organizations frequently meet to set the standard of care for specific subspecialties. *See, e.g.*, Wylie Burke, Ellen Wright Clayton, Susan M. Wolf, Susan A. Berry, Barbara J. Evans, James P. Evans, Ralph Hall, Diane Korngiebel, Anne-Marie Laberge, Bonnie S. LeRoy & Amy L. McGuire, *Improving Recommendations for Genomic Medicine: Building an Evolutionary Process from Clinical Practice Advisory Documents to Guidelines*, 21 GENETICS MED. 2431 (2019); Suran, *supra* note 133, at 1674.

268. SOC'Y FOR MATERNAL FETAL MED., https://www.smfm.org/ (lasted visited Mar. 23, 2024) [https://perma.cc/94RW-DEN4].

269. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/ (lasted visited Mar. 23, 2024) [https://perma.cc/W5UV-FCVG].

270. SOC'Y FAM. PLAN., https://societyfp.org/ (last visited Sept. 17, 2024) [https://perma.cc/JP2V-DHHV].

271. *See supra* note 117–122 and accompanying text.

272. *See supra* note 117–122 and accompanying text.

273. *See supra* note 117–122 and accompanying text.

274. *See supra* note 117–122 and accompanying text.

with more confidence if they could point to a published, nationwide resource that legitimizes abortion as medical custom in cancer cases.[275] Better yet, the doctor may be further incentivized to provide care if the provider anticipates medical malpractice liability associated with deviations from the national industry standards and refusal to provide evidence-based care.[276]

Overall, this approach subverts the pernicious incentives deriving from abortion bans: self-preservationist providers will conform to nationally recognized standards of care to avoid triggering medical malpractice suits.[277]

2. Implementation of Uniform Standards of Care

Nationalization of professional norms requires large-scale dissemination, understanding, and adoption of the published standards of care.[278] This Note recommends issuing trainings among hospitals—such as those available to satisfy Continuing Medical Education requirements for medical license renewals—to review the guidelines and ensure providers understand the role of the nationalized publication.[279] The national guidelines would serve as a resource that bolsters providers' confidence and mitigates hesitancy when cancer patients seek treatment.[280]

Once adopted and integrated into the broader medical system, these professional guidelines would become the reasonable medical judgment standard, thereby offering a clear defense if provision of the abortion is challenged in court.[281] Courts, in fact, frequently defer to such medical standards to evaluate industry customs.[282] For example, the Court of Appeals for the District of Columbia has admitted testimony of expert witnesses on the grounds that such statements reflected guidelines promulgated by the ACOG[283] and the HHS's Public

275. *See supra* Part I.

276. Silverstein & Van Loon, *supra* note 19, at 1394.

277. *See supra* Section I.C.

278. *See supra* Figure One (illustrating the need to uniformize standards of care to avoid arbitrary risk assessments conducted out of fear of prosecution).

279. *See supra* Section I.C.

280. *See supra* Section I.C.

281. *See supra* notes 204–207 and accompanying text.

282. For example, the Court of Appeals for the District of Columbia has admitted testimony of expert witnesses on the grounds that such statements reflected national guidelines. *See* Hawes v. Chua, 769 A.2d 797, 799 (D.C. App. 2001); District of Columbia v. Wilson, 721 A.2d 591, 595 (D.C. 1998). Other courts have adopted similar positions. *See, e.g.*, Gerace v. United States, 272 Fed. Appx. 6, 9 (2d Cir. 2008) (holding that guidelines developed by the Consensus Conference on Antithrombotic Therapy of the American College of Chest Physicians constituted standard of care).

283. *Hawes*, 769 A.2d at 808 (invoking materials promulgated by ACOG).

Health Service.[284] The Michigan Supreme Court also deferred to the ACOG's national guidelines when it established standard-of-care testimony.[285]

In states with objective reasonable judgment standards, guidelines may shield doctors from liability if abortion is nationally recognized as medically necessary for patients requiring chemotherapy, radiation, surgery, and other cancer treatments.[286] Currently, several state legislatures employ reasonable judgment as the standard for determining when care is necessary.[287] This approach will be especially effective if states continue to erect objective mens rea requirements in abortion laws.[288]

Additionally, the comprehensive healthcare approach should educate providers on federal requirements to provide care to pregnant individuals with cancer diagnoses.[289] This aspect of the training may provide uniform consensus and clarity concerning the function of EMTALA in relation to emergent procedures.[290] For example, national policy guidelines might acknowledge federal requirements like those of the Biden Administration, which noted that hospitals' mandate to intervene during medical emergencies explicitly extends to abortion patients.[291] If hospitals generally agree to abide by such standards when faced with emergent pregnant patients, the objective standards of care would conform to general medical consensus without necessitating federal preemption claims.[292] Notably, when hospitals consider whether EMTALA compels immediate treatment, industry standards may adopt cancer as a qualifying condition for patients seeking treatment or termination. This method would serve to reduce confusion and mitigate the chilling effect in emergent cancer cases.[293]

On a broader scale, this informational approach will incentivize providers to tend to cancer patients by employing nationally recognized standards of care. This de facto shift in the medical industry would address the multidimensional concerns of cancer patients and their providers by expanding the allowances for evidence-based treatment.

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284. *Wilson*, 721 A.2d at 598 (deferring to standards released by the HHS's Public Health Service).

285. Est. of Jilek *ex rel.* Jilek v. Stockson, 805 N.W.2d 852, 852–53 (Mich. 2011).

286. *See supra* Section I.C.

287. *See* Sobel et al., *supra* note 25.

288. *See id.*

289. *See supra* Section II.B.

290. *See supra* notes 211–215.

291. *See supra* notes 207–208 and accompanying texts.

292. *See supra* Section II.B.

293. *See supra* Part I.

CONCLUSION

The melanoma patient from Ohio, made to flee her state to receive necessary abortion care before treating her stage III cancer,[294] is just one of many emergent pregnant patients who have had to endure the emotional, physical, and medical reverberations of the *Dobbs* decision.[295] At this murky intersection of medicine and state abortion bans, providers have struggled to rectify conflicting interpretations of lifesaving care, especially in the nuanced context of shared decisionmaking with cancer patients.[296] This Note has identified the primary gaps in emergency treatment of pregnant cancer patients and highlighted the harmful impacts of arbitrary assessments conducted by risk-adverse providers seeking to avoid criminal prosecution and delicensing.[297]

While full restoration of reproductive rights is a long-term ambition, this Note focuses on a short-term proposal to address several urgent needs of the most vulnerable patients. Specifically, this Note proposes (1) decriminalizing abortion under vagueness challenges and (2) creating national standards that adopt abortion as a medically recognized approach to cancer treatment. This two-prong model seeks to centralize patient-provider relationships in the abortion context by addressing widespread deficiencies in the healthcare system. This approach is by no means exhaustive, but it does provide incremental steps toward the restoration of abortion care for pregnant cancer patients in the most restrictive states.

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294. Trick Affidavit, *supra* note 1, at 3.

295. *See supra* Section I.C.

296. *See supra* Figure One.

297. *See supra* Figure One.

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