CORE RESEARCH BRIEF

How the *Dobbs* Decision and State-Level Abortion Restrictions Undermine Obstetrical Care and Reproductive Health in Wisconsin

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Executive summary

- Timely access to obstetric and emergency care, including abortion care, is an essential component of comprehensive reproductive health. However, abortion restrictions at the state level can impede access to a wide range of obstetric healthcare services beyond abortion.
- The June 2022 US Supreme Court's *Dobbs* decision overturned *Roe v. Wade* and created the latest state-level change in abortion access. Following *Dobbs*, Wisconsin physicians faced the threat of an 1849 state law widely interpreted to criminalize the provision of abortion except in life-saving emergencies.
- CORE researchers from the University of Wisconsin School of Medicine and Public Health set out to document the impacts of the *Dobbs* decision on reproductive and obstetrical healthcare in Wisconsin.
- Investigators conducted and analyzed 21 in-depth interviews with obstetrician-gynecologist (ob-gyn) physicians from across the state. The research team found:
    - Following *Dobbs*, clinical care for pregnancy-related complications varied widely across the state, in large part due to differing interpretations of the vague 1849 law. Confusion surrounding the law led to substandard, delayed, and fragmented patient care.
    - The threat of a criminal abortion ban in post-*Dobbs* Wisconsin amplified and exacerbated pre-*Dobbs* abortion restrictions and barriers to timely and evidence-based pregnancy care. Barriers to care continued to disproportionately harm patients who already struggled to access healthcare.
    - Threat of criminalization compounded by institutional policies that restricted the provision of clinical care significantly jeopardized physicians' professional autonomy and personal wellbeing.
- Evidence suggests that abortion restrictions, exemplified most glaringly by the 1849 law, make it difficult if not impossible for Wisconsin ob-gyns to ensure timely, full-spectrum, evidence-based care to their pregnant patients. Study findings demonstrate that restrictions on the provision of pregnancy care threaten patient health and wellbeing, as well as physician autonomy and wellbeing.

Background: Wisconsin, the fall of Roe v. Wade, and the need for state-level research

Although *Roe v. Wade* created a federal right to abortion, abortion has been heavily restricted at the state level for decades. Research has long shown that abortion restrictions impede access to a wide range of obstetric healthcare services beyond abortion, including miscarriage and ectopic pregnancies.[1-4]

Since the fall of *Roe* in 2022, a substantial number of U.S. states now ban or severely restrict abortion, and many of these laws contain criminal penalties for physicians.[5]

Following the US Supreme Court *Dobbs v. Jackson Women's Health Organization* decision on June 24, 2022, Wisconsin physicians faced the threat of an 1849 state law widely interpreted to criminalize the provision of abortion except in life-saving emergencies (see Box). Freestanding abortion clinics which, due to numerous preexisting restrictions, had long provided the bulk of abortion care in Wisconsin prior to *Dobbs*, immediately stopped providing abortion services. Wisconsin's healthcare systems (including hospitals and outpatient clinics) followed suit, leaving ob-gyn physicians without clear guidance regarding how to legally provide evidence-based care for patients experiencing complications of pregnancy, including ectopic pregnancy, threatened miscarriage, previable premature rupture of membranes (PPROM), and fetal anomalies. Without the ability to obtain care from their own doctors, many pregnant Wisconsinites found themselves navigating unfamiliar and complex systems to obtain abortion services for unwanted pregnancies as well as for pregnancy complications — often across state lines.

Wisconsin 1849 law reflected in state statute (940.04)

Any person, other than the mother, who intentionally destroys the life of an unborn child is guilty of a Class H felony…This section does not apply to an…abortion which… is necessary to save the life of the mother.

The 1849 statute made its way through the courts, resulting in a preliminary decision from a Dane County circuit court in July 2023 that the law does not apply to voluntary abortions. As a result, Planned Parenthood of Wisconsin resumed abortion services in two locations in September 2023. Following a final ruling issued by the same court in December 2023, many Wisconsin hospitals and practices were comfortable enough to resume their provision of abortion services, in accordance with pre-*Dobbs* state laws. In response to an appeal, in July 2024 the Wisconsin Supreme Court agreed to hear this case and another filed by Planned Parenthood of Wisconsin.

From a human rights perspective, abortion access is worth preserving regardless of its effect on other reproductive and birth outcomes. However, it is also critical to understand the impact of abortion restrictions on broader reproductive and obstetrical healthcare — including both patients' ability to receive needed care and providers' ability to freely practice their chosen profession. To address this need, a research team from the University of Wisconsin School of Medicine and Public Health sought to document how the post-*Dobbs* legal landscape shaped Wisconsin ob-gyns' ability to provide healthcare to patients facing pregnancy-related risks and complications between June 2022 and December 2023, prior to the widespread resumption of abortion services across the state. Study interviews focused primarily on the impact of the *post-Dobbs* legal landscape on the provision of care for pregnant patients. However, many participants also discussed the ways in which *Dobbs* exacerbated preexisting restrictions, legal and otherwise, that had already hindered their ability to provide comprehensive pregnancy care.

Speaking with Wisconsin ob-gyns about management of pregnancy complications following *Dobbs*

The research team, led by a practicing ob-gyn, comprised two additional physician scientists, one PhD-level social scientist, and a masters-level graduate research assistant. The team interviewed 21 Wisconsin-based ob-gyn physicians whose current practice included taking care of patients facing pregnancy complications in the hospital or outpatient setting. All had practiced in Wisconsin at least one year before and one year following the *Dobbs* decision. Investigators recruited participants from both

rural and urban areas with varying hospital affiliations, scopes of practice, and individual demographics. Interviews examined how the legal landscape shaped management of pregnancy and related complications, and the institutional- and system-level factors that contributed to participants' experiences. Research team members employed an iterative coding process to code all interview transcripts and identify major themes in the data.

Participants had a mean age of 43 years and, consistent with national demographics of practicing ob-gyns, most were white (71%) and identified as female (76%). Interviewees represented a range of scopes of practice, including general obstetrics and gynecology, maternal-fetal medicine, and complex family planning. They also represented diverse clinical settings and institutional affiliations, including religiously-affiliated institutions, academic medical institutions, and community-based healthcare organizations.

Research findings

1. *Dobbs* upended the provision of standard obstetric practice in Wisconsin

According to physician interviewees, criminalization of abortion had implications for a wide array of pregnancy problems: early pregnancy complications, such as incomplete miscarriage and ectopic pregnancy; second trimester complications, such as previable preterm premature rupture of membranes (PPROM) and preeclampsia; and pregnancies affected by fetal anomalies. The imprecise wording of the Wisconsin 1849 statute made it impossible for ob-gyns to know exactly when it was legally acceptable to provide standard care to a patient whose pregnancy complication threatened their health — that is, if doing so entailed terminating the pregnancy.

Physicians described the 1849 statute as uninterpretable and vague, which created inherent conflict between providing standard, evidence-based care and abiding by the law.

Nearly all physicians described struggling with how to provide standard care within the bounds of a vague, archaic statute that stopped short of defining the clinical conditions in which intervening to "save the life of the mother" would be justified under the law. For example, one physician described grappling with the problematic uncertainty posed by the 1849 statute even prior to the fall of *Roe*:

> *"So prior [to Dobbs], we had some notion that the Supreme Court would overturn Roe, and we were prepared for the fact that if that happened, we would or could be reverting to practice under this 1849 statute, which would, again, ban abortion under nearly all circumstances except, quote, 'to save the life of the mother,' which is not really interpretable and not a medical term and difficult to define."*

This physician further described the confusion that ensued immediately following the *Dobbs* decision:

> *"Initially, it was very confusing because the law is so vague around what constitutes a threat to 'the life of the mother' and what is significant enough of a threat or immediate enough of a threat to be considered within the law."*

Many physicians described the difficult if not impossible task of interpreting the law's imprecise language and knowing how to apply it to the care they provided to patients:

> *"Well, I think that the available wording about what is life-threatening to the mother is very subjective and leaves room for a lot of debate about how life-threatening it is and how immediately it could be life-threatening for someone. And if I am offering somebody an abortion, and they have a*

5% chance of dying if they don't have an abortion done, is that good enough for me to offer that and be legally protected or do I need them to have a higher risk?"

Unsure how to translate the statutory language into clinical practice, physicians described having to rely on their institutions to provide guidance in interpretation and application of the 1849 law. However, interpretations of the law varied widely across state institutions, as did the degree of guidance and support extended to physicians:

"There was little guidance on what we would do except that [..]– it was made clear to us that if we violated the law, we would be getting our own attorney and defending ourselves. And it was like, 'we have lawyers working on this,' but [we received] no support or guidance, because no one knew what to do."

Another physician reflected:

"I do wish that the state would have provided our administrators, our chief medical officer, and our risk management or quality department with a little bit more guidance about how to support providers and patients. Because...we don't always know how to interpret legal language. And we didn't really get a lot of guidance about how to execute ourselves, either administratively or clinically, in the new landscape."

Consequently, the threat of criminalization posed by the 1849 law resulted in substandard pregnancy care.

In light of the law's extreme vagueness, many physicians were immediately concerned with how to legally and safely manage common complications of pregnancy — particularly previable PPROM, which involves a rupture of the amniotic sac prior to fetal viability (22-25 weeks of gestation). Without delivery, previable PPROM poses significant maternal and fetal health risks, including the possibility of life-threatening infection and bleeding. Standard care for previable PPROM involves offering termination of pregnancy — either by dilation and evacuation (D&E) or induction of labor — or expectant management, where patients are watched closely for signs of worsening health status. Following *Dobbs*, it did not take long before Wisconsin ob-gyns found themselves wrestling with how to manage previable PPROM in the new legal environment:

"We were affected by the [Dobbs] decision within two weeks of the ruling. There was a patient who had previable PPROM at 18 weeks. And there were still fetal heart tones. And the patient was counseled about the risks and benefits potentially of expected management, versus terminating the pregnancy. But because of [the Dobbs] ruling, despite how early she was, and how poor the outcomes would be in that circumstance, we were no longer able to offer an induction, or surgical procedure in that circumstance until the patient's life became in danger. So, before we could intervene on her behalf, she either needed to basically become infected, septic; or, she needed to start to hemorrhage, as long as there were fetal heart tones. It was quite the ordeal. The patient's partner became irate and actually threatened to call his family's lawyer, claiming that we were not going to take care of his partner until she was essentially dying."

Restricted by his institution from offering termination of pregnancy because of the 1849 statute, this physician continued to describe the implications of expectantly managing his patient's previable PPROM. Here he described what happened when he was prohibited from caring for a patient in this situation as he might have prior to *Dobbs*:

"The patient ended up getting infected. [Only] then we were allowed to proceed with the induction. She did go on to deliver vaginally a stillborn infant. However, she became so sick that she was admitted to the ICU with concerns for sepsis. And so, on our end, what should have been less than a 48-hour stay turned into a five-day hospital admission, including ICU care."

Cases involving previable PPROM were especially illustrative of potentially acute threats to the health of the pregnant person. However, physicians also described struggling with how to provide high-quality care to patients for whom pregnancy would simply worsen their overall health because of unrelated medical conditions:

"[There are] folks with chronic medical maternal health conditions that could worsen because of pregnancy, or a new condition such as cancer that is diagnosed in early pregnancy, but the patient is not yet at the threshold of losing her life. But continuing a pregnancy could worsen that condition or worsen her prognosis for cancer because of the nine months of gestation required to complete a pregnancy."

This physician and others indicated that such scenarios were made more difficult by the 1849 statute because physicians could no longer provide comprehensive pregnancy care that considered the individual patient before them. While some patients for whom pregnancy could worsen their health might choose to remain pregnant, others might opt against incurring any amount of additional risk that a pregnancy posed to their health. But unless they faced a pregnancy complication deemed to be imminently life-threatening, such patients had little to no chance of accessing abortion care in Wisconsin.

The same physician described taking care of one such patient for whom even an early pregnancy posed significant risk to her underlying health. However, institutional leadership decided the threat to her life was not serious enough to warrant abortion care under the 1849 statute:

"The patient had decided she didn't want to be pregnant [because she] had a lot of medical comorbidities that would have made an ongoing pregnancy very dangerous for her. However, none of those comorbidities or medical problems included the conditions that I mentioned before — previable rupture of membranes, preeclampsia, hemorrhage. She had several chronic underlying maternal health conditions that would inevitably worsen because of pregnancy. [But] she was deemed by a committee of people to not meet the threshold by which we could confidently intervene and still feel like we were following the law. I really disagreed with that."

In the absence of legal clarity, clinical management of pregnancy problems differed widely across Wisconsin health systems, and transfers of care between hospitals — delaying patient care — became more commonplace.

Physicians in our study described an increase of transfers of pregnant patients between healthcare systems and hospitals after *Dobbs.* These transfers contributed to more fragmented care, delays in treatment, and poorer pregnancy outcomes. One physician working at a large referral hospital described receiving patients from other hospitals whose doctors had not felt comfortable offering delivery for previable PPROM:

"Yeah, definitely [PPROM] was a major source of problems, especially in the beginning with people getting really sick before they were able to get care. So, we got a lot of transfers because of that, for sure, people that got really sick waiting for care because they couldn't intervene earlier or thought they couldn't intervene earlier."

The same physician described the experience caring for one such patient:

"A patient had experienced previable PPROM. And my understanding was, in her home community, she was informed that they couldn't offer anything while the baby was still alive or while she didn't have an obvious infection. And then ultimately, she came to our institution to get care. At that point, she may have had a mild infection. My recollection was she, ultimately, was able to have a termination and did fine. But it was pretty concerning about the lack of options she received from her home community."

Physicians described how the threat of criminalization even affected management of patients with nonviable pregnancies, including ectopic pregnancies and early pregnancy loss, resulting in delayed and substandard care:

"I will say that initially following the Dobbs decision, there were reported cases across the state, including at our institution, of at least some delays in care. [These delays resulted from] confusion or concerns about whether it was permissible under the new legal landscape to administer methotrexate for an ectopic pregnancy, even if it was diagnosed and known."*

Several physicians expressed concern that the 1849 statute had caused doctors to be exceedingly cautious in their care, requiring patients to undergo more diagnostic testing for suspected but not yet definitive pregnancy failure — regardless of a patient's own preferences regarding management or intervention:

"I mean, ...my partners [and I] have all, on multiple occasions, experienced patients coming in with a very clear nonviable pregnancy as they come in to establish care. However, because of the implications of the law, we have to have them come back for multiple images and labs to quote 'confirm' this before we can intervene, which results in a lot more emotional and physical distress for these patients, potentially increasing their risk for other complications like hemorrhage or infection."

2. *Dobbs* exacerbated preexisting barriers to care

The findings above described how *Dobbs* resulted in an increase in out-of-system referrals and transfers of care for pregnant patients. Such challenges only augmented the access limitations to timely obstetrical care that long predated *Dobbs*. According to the providers in our study, it was onerous, if not impossible, for some patients to overcome the obstacles to necessary pregnancy care (financial costs, travel time, absent insurance coverage, lack of childcare, unfamiliar and complex healthcare systems) if they could not obtain such care at their own institution. Many of these obstacles existed prior to the *Dobbs* decision but were exacerbated as patients post-*Dobbs* needed to travel more often, and farther than ever before, to obtain needed care.

Additional logistical barriers to care disproportionately harmed patients who already struggled to access healthcare.

Following *Dobbs*, all patients seeking abortion in the absence of a "life-threatening" pregnancy complication needed to seek care outside of Wisconsin. This change included patients whose pregnancies were affected by fetal conditions, even fatal fetal anomalies, unless they happened to be experiencing a pregnancy complication that was deemed immediately life-threatening. Physicians described how traveling such distances to access abortion care was most difficult for those who already struggled to access any type of healthcare. As one physician stated,

"It's a very big deal to have to travel far away for these [abortion] services. I had several patients tell me outright, 'I don't have the time to get down to the other state. I don't have the money for gas to

* Methotrexate is a medication commonly used to treat ectopic pregnancy.

get down to the other state. What am I supposed to do about childcare if they want me there for 24 to 48 hours?' So, [the 1849 statute] was a barrier to some of our lower socioeconomic patients."

Another physician expanded on the logistical barriers patients routinely encountered when forced to seek abortion care outside of Wisconsin:

> *"There's obviously...all the logistical hurdles that patients need to overcome in order to access the care. The drive out of state, the money involved in getting there. And that means...gas, money, transportation, lodging once they're there if applicable, childcare because most patients who have abortions are already parents, missed time from work. There are also logistical barriers like needing a person to come with them, not just for emotional support, but because they might need a ride home after the procedure or can't drive themselves. And then obviously all of these logistical barriers fall hardest on people who already have trouble accessing healthcare, patients who are already marginalized in our healthcare system — Black, Brown, Indigenous patients, patients with low-incomes or low resources, patients who are in rural settings. I've seen a lot of inability to access care at all because of where they live. These patients are disproportionately disadvantaged and burdened."*

New institutional policies governing provision of care post-*Dobbs* left patients with limited support to navigate complex healthcare systems.

From the services physicians were allowed to provide to the counseling they were allowed to offer, doctors were additionally constrained in the care they could provide to patients after *Dobbs*. Due to both legal confusion and abortion stigma, healthcare institutions often took conservative if not obstructionist stances about services related even remotely to abortion. Several physicians who worked at institutions with particularly restrictive or unclear policies regarding abortion described the ways in which patients needing abortion were left to navigate unfamiliar and complex systems on their own, with limited support from their doctors:

> *"For patients with unwanted pregnancy, I used to be able to refer them to our local site for care — for medication termination versus surgical termination. Now, I direct them to online sites if they're interested in medication termination, which is technically illegal in the state. [I've been told] I can't document anything for them [if we talk about abortion], and I can't provide them with any written information in that case or I direct them to the surrounding states that can still provide that care …The guidance that we were given in our system was that we were not allowed to provide any written information about obtaining terminations."*

Even though the 1849 law makes no specific mention of counseling for abortion, this physician's quote illustrates how even simply talking or sharing information about abortion with patients made some healthcare systems and leaders nervous. In other words, exceedingly conservative readings of the ban led to constraints on healthcare provision above and beyond the provision of abortion care itself.

Another physician described encountering patients whose efforts to seek abortion care outside of Wisconsin failed, leaving them to continue unwanted pregnancies now that much farther along:

> *"I've seen patients somehow get themselves to Illinois, and then show up in an emergency room near Chicago requesting an abortion, and then being unable to receive that care because that's not really an appropriate place to get the care, but not understanding how to navigate the system and make it happen. Then they end up back in Wisconsin without receiving an abortion, and then maybe even continuing the pregnancy on because they just can't navigate the difficulties of going to another state to receive care and outside of the healthcare system that they're used to."*

3. *Dobbs* caused physicians moral distress and professional vulnerability

As the findings above document, many participants described *Dobbs*-created constraints on their ability to provide care for patients experiencing pregnancy complications or otherwise unwanted pregnancies. Whether due to institutional restrictions or individual fear of criminalization, these constraints significantly jeopardized their professional autonomy and personal wellbeing. Such moral distress and professional vulnerability were provider-side (versus patient-side) consequences of the *Dobbs* decision and Wisconsin's preexisting abortion restrictions, including the 1849 statute.

Physicians felt conflicted between upholding their ethical obligations to patients and protecting their professional and personal wellbeing.

Several physicians described feeling deeply conflicted between upholding their professional and ethical obligations to their patients on the one hand and avoiding threats to their personal lives, wellbeing, and freedom on the other. As one doctor described:

> *"I think we're all trying to take care of patients to the best of our ability and we're never trying to cause harm, but this [post-Dobbs landscape] is a whole new level. It's not even thinking that you did or did not do your job. It's just, you may have done your job and saved someone, and now you're getting charged with a crime. What does that look like? Because I can't let somebody die. Morally, I can't do that."*

Another physician described the anguish she experienced while weighing the risks of doing the right thing for her patients against her livelihood, career, and family's security:

> *"I had to just look at myself in the mirror and say, 'well, [providing an abortion] is fundamentally the right thing for this patient, and I can't envision how anyone would say otherwise. And so, I'm going to do it, and the consequences will be what they are.' But, yeah, I think about my whole family, my whole career, my student loans. I think of everything would be, poof, gone. Or even if my privileges and license were suspended until an investigation was done, that could be a really long time. So, yes, I had to just say, well, I'm going to put my whole life and career on the line for this patient here in this moment."*

Another physician expanded on that theme, reflecting on how the post-*Dobbs* landscape and specifically the threat of criminalization made it impossible to do her job ("be a physician") for her patients:

> *"As much as I am here for my patients and want to be an advocate for them and do everything I can to give them the care they need, at the end of the day, I'm still a human. I'm a mom. I'm a person. And I have this life that I've worked really hard for, and I want to provide for my children. And I can't afford to go to prison to do this either. And so, it is something that weighs on you, because it's a huge conflict between the oath you took as a physician. But also, you're human. And it just makes you feel sick that you have to choose between these things."*

Lack of institutional support compounded physicians' moral distress and vulnerability.

For most physicians, the presence or absence of institutional support in the post-*Dobbs* era contributed to the degree to which physicians felt legal vulnerability and professional isolation. Not only were institutional policies and interpretations of the law dictating the type of care their physicians were allowed to provide, but institutional leadership was also in a position of ameliorating or exacerbating some of the stress physicians were experiencing at work. One physician illustrated this theme with the following quote:

> *"I would say that there have been things that have added to [the moral distress], which are unfortunate. I have felt additional scrutiny on physicians from speaking, like when they speak out about this topic, whether that's engaging with the media or speaking to medical students. I think there are other ways that institutions have caused injury to physicians and patients at an institutional level that could be contributing to physicians' experience of their moral injury associated with this situation."*

Several physicians who had engaged in advocacy efforts to protect abortion access for their patients long before *Dobbs* felt especially let down by their institutions, which compounded the moral distress they were already experiencing as a result of being unable to do the work of their chosen profession:

> *"I feel like I've done everything I can to make sure that I'm abiding by the law. But it's still something that looms over you. I'm confident that if I were charged with a felony charge for the 1849 ban, my employer would want nothing to do with me; they would wash their hands of me as fast as possible and say they had nothing to do with [the abortion]. So, it's a strange situation where you feel like you're very much on your own to defend yourself."*

Conclusion

In this study, a sample of 21 ob-gyns from across the state and from a range of healthcare settings described far-reaching impacts of the *Dobbs* decision on the provision of pregnancy-related healthcare in Wisconsin. Specifically, threat of criminalization posed by an 1849 state law banning abortion led to uncertainty and confusion for physicians caring for pregnant patients; delayed and fragmented care for pregnant patients; exacerbated preexisting barriers to pregnancy-related healthcare; and posed grave threats to physician autonomy and wellbeing. The absence of clear guidance and support from institutions and healthcare systems was a particularly relevant and harmful factor that shaped the experiences of patients seeking care and the physicians responsible for providing it.

These experiences, which contribute to a critical evidence base on the harms of abortion restrictions, remain ever relevant to states facing any laws that criminalize or restrict the provision of pregnancy-related healthcare. These findings also underscore why leading professional organizations such as the American College of Obstetricians and Gynecologists insist that to ensure high quality, evidence-based, patient-centered healthcare, the patient-physician relationship must be free of political interference.

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Cutler A, Hale C, Higgins J. How the *Dobbs* decision and state-level abortion restrictions undermine obstetric care and reproductive health in Wisconsin. CORE Research Brief. Madison, WI: University of Wisconsin Collaborative for Reproductive Equity. 2024.

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