

Criminalized Care

How Louisiana's Abortion Bans Endanger Patients and Clinicians

March 2024



Physicians for
Human Rights



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REPRODUCTIVE
RIGHTS

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Executive Summary

In the nearly two years since the U.S.' Supreme Court overturned the constitutional right to abortion first established in 1973 under *Roe v. Wade*, lawmakers across the country have introduced hundreds of state legislative bills aimed at restricting or banning legal access to this essential health care. To date, 14 states have criminalized abortion.

Louisiana has been one of the most aggressive in enacting and enforcing legal bans on abortion. Even before the *Dobbs v. Jackson Women's Health Organization* decision in 2022, it had one of the most restrictive and punitive anti-abortion legal frameworks in the U.S.. The state legislature enacted a trigger ban with very narrow exceptions as early as 2006 to prohibit abortion immediately if *Roe* were ever to be overturned. The state legislature also increased legal and professional penalties for those providing abortion care just before the *Dobbs* ruling, with penalties of up to 15 years imprisonment and \$200,000 in fines. Just days after *Dobbs* was decided, the state's Attorney General (now the state's Governor) sent a letter to the Louisiana State Medical Society threatening legal action against any clinician who provided abortion care in the state.

To gauge the on-the-ground human rights impacts of these escalating attacks on reproductive rights and bodily autonomy in

Louisiana, four organizations—Lift Louisiana (Lift LA), Physicians for Human Rights (PHR), Reproductive Health Impact (RH Impact), and the Center for Reproductive Rights (CRR)—conducted extensive fact-finding in Louisiana beginning in May 2023. The research, completed in November 2023, was designed to assess the impact of the abortion bans on pregnant patients and clinicians in the state. Research teams conducted dozens of in-depth interviews with clinicians and patients and held focus group discussions with community-based organizations involved in reproductive health care access in Louisiana.

The findings contained in this report are alarming: the research shows how Louisiana's abortion bans violate federal law meant to protect patients, disregard evidence-based public health guidance, degrade long-standing medical ethical standards, and, worst of all, deny basic human rights to Louisianans seeking reproductive health care in their state.

The research makes clear that:

- ▶ Existing federal statutes put in place to protect patient access to emergency care, including the federal law known as EMTALA, are being nullified by Louisiana's abortion bans.

- ▶ The abortion bans contravene long-accepted public health guidance, including guidance issued by the World Health Organization, and undermine clinicians' core ethical obligations to provide patients with the proper standard of medical care.
- ▶ The bans flout the U.S.' international legal obligations and violate a range of human rights that protect reproductive health and autonomy, including the rights to life, health, equality and non-discrimination, information, and freedom from torture and other cruel, inhuman or degrading treatment.

The experiences documented in this report reveal in stark ways how the criminalization of abortion care by anti-abortion lawmakers harms pregnant patients in Louisiana, their communities, and the clinicians who care for them. **This anonymized fact-finding and research shows how the bans' narrow and ill-defined exceptions create confusion, uncertainty, and fear for both pregnant patients and clinicians,** who face significant professional, civil, and criminal penalties for providing the patient-centered and compassionate care they were trained for and could legally offer before *Roe* was overturned.

One maternal-fetal medicine (MFM) specialist articulated the fear many others shared:

Our attorney general, Jeff Landry, sent us all a letter saying, 'I will put you in jail if you break these rules.' Literally, I am out to get you, so don't break these rules. So, you do feel a little bit like there's a target on your back because you want to do what's right for the patient. And these aren't situations that happen infrequently, these aren't clinical scenarios that happen once a year. They happen all the time. Every time I'm on call, I have a patient that's considered to potentially be in a life-or-death situation.

The bans erode clinicians' ability to use their medical judgment to provide the appropriate

standard of medical care, resulting in pregnant patients being delayed or denied abortion care, even in cases where they present with serious preexisting health conditions or receive severe fetal diagnoses. The threat of punitive measures levied at clinicians creates an untenable situation for them and causes pregnant patients to experience grave risks to their physical and mental health.

Another MFM specialist described the case of a pregnant patient who was forced to remain pregnant despite having serious cardiac complications that threatened her life:

[S]he was quite sick, and they said, 'No. We have to maximize all medical management options before we could offer any sort of termination procedure.' And I'm thinking, but what if she doesn't want to wait that long because she could have a heart attack and die? I don't know. At what point can you act? How many cardiac meds have to fail? Okay, you failed 10 cardiac meds, so now we can talk about it? And in that case, the patient had no voice. There is no shared decision-making. None at all.

Pregnant patients in Louisiana are also having to navigate their first trimester of pregnancy without critical information and obstetrical support in a state that already is experiencing a maternal health crisis. **Initial prenatal care in Louisiana is being pushed deeper into pregnancy, often beyond the first trimester when miscarriage is more common—purposely delayed to avoid the risk of miscarriage care being misconstrued as an abortion in violation of the bans.** This results in pregnant people struggling to access time-sensitive, appropriate care for early pregnancy and miscarriages.

One patient with a history of miscarriages shared her experience:

I'm used to them saying, 'Okay, well can you wait until eight [weeks]?' That's fine. But to

wait until 12 [weeks] was very alarming for me and not something that I really wanted to do. I did go to several different doctor's offices and physician groups and said, 'Hey, this facility or this facility wouldn't see me, can you do it?' And they're like, 'No, I'm sorry. Our new policy is that we have to wait until 12 weeks.' When I asked why ... she straight up said, 'The abortion ban is something that's new. We're still dealing with it as well.' She stated that they schedule people based on the 12-week mark, because they want to eliminate some of the spontaneous abortions, or miscarriages, that may happen up until that 12-week mark ... Unfortunately, I didn't make it to 12 weeks.

The abortion bans disproportionately impact and harm historically marginalized communities and groups in the state.

Most pregnant Louisianans already live in vast “maternity care deserts” (areas where pregnancy-related care is entirely unavailable) and Black Louisianans suffer disproportionately high rates of preventable maternal deaths. Leaving the state to access a legal abortion remains impossible for many, especially marginalized communities who need to secure substantial economic and social support to travel.

A community-based organization representative contemplated the individual harm to pregnant people as well as the impact on families that choose to build their families in Louisiana:

[P]eople are not going to be able to access the care that they want. And they're going to be circumstanced into growing their families or reproducing in a way that they didn't consent to or choose for themselves. And, so, we're trying to think about what that means for making Louisiana a healthy and sustainable place because we already know it is hard here for people that choose to have children because of the multiple and intersecting crises that we are faced with on the front lines.

Other major takeaways from the research show that the state abortion bans:

- ▶ Cause confusion about what reproductive health-related information clinicians can provide pregnant patients, exacerbating mistrust of the health system and harming the patient-provider relationship. Clinicians and pregnant patients alike are confused about what information they can ask for or provide, including referrals to abortion care outside the state, because they fear legal penalties for the disclosure of information concerning abortion-related care.
- ▶ Lead clinicians to face “dual loyalty” dilemmas that cause them moral distress and injury, with likely long-term impacts on the state’s health care workforce. Clinicians stressed that the bans hinder their ability to respect pregnant patients’ autonomy by prohibiting them from acting in accordance with their preferences and rights. Several expressed doubt that they or their colleagues could continue to practice in the state in light of the professional, civil, and criminal risks they are forced to navigate under the bans. The loss of clinicians in the state, many pointed out, will ultimately harm pregnant Louisianans.

Given these findings, Lift LA, PHR, RH Impact, and CRR make the following topline recommendations (full recommendations can be found on page 47):

To the Louisiana Legislature:

- ▶ **Repeal Louisiana’s abortion bans and decriminalize abortion.**
- ▶ **Ensure that pregnant people and all Louisianans have access to the full spectrum of reproductive health care,** including comprehensive sexual health education, contraception, abortion, maternal health care, and perinatal mental health care without discrimination.

To Louisiana's Hospitals and Health Care Professionals:

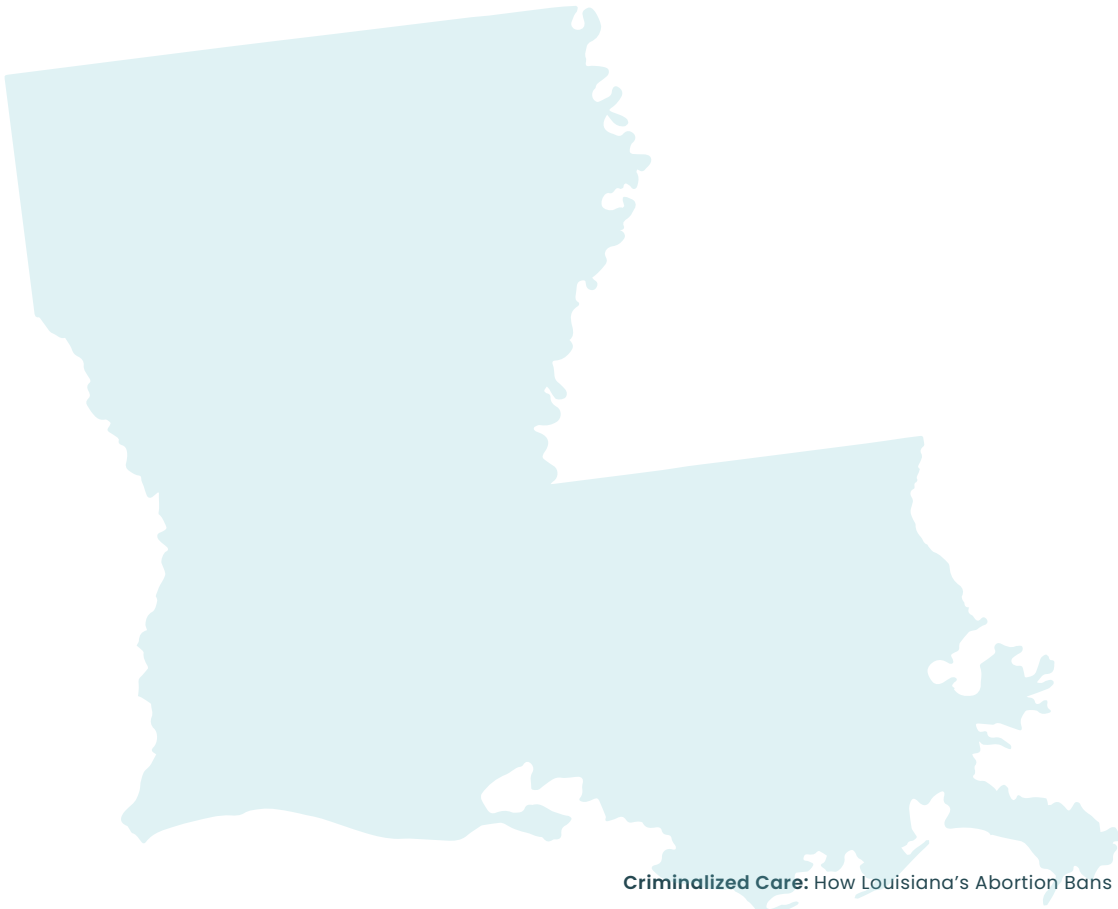
- ▶ **Speak out against laws criminalizing abortion or otherwise restricting access to abortion**, including by raising awareness of the harm caused to pregnant patients and health care systems and ensuring clinicians are not prohibited by their medical institutions from speaking out against such laws.

To State and National Medical Associations:

- ▶ **Vigorously advocate for the repeal of abortion bans and restrictions and continue to speak out against the range of injuries—criminal, civil, and moral—caused by abortion bans and restrictions**, including citing evidence of how such laws lead to violations of ethical obligations, interfere with professional duties of care, and exacerbate existing health inequities.

To the Federal Government:

- ▶ **Integrate the World Health Organization's newly issued Abortion Care Guideline into the whole-of-government approach to ensure access to abortion.**
- ▶ **Conduct oversight of and issue updates to regulatory language to strengthen the effectiveness of relevant legislative measures**, including the Emergency Medical Treatment and Labor Act (EMTALA), in order to secure access to abortion in life-threatening situations even in states where abortion is banned, and the Health Insurance Portability and Accountability Act (HIPAA), in order to protect sensitive personal health information disclosed when seeking or receiving abortion care.



Glossary of Terms

Certified Nurse Midwife (CNM): An advanced practice registered nurse who has completed registered nursing and midwifery education. CNMs provide pregnancy care and other reproductive health care.

Cesarean Birth: The birth of a fetus from the uterus through an incision (cut) made in the pregnant person's abdomen.

Chorioamnionitis or intraamniotic infection: An acute inflammation of the membranes the placenta, typically due to bacterial infection after rupture of the membranes.

Dilation and Curettage (D&C): A surgical procedure in which the cervix is opened (dilated) and a thin instrument is inserted into the uterus to remove tissue from inside the uterus (curettage). It is used for both diagnostic and therapeutic purposes, including for first-trimester abortion or after a miscarriage to remove all pregnancy tissue.

Dilation and Evacuation (D&E): A procedure used after 12 weeks pregnancy in which the cervix is opened (dilated) and the contents of the uterus are surgically removed (evacuated) using instruments and a suction device. It is also a common procedure used after a miscarriage to remove all pregnancy tissue.

Ectopic pregnancy: A pregnancy in a place other than the uterus, usually in a fallopian tube.

Emergency Medicine: The medical specialty concerned with the care of illnesses or injuries requiring immediate medical attention. Emergency physicians specialize in providing care for unscheduled and undifferentiated patients of all ages.

Family Medicine: A medical specialty within primary care that provides continuing and comprehensive health care for the individual and family across all ages, genders, diseases, and parts of the body, including obstetric care.

Hypotension: A decrease in systemic blood pressure that can cause faintness, lightheadedness, and—if blood pressure is low enough—inadequate blood perfusion to vital organs causing death.

Vacuum aspiration: The removal of the contents of the uterus using a suction device.

Maternal-Fetal Medicine (MFM) specialist: Also known as a perinatologist, an obstetrician-gynecologist with additional training in caring for pregnant patients with high-risk pregnancies.

Medical management of miscarriage: There are three main treatments for early pregnancy loss aimed at removing any pregnancy tissue left in the uterus: expectant management (letting the tissue pass on its own), medication, or a surgical procedure (dilation and curettage).

Medication abortion: A protocol to induce abortion using medications. The World Health Organization endorses two regimens: one is the combination of mifepristone and misoprostol and the other uses misoprostol alone.

Obstetrics-gynecology (OB-GYN): The medical specialty that encompasses the two subspecialties of obstetrics (care of pregnant patients) and gynecology which focus on reproductive health and pregnancy. These physicians are often called "OB-GYNs" and the specialty of obstetrics is often called "OB."

Preterm prelabor rupture of membranes (PPROM): A condition where the pregnant person's amniotic sac (bag of water) breaks prior to 37 weeks' gestation and prior to the onset of labor. Delivery occurs within one week of PPRM in 50 percent of patients.

Qualitative research: A type of research that gathers and analyzes nonnumerical data in order to gain an understanding of individuals' social reality, including understanding their perceptions of their experiences, attitudes, beliefs, and motivations.

Self-managed abortion: Where a pregnant person performs their own abortion outside the formal health care system.

Spontaneous abortion: Also called a miscarriage, it is the loss of a pregnancy before 20 weeks' gestation.

Standard of care: Treatment that is accepted by medical experts as the most appropriate for a certain type of disease in a particular setting and is widely used by health care professionals. Also called best practice, standard medical care, best available therapy, and standard therapy.



Introduction

On June 24, 2022, the United States (U.S.) Supreme Court ruled in *Dobbs v. Jackson Women’s Health Organization* (*Dobbs*) to reverse nearly 50 years of legal precedent recognizing and protecting a federal constitutional right to abortion.¹ For the first time in its history the Court took away a fundamental right.² The *Dobbs* decision overruled *Roe v. Wade* (*Roe*), which recognized that the U.S. Constitution guarantees the right of every person to decide whether to continue or end their pregnancy prior to viability without government interference.³ In their first full state legislative sessions after the Court cleared the way for legislatures to ban abortion entirely, anti-abortion lawmakers across the country introduced over 500 bills to ban or limit legal access to abortion.⁴ As of March 2024, 14 states have now criminalized abortion—many of them in the South and Midwest—leaving nearly a quarter of the U.S. population without access to abortion in their state.⁵

Louisiana was among the first states to move to enforce bans on abortion. As early as 2006, its legislature enacted a trigger law that would ban abortion if *Roe* were to be overruled.⁶ A few days before the *Dobbs* ruling, the legislature enacted two additional trigger bans that increased penalties for health care providers who administered abortion care.⁷ Only days after *Dobbs* was decided, the state’s Attorney General sent a letter to the Louisiana State Medical Society that reinforced that abortion was now criminalized and threatened legal action against physicians who provided abortion care.⁸

Currently, abortion is banned in Louisiana except under narrow legal exceptions to save the pregnant person’s life or where the pregnant person’s fetus is deemed “medically futile.”⁹ While these laws technically have exceptions, they are referred to as total bans because that is how they operate in practice because clinicians are afraid to provide abortion care even in the most dire situations.

The Louisiana legislature enacted these trigger bans in the midst of an ongoing maternal health crisis and against a backdrop of historical and institutionalized conditions of inequality, racism, sexism, and discrimination that have long undermined the ability of its most impacted communities—particularly Black, Indigenous, and other people of color, women, pregnant people, LGBTQ people, immigrants, and people with disabilities—to live safe and healthy lives. Louisiana’s painful history of enslavement,¹⁰ discrimination against women and racial minorities,¹¹ and reproductive oppression¹² underscore that racism and inequality remain deeply entrenched in the state. In addition to harmful restrictions on their reproductive rights, Black, Indigenous, and other communities of color in Louisiana today continue to face structural discrimination—including housing discrimination,¹³ mass incarceration,¹⁴ and environmental racism¹⁵—that negatively impact their health in a range of ways.

To document the growing impact of Louisiana’s abortion bans on people of reproductive age,

their communities, and reproductive health care providers (referred to as “clinicians” in this report) in the state, Lift Louisiana (Lift LA), Physicians for Human Rights (PHR), Reproductive Health Impact (RH Impact), and the Center for Reproductive Rights (CRR) partnered to undertake human rights fact-finding in the state. The research focused on the questions of whether and how access to abortion and other reproductive health care has changed in the state in the wake of *Dobbs*, and what effects those changes have had on patients, providers, and community members alike. To explore these questions research teams used qualitative methodologies to undertake, between May and November 2023, 43 in-depth interviews with people of reproductive age (referred to as “patients” in this report) and clinicians practicing across the state and convened focus groups with community-based organizations that serve as resources to people seeking reproductive health care in Louisiana. This report describes the current legal and health care context in Louisiana and delineates how the state’s abortion bans breach the human rights obligations of the state and the U.S. by violating the rights to life, health, equality and non-discrimination, privacy, information, and freedom from torture and other cruel, inhuman, or degrading treatment or punishment, and prevent clinicians from meeting their professional and ethical obligations to patients.

This research adopts a human rights lens to not only understand the harmful impact of the state’s abortion bans on reproductive health care, but also the intersecting oppression that people and communities across the state experience, including those who face heightened levels of discrimination. While the rollback of *Roe* has catastrophic implications for health care access and disparities in the U.S., it is critical to understand that even the constitutional protection for abortion under *Roe* did not guarantee access for everyone who wanted or needed it. Abortion was particularly difficult—if not impossible—to access for Black,

Indigenous, and other people of color, people living on low incomes, people with disabilities, and other communities historically pushed to the margins. The human rights framework recognizes that while the legal rights to access abortion is critical to reproductive and bodily autonomy, it alone does not enable people to fully exercise their human rights. Indeed, governments must ensure access to the full spectrum of sexual and reproductive health care by removing legal, policy, financial, and other barriers and securing adequate funding for sexual and reproductive health care services. This includes ensuring access to comprehensive sex education, contraception, abortion care, and patient-centered prenatal, birth, and postpartum care. Governments must also create enabling conditions for people to lead healthy and dignified lives, including safe work environments, adequate housing, healthy environments, and equal participation in elections and politics.

This report documents how patients seeking reproductive health care in Louisiana are facing delays or denials of care caused by the state’s abortion bans, which threaten health care providers with severe civil and criminal penalties for providing abortion care. The impacts of these bans are falling hardest on communities that experience multiple and intersecting forms of discrimination. At the state level, the bans are exacerbating what is already a broken state health care infrastructure that currently ranks among the worst-performing state health care systems in the U.S.,¹⁶ with long-term implications for Louisianans’ health. While the findings presented in this report reflect the harms communities in Louisiana are suffering under the state’s abortion bans, theirs is not an isolated experience. Indeed, these findings are likely illustrative of the harms that nearly a quarter of the U.S. population is experiencing in states with similar abortion bans.¹⁷



Legal Background

Even before *Dobbs*, Louisiana was one of the states with the most restrictive and punitive abortion legal frameworks, with a complex patchwork of prohibitions and restrictions on both patients and clinicians that significantly limited access to abortion throughout the state.¹⁸ Starting in 1973, after *Roe* was decided, Louisiana enacted more than 89 laws restricting access to abortion.¹⁹

Legislative efforts targeting pregnant people and abortion providers in the state accelerated in the lead up to the *Dobbs* decision. On June 17, 2022—likely emboldened by the leaked draft *Dobbs* ruling in May 2022—the state legislature passed, and then-Governor John Bel Edwards signed into law, amendments to the state’s 2006 trigger ban, which banned abortion with narrow exceptions, including to prevent the death of the pregnant person.²⁰ On the same day, the state also enacted two additional trigger bans; these bans contain limited exceptions, such as when a patient experiences an ectopic pregnancy or when the patient’s fetus is “medically futile,” a statutory term that is not medically recognized.²¹ Notably, the bans explicitly state that a pregnant person’s emotional, psychological, or mental health condition cannot be considered when determining whether pregnant people are experiencing a qualifying “medical emergency” or “serious health risk.”²² This is true even though mental health conditions, including death by suicide, are the leading underlying

causes of pregnancy-related deaths in the U.S.²³ The bans also increased civil and criminal penalties for doctors who provide abortion care, subjecting them to up to 15 years imprisonment and up to \$200,000 for any violation.²⁴

Louisiana’s Department of Health subsequently issued a declaration on August 1, 2022, stating that an emergency rule was necessary because—if physicians did not have a list of diseases and disorders that signified a “medically futile” fetus—there could be imminent peril to public health, safety, and/or welfare.²⁵ As discussed further below, the most recent iteration of the emergency rule contains 25 “medically futile” conditions and allows abortion care for a fatal fetal condition that is not explicitly named on the list only if it can be certified by two physicians licensed in Louisiana.²⁶

Because the Department of Health’s declaration did not resolve clinicians’ lack of clarity, they requested greater insight into what kinds of conditions would qualify a pregnant person to receive legal abortion care.²⁷ In response, the Department refused to provide clarity and instead referred clinicians to the state’s Attorney General.²⁸ Clinicians were wary of asking the Attorney General, Jeff Landry (now governor of Louisiana), for guidance, however, since this office issued letters to the state’s Medical Society a few days after *Roe* was overturned that

threatened legal action if medical providers performed abortions contrary to the state's bans.²⁹ Meanwhile, efforts by some legislators to clarify the existing medical exceptions have been met with extreme resistance and have all been unsuccessful to date.³⁰

“ Subject to certain exceptions, **abortion is a criminal offense in the State of Louisiana**, and it has been since last Friday. It is incumbent on this office to advise **you that any medical provider who would perform or has performed an elective abortion after the Supreme Court's decision in *Dobbs* is jeopardizing his or her liberty and medical license.** It is the intent of this office to see the laws and Constitution of the State of Louisiana are upheld. I trust you will disseminate this information to your members.”

— **Attorney General Jeff Landry**, Letter to LA State Medical Society, June 29, 2022, just days after the *Dobbs* ruling.

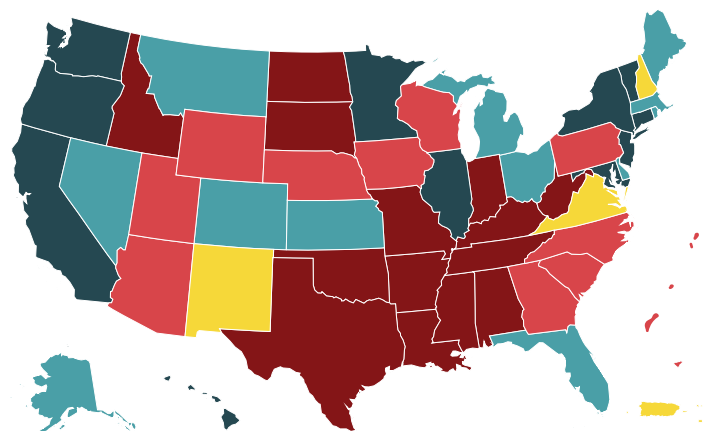
Also in 2022, Louisiana legislators introduced House Bill 813 (HB 813), which would have redefined personhood as beginning at fertilization, allowed for the prosecution of pregnant people for homicide after receiving abortion care, and subjected abortion care providers to prosecution.³¹ Although HB 813 was not enacted, it demonstrated the commitment of anti-abortion legislators to increase penalties for those who receive and provide abortion care. Legislators did, however, manage to enact Act 548, which prohibits the mailing of abortion medication to anyone in Louisiana.³² Whoever violates this statute can be fined up to \$1,000, imprisoned for up to six months, or both.³³ The

legislature continues to support the enacted abortion bans despite a 2023 poll reporting that more than half of all voters in the state said abortion should be legal in all or most cases.³⁴

Louisiana's neighboring states of Arkansas, Mississippi, Oklahoma, and Texas also have abortion bans.³⁵ While five states have enacted interstate shield laws that protect abortion providers who use telemedicine to provide abortion care to patients regardless of the patient's location,³⁶ the number of states nearest to Louisiana that permit abortion is dwindling as more of them enact bans and restrictions.³⁷ At the time of publication, the closest states to Louisiana with protected abortion rights are Illinois and Colorado, both about 1,000 miles away.³⁸ The closest states where young people can access abortion without parental involvement laws are Illinois and New Mexico, each also approximately 1,000 miles away.³⁹

Post-Roe State Abortion Laws

Source: Center for Reproductive Rights



- EXPANDED ACCESS** The right to abortion is protected by state statuses or state constitutions, and other laws and policies have created additional access to abortion care.
- PROTECTED** The right to abortion is protected by state law but there are limitations on access to care.
- NOT PROTECTED** Abortion may continue to be accessible in these states but would be unprotected by state law.
- HOSTILE** States that have expressed a desire to prohibit abortion entirely, and are vulnerable to the revival of old abortion bans or the enactment of new ones. No legal protections for abortion.
- ILLEGAL** States that ban abortion entirely and enforce those bans through criminal penalties.




Louisiana's Reproductive Health Landscape

Louisiana is in the Southern region of the U.S. and is made up of 64 parishes, which are analogous to counties.⁴⁰ Though Louisiana has a mainly rural landscape—where nearly one third of its population lives⁴¹—most of its population is concentrated in urban centers, specifically New Orleans and Baton Rouge.⁴² The state is home to nearly 4.7 million people⁴³ and almost a quarter of them are either women of reproductive age (ages 15-44),⁴⁴ young people under the age of 18 (23.1 percent), or both.⁴⁵ More than half of the U.S.' non-Hispanic Black population lives in the South, including in Louisiana, where the 2022 U.S. Census found nearly a third of its residents identify as Black or African-American.⁴⁶

Louisiana ranks highest in the nation in percentage of households living in poverty: nearly 20 percent of people in the state live below the federal poverty line.⁴⁷ Between 2020 and 2022, about one in five women of child-bearing age in Louisiana were living in families with incomes below the federal poverty line.⁴⁸ Louisiana's Black population is disproportionately impacted by poverty, and Black residents are nearly three times as likely as their white counterparts to live below the federal poverty level.⁴⁹ The state's staggering poverty levels go hand in hand with wage disparity: in 2018, Louisiana was ranked fourth highest in the nation for income inequality.⁵⁰ Black Louisianans have the lowest median earnings of all racial and ethnic groups in the state.⁵¹

There is also a wide gender gap in earnings that is greater than the national average.⁵²



Since 2011, the Louisiana state legislature has moved over \$11 million from the Temporary Assistance to Needy Families program to the state's "Alternatives to Abortion" program.⁵³ The program distributes funds to anti-abortion centers, facilities that are run by anti-abortion groups that try to persuade pregnant people against getting abortions. **These centers do not employ medical providers or comply with basic medical ethics** (like the privacy provisions of the Health Insurance Portability and Accountability Act) and often provide inaccurate information that can delay or interfere with a patient's care. **There are more than 30 anti-abortion centers operating in Louisiana and 19 of them have received funding through the "Alternatives" program.**⁵⁴

a. Limited Access to Health care Systems, Insurance, and Providers

Louisiana's health care system currently ranks among the worst-performing state health care systems in the U.S.⁵⁵ Many Louisianans, particularly those from underserved and rural communities, face barriers to accessing health care facilities and professionals. Most Louisianans live in areas where there are too few primary care physicians, dentists, and mental health providers relative to the population.⁵⁶ Louisiana's poor infrastructure, including a lack of public transportation options, makes it particularly difficult for rural residents to access the care they need.⁵⁷

By the end of 2022, more than 300,000 women in Louisiana lived in contraceptive deserts, counties where women lack reasonable access to a health center offering the full range of contraceptive methods.⁵⁸ Lack of access to contraceptive care and the absence of a state requirement for comprehensive sex education in schools contribute to the state's high rates of sexually transmitted infections (STIs), unintended pregnancies, and adolescent births.⁵⁹ Indeed, Louisiana ranks among the states with the highest rates of STIs in the country and, in the state, STI rates are highest in counties with higher levels of poverty and five times higher among Black women than white women regardless of income and education.⁶⁰ At the same time, the number of health clinics providing abortion care in Louisiana has been declining for decades. In 1992 there were 17 clinics in the state, but by 2022, only three remained.⁶¹ This left 94 percent of the state's parishes—where 72 percent of Louisianans live—without a clinic. The last three clinics stopped providing care in July 2022 when Louisiana's abortion bans went into effect.⁶²

Health insurance coverage and regulations also impact access to health care services, including abortion and other reproductive health care.

Government programs like Medicaid—a joint federal and state program that helps to cover health costs for people living on low incomes—and Medicare—a federal insurance program for people 65 and older (and some people under 65 with certain disabilities or conditions)—provide uninsured people access to critical health care. Compared to other states, Louisiana has some of the highest percentages of people covered by Medicaid and the Children's Health Insurance Program, another federal program which provides low-cost health coverage to children in families that earn too much to qualify for Medicaid.⁶³ Pregnant people, women, and people of color in Louisiana are more likely to be uninsured or on Medicaid,⁶⁴ with people of color making up more than half of uninsured people in the state⁶⁵ and Black people making up over half of the state's Medicaid participants—more than twice the rate of their white counterparts.⁶⁶ In 2022, nearly two-thirds (61 percent) of the state's births were financed by Medicaid, the highest percentage in the nation.⁶⁷

The state has expanded its Medicaid program to allow greater access to preventative care throughout pregnancy, coverage for postpartum people up to 12 months, and up to six months of contraception at a time.⁶⁸ However, at the same time, it has consistently ignored or rejected many other policies that would improve the health of women, pregnant people, and their families in Louisiana. For instance, multiple times over the past decade, the Louisiana legislature has declined to pass legislation that would introduce comprehensive sex education, paid leave policies, and equal pay legislation in the state.⁶⁹

The legislature has enacted laws and policies contrary to the health and interests of women, pregnant people, and their families, and has reduced access to critical health services. For example, the legislature recently approved a \$5 million tax credit for donations made to anti-abortion centers.⁷⁰ Most recently, in 2023, the legislature attempted to slash the state's health care budget by \$100 million,⁷¹ a measure

that was ultimately vetoed by the Governor. During the same time, the state removed more than 50,000 people from its Medicaid program when eligibility was reevaluated after a three-year pause during the COVID pandemic.⁷²

b. Maternal Health Inequities and Preventable Pregnancy-Related Deaths

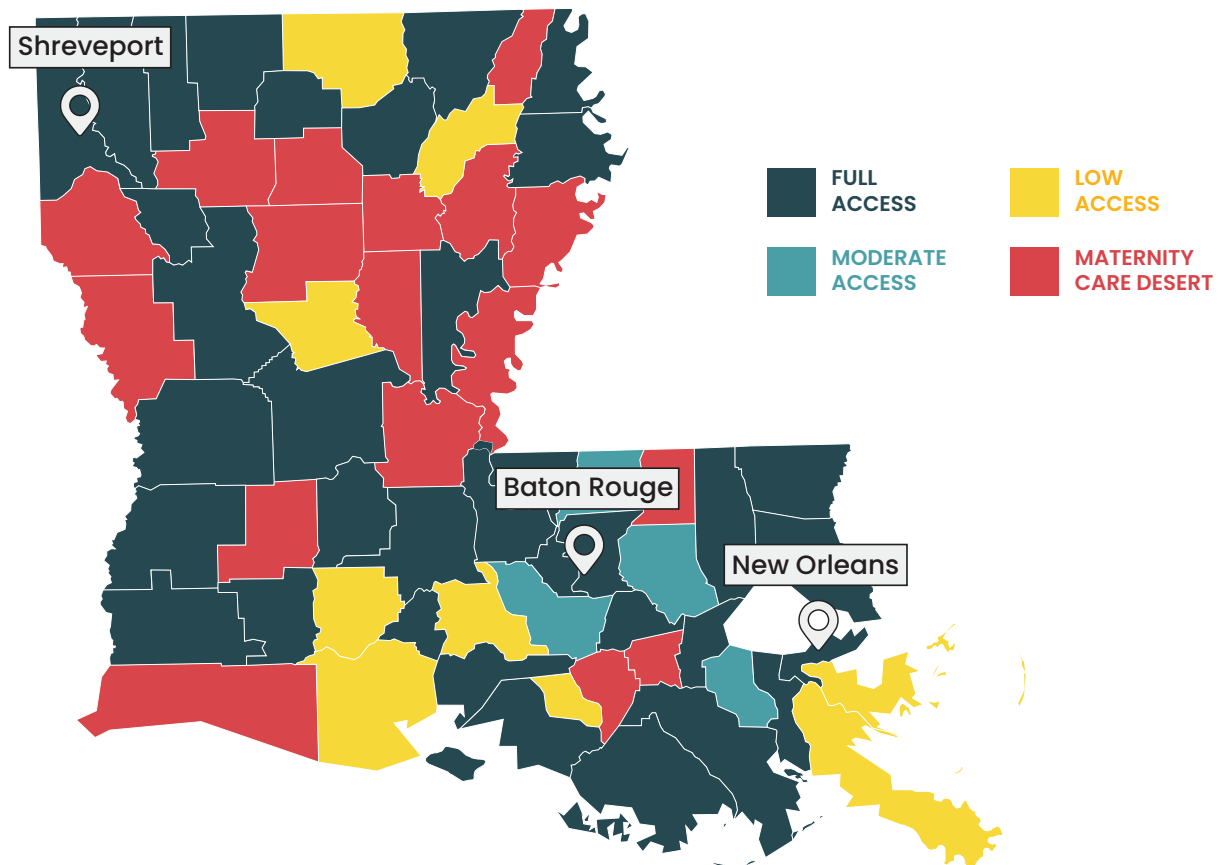
Maternal health outcomes are often viewed as indicators of population health and gender equality. With the highest maternal mortality ratio among wealthy countries and pregnancy-related deaths continuing to increase, the U.S. is facing a human rights crisis in maternal health.⁷³ For every person who dies from a pregnancy-related cause in the country, about

100 more women will experience maternal morbidity—a life-threatening pregnancy complication.⁷⁴ Nationally, regardless of income or education, Black and Indigenous women are two to three times more likely to die of pregnancy-related causes than white women.⁷⁵

Louisiana contributes to these alarming outcomes with one of the highest maternal mortality rates in the nation.⁷⁶ Between 2017-2019, Black women in Louisiana died from pregnancy-related deaths at more than two times the rate of white women, and a majority of all pregnancy-related deaths in the state were preventable.⁷⁷ In 2019, the state recorded 17 pregnancy-related deaths—accounting for the preventable maternal mortality of at least one pregnant person in the state per month.⁷⁸

More than a quarter of Louisianans live in a maternity care desert

Source: March of Dimes



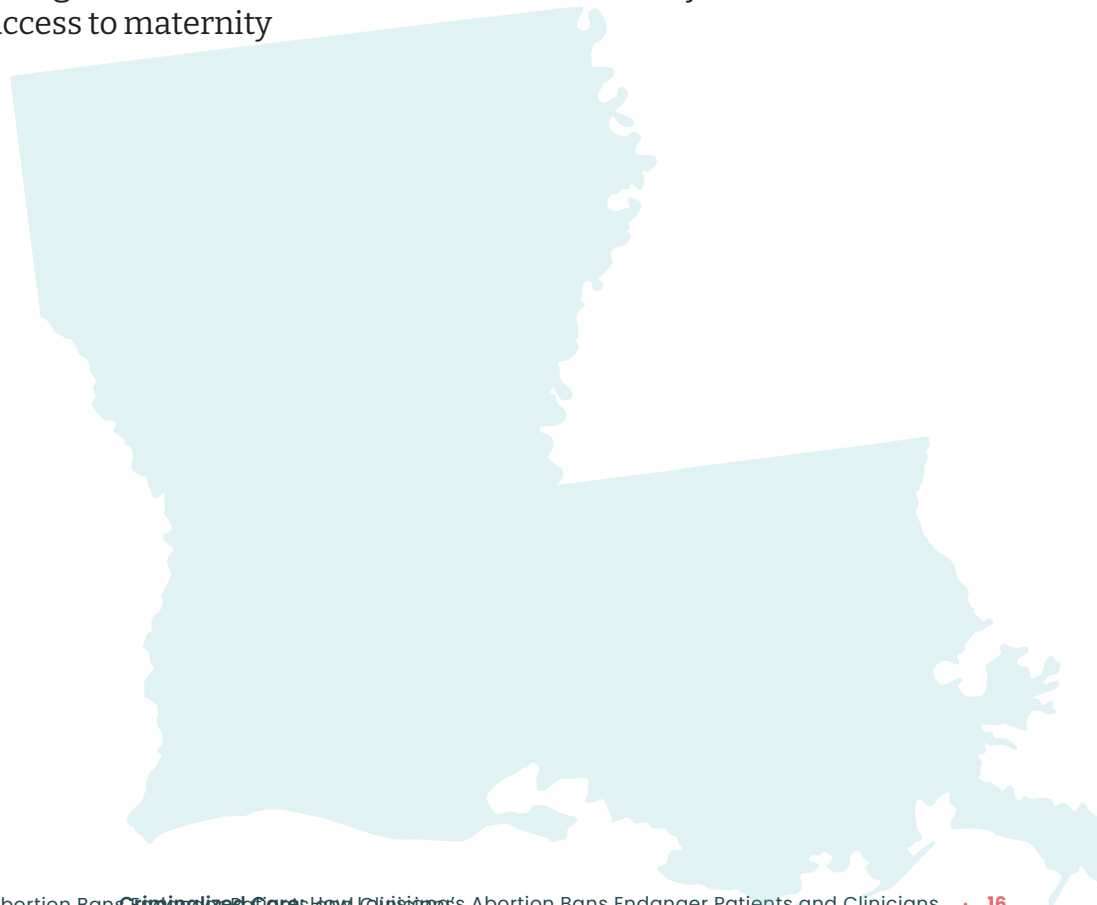
The maternal health crisis in Louisiana is exacerbated by inadequate access to care and a shortage of available providers.

- ▶ In 2021, more than a quarter of parishes in Louisiana were designated as maternity care deserts (defined as a parish without a hospital or birth center offering obstetric care and without any obstetric providers) and 12 percent of women had no birthing hospital within 30 minutes of their home.⁷⁹
- ▶ In 2023, 18.6 percent of pregnant people in the state had inadequate prenatal health care, a rate higher than the national average.⁸⁰
- ▶ More than 50 percent of the time, people in Louisiana do not get the postpartum care they need—including follow up appointments, physical and mental health screenings, and other gynecological exams—which can result in them experiencing untreated hypertension, diabetes, and/or depression.⁸¹

Louisiana is among the U.S. states with the lowest number of employed obstetricians and gynecologists (OB-GYNs) in the country with the majority of its parishes having less than two per 100,000 residents,⁸² and access to maternity

care in the state is not likely to improve as fewer providers are willing to work in states that have banned abortion. In 2023, applicants for OB-GYN residency positions fell by over 10 percent in U.S. states that ban abortion.⁸³

Pregnant people in Louisiana also lack sufficient access to midwives. Louisiana is one of 36 states and the District of Columbia that license certified professional midwives (CPMs).⁸⁴ CPMs are trained to provide prenatal, birth, and postpartum care to people in their homes and in birth centers and can be particularly effective in addressing health care gaps in rural areas. As of 2015, Louisiana's Medicaid program covers births assisted by licensed midwives in certain birth centers.⁸⁵ Despite these positive developments, midwives continue to face challenges, including a lack of support from hospitals and physicians reluctant to integrate them into the health care system.⁸⁶ Certified nurse midwives, who primarily provide care in hospital settings, are also scarce. There are currently only 85 licensed and active nurse midwives in the whole of Louisiana—less than two for every 100,000 residents—and most are clustered in the state's major cities.⁸⁷





Research Methodology

This descriptive study used qualitative methodologies to understand the experiences of clinicians in providing pregnancy and reproductive health care to patients in Louisiana and the experiences of people of reproductive-age and their communities since the state’s abortion bans took effect.

a. Recruitment

From May to November 2023, through outreach to networks of physicians, midwives, and administrators, medical associations, health systems, legal, human rights, and community organizations, and educational institutions in Louisiana, the PHR and RH Impact research teams identified and reached out to three categories of respondents for individual and focus group interviews:

- ▶ Reproductive health care providers (“clinicians”) or medical students in training who have provided reproductive or pregnancy health care prior to or after the *Dobbs* decision;
- ▶ People of reproductive age older than 18 years (“patients”) who have had recent experiences seeking and/or receiving reproductive health care that has been affected by Louisiana bans; and
- ▶ Representatives from community-based organizations supporting access to reproductive health care in Louisiana.

Research teams used snowball sampling, an established sampling strategy for research on hard-to-reach populations or sensitive topics, which has been used to conduct qualitative research in comparable studies.⁸⁸ This strategy asks research participants to identify other potential participants.⁸⁹ Purposive sampling was also used to reach patients and clinicians in underrepresented geographical areas and communities. The RH Impact team contacted community-based organizations working to advance maternal and reproductive health, rights, and justice in Louisiana and disseminated recruitment flyers for patients. The PHR research team contacted and provided information about the study to clinicians from varied hospital and clinical locations across Louisiana. Clinicians with specialties that included maternal-fetal medicine, obstetrics and gynecology, family medicine, emergency medicine, public health, reproductive endocrinology, and certified nurse midwifery were recruited. Researchers conducted semi-structured interviews with 30 clinicians, health care workers, and medical students, 13 people of reproductive age, and two focus groups with representatives from eight community-based organizations. Demographics of the semi-structured interviews with people of reproductive age and reproductive health care providers are represented in Table 1.

b. Questions

Interview and focus group guides were developed based on the expertise of the research teams and conversations with partner organizations in Louisiana. The PHR team developed the interview guide for clinicians, while RH Impact developed interview guides for patients and community-based organizations. Each guide was reviewed by partner organizations and research colleagues.

c. Security

Because of the sensitive nature of the research, extensive security precautions were undertaken throughout all phases of the research. Eligible interview and focus group participants provided verbal informed consent after being read consent information by the interviewers. All participants were advised not to provide any identifying information (for instance, names, city or town of residence, names of health systems, or organizational affiliation), and no identifying information was gathered. Once participants provided consent, interviews were conducted over the phone or an encrypted Zoom platform. Clinician interviews lasted 30 to 60 minutes and were transcribed using an AI-encrypted transcription service (Fireflies). Audio files were deleted immediately after transcripts were generated. Interviews with people of reproductive age also lasted 30 to 60 minutes, while focus groups with community-based organization representatives lasted 45 to 60 minutes. Both were recorded using a digital voice recorder. The recordings were transcribed using Rev, an online transcription service. Audio files were deleted after the transcripts were generated. All transcripts were further de-identified by interviewers. Data was stored on a password-protected server and only accessed by the research teams. Study recruitment ended when we reached both representative numbers of interviews amongst included specialties and concept saturation, the point at which no new themes emerged from

additional interviews.⁹⁰ PHR's Ethics Review Board (ERB) approved the study.

d. Coding and Analysis

Six members of the PHR research team read transcripts of the clinician interviews after a third of the interviews were completed and together developed a preliminary codebook. The codebook consisted of codes that identified key themes emerging from the data (inductive analysis) and based on the research questions (deductive analysis).⁹¹ The codes and definitions were reviewed by two additional research team members for clarity. Four members of the research team independently coded the same two transcripts, then met to discuss the codes used and to refine the codebook. Using the revised codebook, the research team independently coded two additional interviews and met again to further refine the codebook. The research team then used a dual coding method, where two people independently coded each transcript to ensure a thorough coding process, to code the remaining interviews. At regular meetings, the research team discussed the coding and resolved discrepancies through consensus. The coding team used Taguette for data analysis, to allow for simultaneous coding of each transcript, then exported the files to NVivo 11.0. The RH Impact research team, which consisted of three members, followed similar coding and analytic processes. Both inductive and deductive coding were used by the research team. Codes were compared, and similar codes were organized into larger themes. Data analysis was conducted in NVivo 11.0.

e. Limitations

While qualitative methods enable researchers to elicit more in-depth information about participant's experiences and perceptions than is possible using quantitative survey methods, they cannot speak to the prevalence of reported incidents, attitudes, and experiences. Furthermore, because non-probability

sampling was used, findings may not be generalizable to other settings and policy environments, though emergent themes are comparable to other research studies on U.S. abortion bans.

While the research team sought to reach out to a broad spectrum of patients, clinicians, and community-based organizations in Louisiana, the teams' networks included only a limited number of patients and clinicians in rural and northern parts of the state. Their

voices and experiences are thus less well represented. Although the research teams asked all participants about current and recent events and experiences, participants' accounts of prior events may be affected by recall bias and/or misrepresentation. Wherever possible, the research teams sought to triangulate accounts of specific harmful events relayed by participants with media accounts by reputable sources, legal case documents, other clinicians, and other credible evidence.

| Table 1: Combined Characteristics of 43 Interview Participants | |
|---|---------|
| Data represented as n (%) or median (range), n=43* | |
| GENDER | |
| Male | 7 (16) |
| Female | 34 (79) |
| RACE | |
| White/Caucasian | 21 (49) |
| Black/African American | 10 (23) |
| Hispanic/Latina/o | 1 (2) |
| Asian/Pacific Islander | 7 (16) |
| Multi-racial | 2 (5) |
| AREA TYPE | |
| Rural | 1 (2) |
| Urban/big city | 36 (84) |
| Small city/town | 3 (7) |
| Suburban/greater metropolitan area | 1 (2) |

| Sub-Characteristics of 13 Louisiana Residents of Reproductive Age* | |
|---|---------|
| *Missing Data for 2 Participants | |
| AGE | |
| 18-28 | 7 (54) |
| 29-35 | 1 (8) |
| 36-45 | 3 (23) |
| SEXUALITY | |
| Heterosexual/Straight | 10 (77) |
| Bisexual | 1 (8) |
| RELATIONSHIP STATUS | |
| Single | 6 (46) |
| Committed Relationship/Partnered | 3 (23) |
| Divorced | 1 (8) |
| BORN IN U.S. | |
| Born in U.S. | 10 (77) |

| Sub-Characteristics of 13 LA Residents of Reproductive Age (cont'd) | |
|---|---------|
| HEALTH INSURANCE TYPE | |
| Private | 6 (46) |
| School Insurance | 2 (15) |
| Public Insurance | 2 (15) |
| Decline to Answer | 1 (8) |
| HIGHEST LEVEL OF EDUCATION | |
| Some College | 6 (46) |
| Bachelor's Degree or Higher | 5 (38) |
| ANNUAL INCOME | |
| Less than \$24,999 | 5 (38) |
| \$25,000-\$49,999 | 1 (8) |
| \$50,000-\$74,999 | 3 (23) |
| \$75,000-\$99,999 | 1 (8) |
| \$100,000 to more | 1 (8) |
| NUMBER OF PEOPLE IN HOUSEHOLD | |
| 1 | 5 (38) |
| 2-3 | 3 (23) |
| 4-5 | 1 (8) |
| 6 or more | 2 (15) |
| MAIN DAILY ACTIVITIES | |
| School Full-time | 3 (23) |
| School Full-time, Work Part-time | 4 (31) |
| Work Full-time | 2 (15) |
| Work Full-time, School Part-time | 1 (8) |
| Work Fulltime, School Fulltime | 1 (8) |
| RECEIVED PUBLIC ASSISTANCE IN THE PAST YEAR | |
| No | 8 (62) |
| Yes | 3 (23) |
| NOT LIVING WITH A DISABILITY | |
| Not Living with a Disability | 11(85) |
| Sub-Characteristics of 30 Louisiana Health care Workers** | |
| **Clinical practice categories (Setting Practice, Years Since Training, Years Practicing in Louisiana, and Practice Type) exclude information for medical students and administrators | |
| CLINICIAN TYPE | |
| Ob-gyn | 17 (57) |

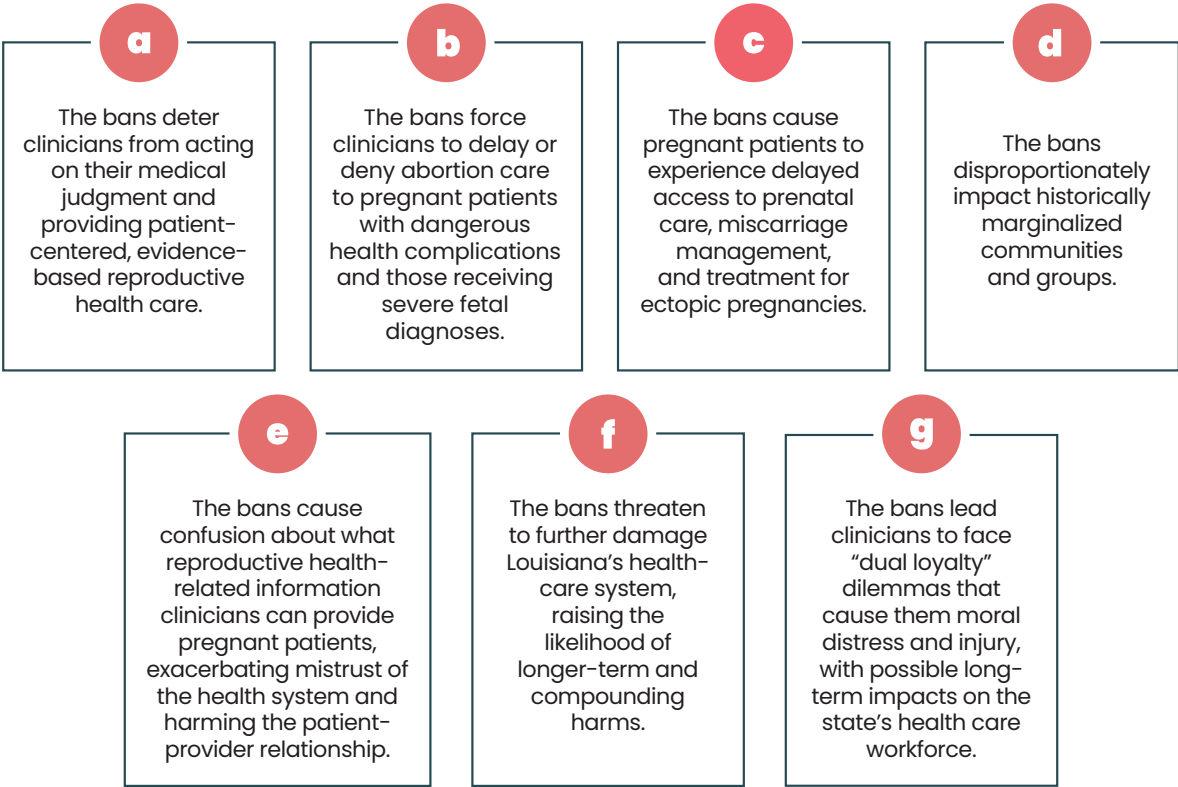
| Sub-Characteristics of 30 LA Health care Workers (cont'd) | |
|---|-----------|
| Family Medicine | 2 (7) |
| Emergency Medicine | 4 (13) |
| Certified Nurse Midwife | 2 (7) |
| Medical Student | 3 (10) |
| Abortion Clinic/Fund Administrator | 2 (7) |
| SETTING PRACTICE | |
| In-patient care | 7 (23) |
| Out-patient care | 1 (3) |
| Both in-patient & out-patient care | 17 (57) |
| Other | 5 (17) |
| YEARS SINCE TRAINING | |
| <10 years | 10 (33) |
| 10-20 years | 8 (27) |
| >20 years | 7 (23) |
| Other | 5 (17) |
| YEARS PRACTICING IN LOUISIANA | |
| <5 years | 6 (20) |
| 5-10 years | 5 (17) |
| 11-20 years | 8 (27) |
| >20 years | 6 (20) |
| Other | 5 (17) |
| HOURS PER WEEK PROVIDING DIRECT CLINICAL CARE TO PATIENTS | |
| Hours per week providing direct clinical care to patients | 36 (8-60) |
| PRACTICE TYPE | |
| Large health system | 8 (27) |
| Academic Medical Center-affiliated | 9 (30) |
| Small independent practice | 5 (17) |
| Practiced in multiple settings | 3 (10) |
| REGION OF LOUISIANA | |
| Southwest | 4 (13) |
| Southeast | 24 (80) |
| Central | 1 (3) |
| Northwest | 1 (3) |

V.

Findings

Louisiana’s abortion bans’ narrow and ill-defined exceptions create confusion, uncertainty, and fear for both pregnant patients and clinicians, who face significant professional and legal penalties under the bans. Indeed, the threat of punitive measures against clinicians undermines the quality of care they are able to deliver to pregnant patients and erodes their ability to use their medical judgment to provide pregnant patients with the standard of care. As a consequence, pregnant patients are being delayed or denied abortion care even when they present with dangerous health complications or receive severe fetal diagnoses. Additionally, those

seeking an abortion must gather the financial and material support needed to travel hundreds of miles to another state, an often-insurmountable feat for communities that experience multiple and intersecting forms of discrimination, including Black, Indigenous, and other people of color, people living on low incomes, and people living in rural areas of the state. The bans’ impact extends beyond abortion care access. Prenatal care is being delayed beyond the first trimester when miscarriage is more common, leaving pregnant patients without critical information about their health and pregnancy in a state that already faces a maternal mortality crisis.



The confusion and fear caused by the bans have led patients and clinicians to be unsure of what information they can ask for or provide, including whether a patient is experiencing a miscarriage and referrals to abortion care outside the state. The result is a lack of information for pregnant patients and the undermining of the patient-provider relationship.

At the state level, the bans are exacerbating what is already a broken state health care infrastructure with long-term implications for Louisianans' health. Clinicians in specialty hospitals noted an increase in patient referrals from rural hospitals often for routine care that patients should have been able to access sooner and nearer to their home. Further, the bans may lead to a possible loss of health care providers as some clinicians are reconsidering whether to continue practicing in the state and medical students are weighing whether to pursue their residency in Louisiana. An increased shortage of health care providers in the state would expand the state's already extensive maternity care deserts and exacerbate Louisiana's lack of access to reproductive health care.

a. The bans deter clinicians from acting on their medical judgment and providing patient-centered, evidence-based reproductive health care.

Clinicians described how Louisiana's abortion bans inhibit their ability to provide the standard of medical care they had previously been able to provide to patients. More specifically, clinicians described how the bans have adversely affected their ability to provide evidence-based pregnancy care in circumstances including the management of miscarriages, preterm premature rupture of membranes (PPROM), ectopic pregnancies, medical emergencies that may not be perceived as immediately life-threatening, but which may well threaten a pregnant patient's life, and lethal fetal conditions

not included in the state's "medically futile" emergency rule.

Indeed, abortion bans have created an untenable environment, where clinicians attempting to do their jobs in accordance with best medical practices are at risk of criminal, civil, and professional penalties. Nearly every clinician discussed ways the threat of being targeted for criminal prosecution had impaired the care they felt able to provide to pregnant patients. One OB-GYN described how: *"[Louisiana legislators] are interfering with my ability to make a medical judgment and counsel the patient the way that she should be counseled so they can make an informed decision. [Legislators are] interfering with that exact process, taking the patient's autonomy out of their hands."* (24) Another clinician framed it as having to provide care to patients *"with one hand tied behind our back."* (13)

Several clinicians referred to the letter then-Louisiana Attorney General Jeff Landry, now state Governor, sent to the Louisiana medical licensing board stressing that, *"every doctor in Louisiana is afraid of being made the very first example of criminal intent."* (23) One maternal-fetal medicine (MFM) specialist elaborated:

Our attorney general, Jeff Landry, sent us all a letter saying, 'I will put you in jail if you break these rules.' Literally, I am out to get you, so don't break these rules. So, you do feel a little bit like there's a target on your back because you want to do what's right for the patient. And these aren't situations that happen infrequently, these aren't clinical scenarios that happen once a year. They happen all the time. Every time I'm on call, I have a patient that's considered to potentially be in a life-or-death situation. And what's the best thing for the patient? (1)

Clinicians described how the bans have increased the use of medical procedures and treatments that do not meet the standard of care—heightening risk to patients—and which could have been avoided if they had been able to provide abortion care. In one case, a MFM specialist described a

situation where a patient with a cardiac condition was forced to remain pregnant and try multiple medications to mitigate the added stress of pregnancy on her heart, before clinicians advised her on options for abortion care:

[S]he was quite sick, and they said, 'No. We have to maximize all medical management options before we could offer any sort of termination procedure.' And I'm thinking, but what if she doesn't want to wait that long because she could have a heart attack and die? I don't know. At what point can you act? How many cardiac meds have to fail? Okay, you failed ten cardiac meds, so now we can talk about it? And in that case, the patient had no voice. There is no shared decision-making. None at all. (8)

Clinicians noted that in cases of life-threatening pregnancy complications, such as PPROM, if an abortion is performed, clinicians are more frequently using hysterotomy (cesarean section or c-section), an invasive surgery used to deliver a fetus or baby through an abdominal incision, instead of dilation and evacuation (D&E), a common abortion procedure that is performed vaginally. D&E is a common abortion procedure in part because it has fewer documented complications for patients than c-section or induction.⁹² Another MFM specialist at an urban specialty hospital noted:

Before ... providers felt comfortable with what would be considered standard of care. But since there's now the abortion ban[s], there's concern about their ability to provide an abortion even though that still is standard of care for a 16-week pre-viable preterm premature rupture of membranes. In terms of care, that still has to be an option. It's always an option. But now providers are afraid that offering or providing that care ... [we] can face criminal penalties. (11)

One emergency medicine physician recounted a situation where a colleague performed a c-section on a patient with PPROM at 20 weeks' gestation, a condition that would not result in a viable pregnancy:

She ended up having to take this person for c-section to preserve the appearance of not doing an abortion, even though this is not a viable pregnancy. What that means is now this person has had a c-section, right? And that means that she's at higher risk for any future pregnancies. She can no longer deliver vaginally ... [T]he appropriate thing to do, again would be a D&E ... without subjecting the patient to this unnecessary abdominal surgery. But my colleague didn't feel like she could do that while remaining in compliance with the law or appearing to remain in compliance with the law. (17)

Having a c-section increases a patient's risk of morbidity now and may adversely impact their health and reproductive options in the future. Pregnant people who have already had a c-section are at greater risk of complications and are much more likely to have their next pregnancy end in a c-section. Many hospitals do not permit patients to attempt a vaginal birth after cesarean ("VBAC"), and as each repeat c-section becomes more complicated, this may limit the total number of children a patient can safely have.

b. The bans force clinicians to delay or deny abortion care to pregnant patients with dangerous health complications and those receiving severe fetal diagnoses.

Almost all clinicians discussed experiences with pregnant patients who had a serious health condition that did not fall within the bans' allowed exceptions for medical emergencies. One MFM specialist stated the feelings many clinicians expressed about patients for whom they could no longer provide abortion care because of the bans' narrow and ill-defined exceptions:

There are patients that I lose ... a lot of sleep

about ... I know [they] wish [they] could have terminated the pregnancy ... I know [they] are at a high risk of dying or having a bad health outcome. But [they] didn't quite make the cut off [for a serious enough medical condition] for us to be able to offer [abortion care], and [they] just couldn't get out of state. (1)

To avoid the risk of criminal penalties under the bans, nearly every clinician relayed an account in which they and/or their colleagues delayed abortion care until complications worsened to the point where the patient's life was irrefutably at risk. A MFM specialist in a specialty hospital observed: *We are seeing more cases where OB-GYNs are not acting and are making the woman wait until complications arise, waiting for signs of infection, and then it is more complicated and difficult. ... [I]n general, we are seeing more pregnancies where the correct management is delayed. (14)*

In some cases, clinicians described treating severely ill patients whose other physicians had been afraid to even document their assessment of the patient's medical issues before the patient was transferred for care. An OB-GYN shared how the bans' lack of clarity and the risk of professional and legal consequences is causing stress for clinicians as they cautiously document and seek to clearly demonstrate that their medical decisions adhered to the law. One OB-GYN noted: *"I can go to jail for documenting something the wrong way. Even if it was the medically necessary thing to do." (6)* Another expressed their concern that a provider's documentation could be used to prosecute patients in the future: *"It is my hope that anything I'm documenting is not going to be used against my patients. And I'm going to do my best to try to ensure that I can provide accurate documentation but documentation that does not put my patients at risk." (29)*

One MFM specialist recounted the case of a patient with serious medical conditions who almost died due to her specialist physicians' fears of being prosecuted if they documented

accurately her risk of death from pregnancy and having that documentation inform a decision by another physician to perform an abortion:

One patient I took care of last fall, a couple of months after Roe was overturned, she lives in a small town a couple of hours away. She's very sick. She had heart problems and kidney failure and was on dialysis and got pregnant. And she was seeing a doctor there who had told her how risky the pregnancy was. And both [her] cardiologist and the nephrologist would not write in the chart that they thought that the patient was at risk of dying because they knew what the implications of that would be, and they didn't want their name on the chart. So, she didn't get to me until she was about 16 weeks, [very ill], and she had wanted to terminate the whole time and just didn't have the resources available. So, she ended up hospitalized and got transferred to us. (1)

Pregnant patients are also being denied abortion care even when they have previously experienced severe and life-threatening pregnancy complications. The same MFM specialist described treating a patient who was denied abortion care despite experiencing multiple c-sections, hemorrhage, and infections during past pregnancies and having been advised that another pregnancy could be fatal. When the patient sought care after experiencing an unintended pregnancy:

[H]er first OB said, '[N]o way. We can't offer you termination because that's not a life-threatening illness. Yes, you could have complications, but you're not in heart failure, not on dialysis. You don't have some type of malignancy that's going to be life-limiting ... we can't offer you termination.' So, she ended up in my office begging for us to terminate her pregnancy And I agreed with her. But because of the laws, I had to tell her, 'I'm sorry, but this is not considered a life-threatening illness in the state of Louisiana.' None of my partners would agree with that being enough of a life-threatening illness for us to do the

procedure here. It was a risk, but she was not ill right now, not at the brink of death ... And she did not actually die, but she did have a very complicated delivery and she's still at very high risk of having postoperative complications. (1)

Even in cases where pregnant patients receive a life-threatening diagnosis like cancer, they are denied abortion care under the bans because, as one clinician put it, the pregnant patient is not “going to die right away” (5). One OB-GYN asked: “How aggressive does a cancer have to be to put it in the category of the mother’s life being at risk if the pregnancy isn’t terminated?” (6) Another described their experience with a recent patient who had been diagnosed with metastatic cancer and needed radiation:

There’s probably no point of continuing the pregnancy. The tumor might grow faster than the baby. So, if you were in another state, this would just be a thing that happened on Friday. Like, the same way that they’d schedule her for a biopsy, you’d schedule her for termination. Here you can’t do that. (30)

Another OB-GYN recounted conversations with hematologists about how the bans would adversely affect patients with a hematological disorder or cancer. Where before the bans, hematologists recommended abortion care early so that patients could begin treatment, the OB-GYN shared that hematologists were now unsure of whether they could make the same recommendation after the bans because they would risk punitive repercussions: “I think some of the physicians are starting to see how this is going to impact them. Even if they’re not going into OB-GYN.” (4)

The bans explicitly exclude a pregnant patient’s mental health when considering whether their life is at risk. As a result, pregnant patients with severe preexisting psychiatric conditions who are at risk for death by suicide when forced to continue a pregnancy are denied abortion care.⁹³ Several clinicians expressed concern that

a pregnant patient’s mental health could not be considered when determining whether to provide them with abortion care. One OB-GYN described the challenge they are facing:

If I have a patient who has had a history of severe postpartum depression and she’s threatening to commit suicide because of her pregnancy, does that count for her life [being] threatened? We’re asked to make a clinical decision that is being judged in a legal way. And then because the punishment is so severe ... people just are like, okay, well, the best way for me to not get in trouble is just not do anything. (4)

Clinicians also repeatedly raised concerns about delays, denials, and extra-legal requirements imposed by the state’s “medically futile” exceptions. One MFM specialist stated:

[E]verything that is on that list is considered lethal or not compatible with life. So, what’s on there is valid. But there are thousands of other equally lethal conditions that are not included on the list, for example, a skeletal dysplasia ... If I’m evaluating a patient for a skeletal dysplasia, there are hundreds of genetic mutations that I’m evaluating for because there are so many different types of abnormalities that can affect how bones grow. Of those, they only include some on the list but not others. What is included on the list seems arbitrary—that we can act on some conditions that are included, but not other, equally lethal conditions. (1)

Pregnant patients who experience a serious fetal condition that is not included in the state’s emergency declaration must get two physicians to sign off before abortion care can be provided. An OB-GYN made clear how difficult this is for most pregnant patients in the state: “I am lucky that I work at a hospital where there are always other OBs around because it is an OB specialty hospital that is very busy. But Louisiana is pretty rural ... most of the hospitals where a lot of women are going for care don’t have that.” (2)

Even at well-resourced urban specialty hospitals, clinicians described delays and confusion about requirements for securing sufficient agreement about necessary care. One MFM specialist said:

We're all worried to some degree. Even myself, who's a very senior physician ... even I get a little nervous that there's this criminal penalty that you could go to jail for something. So, I probably would get one of my MFM partners to also sign that they agree with termination, so that would make three physicians. We all are erring on the side of being careful and dotting every 'i.' (19)

c. The bans cause pregnant patients to experience delayed access to prenatal care, miscarriage management, and treatment for ectopic pregnancies.

Patients and clinicians also noted the impact of the state's bans on other forms of reproductive health care. The American College of Obstetricians and Gynecologists and American Academy of Pediatrics recommend early prenatal care, typically during the first trimester.⁹⁴ Nevertheless, patients with pregnancies after the bans were enacted described their inability to receive routine prenatal care during their first trimester, when miscarriage is more common. This had not been the case before the *Dobbs* decision. A patient with a history of miscarriages who was seeking her first prenatal appointment shared:

I'm used to them saying, 'Okay, well can you wait until eight [weeks]?' That's fine. But to wait until 12 [weeks] was very alarming for me and not something that I really wanted to do. I did go to several different doctor's offices and physician groups and said, 'Hey, this

facility or this facility wouldn't see me, can you do it?' And they're like, 'No, I'm sorry. Our new policy is that we have to wait until 12 weeks.' When I asked why ... she straight up said, 'The abortion ban is something that's new. We're still dealing with it as well.' She stated that they schedule people based on the 12-week mark, because they want to eliminate some of the spontaneous abortions, or miscarriages, that may happen up until that 12-week mark ... Unfortunately, I didn't make it to 12 weeks. (31)

Several clinicians emphasized that the deferral of prenatal care to the second trimester caused by the abortion bans can be harmful to patients, especially those at highest risk for adverse maternal and infant health outcomes. One certified nurse midwife stressed that delaying prenatal appointments until the second trimester “[is] a huge thing. It's a huge thing because there's so much information that's needed in the first trimester, and to not have access to it is just not giving good care.” (26) They elaborated:

First trimester pregnancies can change quickly. Any kind of bleeding is very tricky to manage, and it can change quickly. It can be threatened abortion and then missed abortion and then inevitable abortion very quickly. And the bleeding can be life threatening to the woman. So, for anybody taking care of pregnancies or having complications, there's an atmosphere of fear around making that decision because, of course, the penalties in Louisiana are so harsh and they're focused on the providers. (26)

Multiple clinicians in different practice settings described a significant increase in outpatient OB-GYNs deferring first appointments with pregnant patients until the end of, or after, the first trimester to avoid exposure to legal and professional penalties for providing miscarriage management. An OB-GYN hospitalist explained that “[obstetricians] are ... pushing off early visits for folks another couple of weeks so that [patients] can have a miscarriage

on their own without getting too involved in it.” (30) Another OB-GYN who worked in the emergency department stated: “At least where I work, there is no first trimester care in the office setting anymore. Any of this bleeding, any of this anything reports to the ER ... patients are told only to start prenatal care toward the end of the trimester when the risk of miscarriage is less.” (5)

When patients do experience potential signs of miscarriage during the first trimester, some emergency departments are also reluctant to provide care and information because care provided to pregnant patients suffering a miscarriage could be mistaken as providing an abortion and violating the bans. The same patient who was turned away from routine prenatal care during her first trimester also described her inability to receive requested medical care when she experienced heavy bleeding:

And again, went through ultrasound, all that, went to consult with a nurse, an RN that was on staff, and she basically just told me, ‘I can’t really tell you if you’re having a miscarriage or not.’ I was like, ‘I’m almost 12 weeks. It would be nice to know. If you can’t tell me if I’m having a miscarriage, can you at least tell me what an ultrasound said?’ She said she couldn’t, that she was praying for me, she was sending me home with prayers, and I need[ed] to follow up with a physician at the end of the week. (31)

The ban’s narrow and ill-defined exceptions cause confusion and uncertainty for clinicians when treating patients. An OB-GYN reported that pregnant patients presenting to emergency departments with relatively common issues—such as first trimester bleeding—are being denied immediate treatment or information about their condition and are instead referred to urban specialty hospitals due to fears clinicians face of professional and criminal penalties under the bans:

We have definitely had people come into

our emergency department with, say, first trimester bleeding who were transferred from outlying emergency rooms where the doctors there did not want to say anything to the patient, especially if there is still a heartbeat. They don’t want to give the patient any information because they are afraid of being misinterpreted, they don’t want to put anything in the chart. They don’t want to give any diagnosis to the patient for fear that the patient will misinterpret them, or whoever is reviewing the chart might find something they said to be illegal. They are afraid to say anything or do anything, so they send them to us as a specialty hospital. (2)

Reflecting on how miscarriage mismanagement has been impacted, one OB-GYN shared that miscarrying patients “were bleeding heavily and terrified out of their minds coming through the emergency department.” (8) They noted that because of the abortion bans, they now would delay treatment even if a condition:

Definitely looks like a miscarriage, but we haven’t had the definitive 11 days between one ultrasound and the next. But the gestational sac is irregular, and it looks like it’s coming out, but it’s technically not. So, we can’t offer you that manual vacuum aspiration or D&C (dilation and curettage) right now before you start being terrified for your life and cramping and bleeding in pain. (8)

A doula supporting a pregnant woman who began to miscarry described her sense of helplessness as she watched her client being delayed miscarriage management care:

[J]ust thinking about my experience with my last new client, who actually went through a miscarriage and had to have a D&C and had to have all these different things ... [I]t was just like, a wait, and a clearance, and a this, and a that, and, you know, our parents just want answers. In a situation like that, you know, you’re having a miscarriage, and your body is refusing something, you just want it

out. You want it cleared out your system, so you don't have to walk around with it. But ... it was just such a long wait and ... my heart broke for her. (Focus Group B)

Louisiana's abortion bans explicitly allow abortion care for pregnant patients presenting with ectopic pregnancies, which are never viable and where treatment is time-sensitive to avoid complications from tubal ruptures. Nevertheless, the bans have led to delays in care in these circumstances as clinicians take extra pains to ensure that their medical judgment and provision of care cannot be misconstrued as violating the bans. This is in sharp contrast to how clinicians provided care before the bans. One OB-GYN who works in a Louisiana emergency department described how before the bans their approach was to provide care without delay: “[y]ou’re in the ER today? Let’s give you a shot for the ectopic or let’s give you pills or schedule a D&C.” (30)

Since the bans, though, they now often require patients to return the next day before treating an ectopic pregnancy because they “need to prove beyond a very reasonable doubt that the bad thing is happening.” (30) Two other clinicians described cases where ectopic surgeries were delayed for hours after people staffing the case objected to the surgery because there was fetal cardiac activity: “the patient ended up getting the surgery [and did fine], but what if they [had] ruptured in the meantime? There are definitely delays for ... fear of repercussion.” (23) A pregnant patient whose care was delayed after suffering an ectopic pregnancy, put it plainly: “I could have died. I really could have died.” (42)

An OB-GYN conveyed poignantly the difficult position that clinicians are in as they weigh the risks to themselves and patients under Louisiana's abortion bans: “I ask myself if I would act alone to save the life of the mother. Would I do that? Or would I wait, and she might die? You wonder about your courage in cases like that. What would I do?” (2)

d. The bans disproportionately impact historically marginalized communities and groups.

Patients and representatives of community-based organizations shared how the *Dobbs* ruling, and Louisiana's abortion bans, have created additional barriers to abortion care—describing the increased financial and social resources required to access abortion care in another state. They identified communities and groups that are disproportionately impacted by the bans as well as the individual, institutional, and structural factors that drive inequitable access to care.

One patient noted that while it was stressful to access an abortion before *Dobbs*, the bans “made it worse because now you have to make all of these plans that you didn’t anticipate making on top of being in a very difficult position.” (42) Another shared that she is needing to be “safer in everything” noting that she “always[s] need[s] to have \$500 just in case ... anything comes up. So, ... if I know that money is running low, I’m in my head ... [thinking] ‘you have no room for mistakes.’” (37)

A patient who planned to travel to Florida to access an abortion described the many barriers she faced, noting “you’re also on a clock. Even going to Florida, there’s still a window of time in which you need to make this decision and ... make these arrangements,” and the need to come up with money for her procedure, as well as money “to travel ... get a hotel ... [get] childcare.” (42)

A representative from a community-based organization described the increased scale of what people they serve “are having to navigate in addition to travel and ... figuring out the logistics of their life.” (Focus Group A) One patient pointedly noted:

[T]here's going to be a population of women that can't get this done within this amount of time. They're just not going to be able to pull it off. They're not going to be able to get the money together. They're not going to be able to get the transportation together. They're not going to be able to make the arrangements. I think that's part of the point of narrowing the window. I'm sure it is. (42)

Louisiana has one of the highest percentages of people living below the poverty line in the U.S. and participants noted how this population is particularly harmed by the bans. Reproductive health care clinics that served these communities had already closed, they noted, and the bans had compounded the lack of access that already existed in the state. Participants also described how the abortion bans have had broader impacts on patients' ability to access a range of reproductive health care services, including contraception. One patient described the vital role of health care centers such as independent abortion clinics and Planned Parenthood that have had to cut back their services:

But it's always like an on and off thing in our state, which is very frustrating, because a lot of low-income households get their care from Planned Parenthood. And people don't even understand that ... [T]hey don't think health care is at Planned Parenthood. When, hell, [ask] my hairdresser, and she'll tell you. She is below the poverty line, and she was telling me the other day, ... 'Girl, that was where I got my birth control. Now I can't find it [there].' (31)

Many clinicians described the often-insurmountable barriers patients with limited financial and social resources faced that prevented them from leaving the state and forced them to continue unwanted pregnancies. One OB-GYN who works at a safety net health system described a patient who did not have the economic or other means to access care out of state saying: *"[She] took the bus to the emergency room. She didn't have a car. She can't*

fly to southern Illinois." (4) She shared that in her practice: *"It is not really affecting patients with resources, but it is [affecting] most of the patients I take care of."* Whereas, for another clinician, a certified nurse midwife, her experience was that even when patients have the financial means to access care out of state, other barriers keep them from accessing timely abortion care: *"If you can't get across town, you can't get to Baton Rouge, you cannot get to North Carolina. And that's not everybody, but that is a lot of folks. And it's not just the poorest folks. It's folks with means, but these other really complicated social factors."* (28) A MFM specialist reflected a similar reality to the certified nurse midwife's experience:

I've had so many patients that have ended up not terminating because they just can't figure out how to be gone from their homes for three or four days, which is what it takes ... Even if somebody handed them a check for \$6,000 to cover the flight and the expense of the procedure, they don't have the resources to be away from home for four days. They just can't do that. And that's really what's tragic ... Even if they have funding from the [abortion fund] or something like that, it is not always just a financial issue. (1)

Patients and community-based organization representatives frequently described how Louisiana's bans harmed Black, Indigenous, and other people of color and why they were disproportionately impacted. One shared, *"I've seen it affect, of course, the Black and brown community at tremendous levels,"* (Focus Group B) while another noted *"all the Black and brown women, folks of color, immigrants. We are doubly and triply impacted by all of these insensitive laws."* (Focus Group B) One patient shared: *"we're in a state of panic and trying to understand. [The bans are] literally reshaping how we experience health care as Black women and women of color. White women in our state are not feeling that in the same way."* (31)

In addition to noting the magnitude of the bans' impact on these historically marginalized

communities and groups, they identified the “*American medical establishment*,” lack of access to health care, lack of quality care, and the state’s maternal health crisis as contributors to this outsize impact. One participant noted how these communities were impacted “*because of ... the lack ... of access [to] health care, access [to] reproductive health in communities where they have OB deserts.*” (Focus Group B) They underscored that OB deserts do not just exist in rural communities in Louisiana: “*there are still OB deserts here, right here, in the city, lack of hospitals and access to care, reproductive care. So, just putting a ban, just exacerbated the numbers tremendously.*” Another shared:

[E]specially African-American people and just minorities in general are affected ‘cause they might not have the resources in their area already to get abortions. So, closing down the few clinics ... they have is just making it way harder for them to get what they need. And I feel like that affects other things in their lives ‘cause, you know, having a child is a very big financial responsibility. So if someone’s aware enough that like, ‘Hey, I’m pregnant, but I can’t have this baby financially,’ and they’re now boxed in ‘cause they can’t get an abortion, that just leads to more problems within, like, poverty and low income and living in a certain situations. (36)

Many made connections between the abortion bans and the state’s preexisting maternal health crisis. One patient shared:

I think communities of color are going to be disproportionately impacted [by the ban]. We already, just thinking about maternal health in this country, there’s already disparity there. And so now you’re adding on people not being able to get additional health care that they need or may need. So, I am concerned about what that is going to do for maternal health. (40)

Still others stressed that the bans made no exception for patients who became pregnant

due to rape or incest. One community-based organization representative voiced their concern about how the failure to include an exception for rape or incest would affect Louisianans, particularly young people “*who have been sexually abused and do not have options*” in the state. (Focus Group A) One patient shared that they had been sexually assaulted in the time since the bans had been enacted. They had not become pregnant, but they described the difficult scenarios that they and others like them must now consider after an assault:

And so, if I were to have conceived unfortunately after that experience, then there’s the trauma of also potentially living through the pregnancy. And then also what about the well-being of the child afterwards, because in my head I know that child was conceived out of rape, something that was forced upon me, so therefore would I resent the child because of that. So, what are the mental health effects on that child that we’re bringing up if their parent struggles to look at them or struggles to love them in the way they want to because of a traumatic experience? Those are things that I, I’m just not sure necessarily that people who have created these laws necessarily, that they haven’t thought through but ... I don’t know that they realize the detrimental effects that they’re placing upon the child after it’s born. (36)

One representative from a community-based organization contemplated both the individual harm to pregnant people as well as the impact on families that choose to live and build their families in Louisiana:

[P]eople are not going to be able to access the care that they want. And they’re going to be circumstanced into growing their families or reproducing in a way that they didn’t consent to or choose for themselves. And, so, we’re trying to think about what that means for making Louisiana a healthy and sustainable place because we already know it is hard here for people that choose to have children

because of the multiple and intersecting crises that we are faced with on the front lines. (Focus Group A)

e. The bans cause confusion about what reproductive health-related information clinicians can provide pregnant patients, exacerbating mistrust of the health system and harming the patient-provider relationship.

Clinicians and patients both emphasized that Louisiana's abortion bans have caused serious harm to the patient-provider relationship due to fears about legal penalties for the disclosure of information about abortion-related care. The bans do not prohibit clinicians from giving information to patients seeking abortion care out-of-state. Yet, some clinicians had been told by their hospital's legal counsel not to provide this information, and many others stated their belief that they could be prosecuted for offering it. As one OB-GYN described: *"I don't want to be the test case in Louisiana for having to be prosecuted for helping refer a patient to another state."* (25) Even an emergency medicine physician who understood that it is legal to provide information on out-of-state resources stated uneasiness about possible consequences:

Now I'll tell patients to take out their cell phone or pen and paper because [the hospital] doesn't want us putting abortion resources on hospital discharge papers that we print out from our computer system. I don't believe it's actually illegal to do that, but I guess it could be considered a gray zone for facilitating an abortion. (17)

Many clinicians reported concerns about patients losing trust in them. One MFM specialist voiced:

Well, I'm hopeful that [my patients] still trust me, but it's hard to be trusting when you are told that I have to send you here or you have to go there. These are options, but I can't help you. You are on your own ... This is not the physician I trained to be and how I have practiced for more than 20 years, not how I saw or see my role, not to walk with my patients through their whole journey. (14)

Clinicians who worked with marginalized populations noted that the abortion bans further exacerbated mistrust many patients historically felt toward the health care system:

If there was any thought about terminating a pregnancy or anything like that, I think that after Dobbs, they would probably be less likely to come to us for help there's already a lot of mistrust between us and the community ... I think that a lot of them are reluctant to seek health services already and with this on top of it, I think it's just another layer of mistrust between our services in the community. (12)

Clinicians described the confusion and fear they have observed in patients express, including concerns about being criminalized for seeking reproductive health care. As one MFM specialist recounted:

Since Dobbs there is much more confusion on the patient's part about what is or isn't allowed in terms of what their options are. [For example] I had a patient who had a pregnancy with multiple abnormalities, and we were talking about her options, and she asked me, 'Do I need to get a lawyer?' And that wouldn't have been something that a patient would have asked me prior to Dobbs. (27)

The bans contribute to an information vacuum and loss of patient-provider trust, leaving pregnant patients with little guidance to help them understand a confusing and rapidly changing legal landscape in time-bound circumstances where they need to act quickly. One patient described needing access to

additional information to navigate how to access care:

I just wish I had more information ... I wish I would've known more about the process. I hadn't had personally a reason to explore the process before that. I think that's the biggest resource that I wish I had known about. Because I was just thrust into this position, and I had to make these decisions immediately ... the day that I called them to make that appointment was the day that I became aware of [the waiting list]. I was instantly in a crisis ... I really just took the appointment, not even sure if I was really going to attend the appointment because I felt like I needed to. And I was like, 'okay, just if you change your mind, fine, but you actually can't afford to not take this appointment right now.' (42)

A community member who is also a nurse stressed the lack of information in their community and the challenge many pregnant people across the state face to find abortion providers who have inclusive practices:

I literally cannot keep up with what states have outlawed ... because laws are changing so fast. But what I wish that I had as a nurse and a trusted community member was like a green book or an underground ... Like some type of map or some type of directory. Even online when we search laws and things change so fast. Where can my loved one get money and resources? Where is the closest clinic? We just need a roadmap to where is it still allowed and how can I get my folks there in the fastest way possible ... And because I don't want to just send my sister anywhere, we want to send them to providers who are inclusive, supportive. I have sisters in my network who are nurses and nurse practitioners who are queer, and they tell me, 'Hey, this provider discriminated against me ... Do you have any providers who are inclusive and supportive?' So, I just don't want to send you anywhere where abortion is legal. Of course, I do, but then also do we know that

this provider has a history of being inclusive, supportive, non-discriminatory, all those things? It's a shame that we have to ask that in 2023. (41)

Clinicians expressed regret that the bans may prevent patients from seeking their counsel and support if the patients decide to self-manage abortions or from seeking follow-up care in cases of miscarriage or out-of-state abortions due to fears of being reported by health care workers. While emphasizing that self-managed medication abortions are safe, one physician stated, *"I think some of it feels a little bit isolating from the patient-physician relationship because they don't really want to maybe tell us the truth anymore because it could have some implications for them."* (5)

Some clinicians are also confused about their potential liability under the bans and have received varying levels of guidance from their hospital administrators. Several clinicians noted that even though they have received support and legal guidance from hospital administrators, the administrations have voiced uncertainty about how they could help if one of their physicians was charged under the state's abortion bans. One emergency medicine physician shared: *"[T]here's still a lot of uncertainty. There are limits. The hospital, even as good as our attorney has been, they've said, 'we don't know if we can defend you if you come up on criminal charges and your malpractice doesn't cover it.'"* (10)

f. The bans threaten to further damage Louisiana's health care system, raising the likelihood of longer-term and compounding harms.

Clinicians consistently reported that Louisiana's abortion bans have caused health systems throughout the state to increasingly refer or transfer pregnant patients to urban specialty hospitals, rather than providing care where the

patient first seeks it. Many clinicians practicing in large, urban, well-resourced specialty OB-GYN hospitals described receiving an overwhelming number of referrals from all over Louisiana and even from Mississippi since the abortion bans took effect. One emergency medicine physician stated that at smaller, rural hospitals hospital lawyers' advice was often "don't deal with [medical emergencies in pregnancy], transfer [the patient to another hospital]," resulting in more transfers to urban centers. (10) A MFM specialist reflected this and noted how the delays and denials of care are exacerbating the state's maternal health crisis:

We are seeing a lot more transfers of what should be routine cases. That happens because they don't want to take any risk of making a decision that might be medically correct but might be perceived as an [illegal] abortion. Although it would be clinically the appropriate thing to do to end the pregnancy from a clinical standpoint for health and safety of the mother. But they don't want to deal with it ... I hate to say it, but I envision that in the next couple of years, we're going to see more maternal deaths related to pregnancies that should have been taken care of better. We already have areas that are obstetrical deserts and I'm not sure what it's going to look like in the next year or so when the birth rates go up even higher, but I think it's going to get worse ... so that there's going to be fewer places to get obstetric care and more patients. (14)

An emergency medicine clinician agreed, adding:

[W]hen you're in the emergency department, you see the downstream effects of a whole lot of things. Any barrier in access to a woman at the most vulnerable time of her life, which [pregnancy] truly is for most, means more people suffer and more people die. It's just plain and simple. (10)

Another echoed these concerns and the impact of expanded maternal care deserts in the state

on pregnant and birthing Louisianans:

There is no incentive for OB-GYNs to stay in the area that is high risk, whether at risk of being prosecuted, not even if they perform abortions, but the procedures that are required to handle a miscarriage pretty much mimic those of an abortion. So, by them leaving, this decreases the amount of services available to the community, and outside of New Orleans, in Baton Rouge, most of the state is already a maternal care desert with no OB-GYNs available. (41)

As an aspiring midwife in the state, they noted how a shortage of OB-GYNs would impact their ability to care for pregnant and birthing people in the state:

Professionally ... it has definitely impacted my vision for my life, because my vision and hope is to stay in the greater New Orleans metro area. But being aware of how OB-GYNs are leaving states where abortion is banned, having a provider shortage directly impacts aspiring midwives who could not practice without a collaborative practice agreement of a physician. (41)

Participants also expressed their frustration with the hypocrisy between the stated need to improve Louisiana's maternal mortality and morbidity rates and the adoption of abortion bans that ultimately harm maternal health by delaying prenatal care and forcing people to continue pregnancies despite the risk of adverse maternal outcomes. A community-based organization representative noted: "Louisiana was already experiencing a maternal mortality crisis before [Dobbs]. Right? And that was a crisis that disproportionately affects Black parenting. And, you know, I see the impacts of the loss of abortion access." (Focus Group B)

Others underscored the disconnect between rhetoric and policy in the high rates of disenrollment from Medicaid in Louisiana at the end of the COVID public health emergency. One

OB-GYN noted that *“Louisiana’s health policy, social services environments are not improving for women who are giving birth to children or for those children themselves. I am not seeing any actions besides more discussion of how bad health outcomes are.”* (29) One emergency medicine physician who noted their own conflicted feelings about abortion, criticized the lack of resources being devoted in Louisiana for mothers, infants, and children: *“If you are going to have laws like this and then do nothing to support the lives and the health of women and families, then you really don’t have a leg to stand on.”* (10)

An OB-GYN who also studies health systems noted that abortion bans are broader signals of a lack of investment in reproductive health and patient-centered care:

In a society that thinks it’s okay to restrict abortion access, probably the patient centeredness of the maternal care is already also deeply flawed. Abortion legislation is a signal that this is probably not a place where people are getting super patient-centered maternal care ... you just can’t make this many conditions on someone’s decision and provide person-centered care, and that will definitely show up in your maternal morbidity and maternal mortality outcomes. It’s like, are you listening to what people think is happening in their own bodies and what they want for their own body? The answer is either yes or no. It’s not yes sometimes. (22)

g. The bans lead clinicians to face “dual loyalty” dilemmas that cause them moral distress and injury, with possible long-term impacts on the state’s health care workforce.

Louisiana’s abortion bans restrain clinicians from using their medical expertise and prevent them from meeting their professional medical

ethical obligations, including their obligation to consider the preferences and needs of patients. This creates painful dual loyalty conflicts for clinicians.

Dual loyalty occurs when clinicians’ obligations to patients conflict with their obligations to a third party, such as a state, health system, or other entity that holds authority over them.⁹⁵ Clinicians in Louisiana are facing an impossible choice: to comply with the law or to violate their medical, ethical, and human rights obligations, all the while harming pregnant patients by delaying or denying care or information. The difficulties with this coerced choice are only exacerbated by the harsh civil, criminal, and professional penalties a clinician may face for violating the bans.

Dual loyalty creates moral injury or distress, with clinicians feeling that *“they have violated their conscience or moral compass”* by taking part in, witnessing, or failing to prevent *“an act that disobeys their own moral values or personal principles.”*⁹⁶ Indeed, many clinicians described such feelings of moral distress about abandoning patients who they could not provide care for, even if those patients did ultimately receive abortion care outside the state. One family medicine physician described this inability to provide care:

You know that the only way [the patients] are going to start to feel better, the only way they’re going to get any relief is if I can help them not be pregnant. And I legally cannot do that in this state where we are or where they are. And it just feels extremely limited and unethical and immoral and frustrating for both patients and for us. That happens over and over again every day. (16)

A MFM specialist who provides prenatal diagnoses in an outpatient practice described feeling distress when their only option was to tell pregnant patients who had received severe fetal diagnoses and wanted to end their pregnancies that they had to leave the state to

receive care: *“That really, as a physician, makes me feel horrible. You know what I mean? I can’t take care of them, and it is my patient. It’s just horrible because my group has always finished the care of these patients and taking care of them through everything no matter what.”* (14)

One emergency medicine physician reflected on the impact of seeing girls and women who had become pregnant through rape:

One of the most heartbreaking things is about how there are no exceptions for rape and incest. We see too many of these cases in our ED (emergency department) and you wonder how the person is, what happened. And I hear from OB-GYNs about them treating eleven-year-olds that have been raped, nine-year-olds that have been raped, and not having access and so needing to, you know, carry a full, you know, go to full term as a nine-year-old, you know, as a child. That has been pretty horrendous. (13)

While lamenting what they observed as an increase in the failure of clinicians to respond in a timely fashion when pregnant patients face health emergencies, several physicians expressed empathy for the dual loyalty dilemmas all Louisiana clinicians providing care for pregnant patients face: *“It’s really hard for physicians to say, I’m going to put my livelihood on the line I totally get it. I don’t think the physicians are being callous or mean spirited, but then that means the patient suffers. It’s a terrible choice.”* (10)

This threat of civil and criminal penalties for health care providers under the bans may lead some to stop practicing or leave the state and may deter medical students from doing their residency in Louisiana. In 2023, one year after the bans took effect, there was a decline in numbers of applicants to Louisiana’s OB-GYN residencies.⁹⁷ The loss of health care providers will exacerbate health care provider shortages, further distress the state’s already frayed health system, and cause further harm to Louisianans.

As one OB-GYN involved with residency and recruitment noted:

I think one of my biggest concerns is that physicians are going to get frustrated with politics being such a huge part of the care that we provide and that we’re going to start losing doctors. I think we’re already at critical mass. We’ve already got some of the sickest patients in the country liv[ing] here. And to lose really good doctors to just frustration from the law being involved in the care that we provide, I think is still a very real concern. It’s also about recruiting new doctors. (20)

Another OB-GYN feared that:

Fewer people will want to practice here, and fewer people will want to come here to train. [The bans are] going to be driving away a number of really strong clinicians who are dedicated to taking care of really vulnerable populations. I think it’s going to leave our populations in Louisiana further disadvantaged and experiencing more harm. And one hopes that one can survive the pendulum swing and see it swing back the other way and hopefully contribute. But it’s a challenge, and I think that many good people who want to do the right thing and support their patients are being tested by the challenge. (29)

Another shared a conversation they had with their family as they weighed whether to stop practicing in the state:

[I told my husband], ‘If we cannot change this, I cannot practice.’ I mean, I have a four-year-old and a two-year-old. I cannot go to jail for my job, and it will make me feel like I am letting so many people down and so many patients down. But at some point, do I sacrifice a year of my life going to jail and what it will do to ... my license, my malpractice insurance, my ability to even work anywhere. So, it’s a lot. I mean, it is only a matter of time [until they start to prosecute physicians]. I

think most of us feel it's only a matter of time before like I said before, one of us is maybe the example ... And I'm not going to stop taking care of patients. It's hard. It's a conflicting decision. Like, do I risk going to jail? I will never stop taking care of patients. I love what I do ... but do I want to risk being away from my kids? (24)

Several medical students felt torn between recognizing the need for excellent reproductive health physicians in Louisiana and their uncertainty about whether they could endure not being able to provide all the care patients need. As one medical student considering whether to stay in the state for their OB-GYN residency described:

I'm trying to find the words to explain it, but it's really difficult. I feel like you're kicking people while they're down, and that [is] not fun. And that's the biggest thing that I'm concerned about. And I'm worried that I don't know how I'm going to face that if I stay in the south. I would love to stay here and help because I know the South is where my efforts are probably needed most, but it's just at what cost? ... I think it feels like I can't fully help someone. It feels like I'm offering half of what I could be, and I find that against my own moral code. If I want to be a doctor, I want to be able to offer the full spectrum of services and counseling options. I don't think that could happen with me staying here. And I would feel so guilty seeing all of these patients as the future doctor and not being able to help them to the full capacity that I could be. So that's against my own values and I don't think I can do it. (18)

One family medicine physician who teaches at a major medical school confessed to telling students going into OB-GYN that they “need to leave [Louisiana]. I'm like, yeah, you need to just go. Just go ahead and leave because [you are] not going to get the full spectrum of care that [you are] going to need for training.” (7)

The loss of clinicians in the state, many pointed out, will ultimately harm pregnant Louisianans:

[T]he real fear is [that] everybody leaves your state that offers necessary procedures, and the hospital is left with nobody. And then when you have situations like we had a couple of weeks ago where somebody was 21 weeks with chorioamnionitis, heart rates in the 150s, hypotensive, and nobody can get the baby out fast enough ... the patient could die. (8)

Still, clinicians described feeling a moral obligation to patients to continue to practice in Louisiana. One MFM specialist noted: “*If there's ever a time that the high-risk people of Louisiana need a high-risk doctor that's willing to do everything that she can, it's now.*” (1) An OB-GYN elaborated:

I think there were a lot of us who were [saying], how are we going to continue to operate under this law? And the question being, do we leave? But we also have an obligation to our patients to stay and to try to make this better. I don't know that I'm ever going to change the mind of the Louisiana politicians, but I certainly would hate to leave my patients in the hands of folks who don't have a moral problem with this and aren't going to be willing to provide patients with all of the information that they need. So, I think a lot of us, as a form of advocacy, have chosen to stay for that reason. (15)

One OB-GYN who was born and raised in Louisiana, stated their hopes for a future in Louisiana where these bans are revoked: “*I don't foresee leaving Louisiana, and it's my hope that through continued hard work and advocacy, you know, that we'll be able to be here for the people who need us and hopefully be here when we eventually reemerge from the darkness.*” (29)



An Unfolding Constitutional, Human Rights, Public Health, and Medical Ethics Crisis

The findings presented in this report provide significant evidence of how Louisiana’s abortion bans are contributing to a constitutional, human rights, public health, and medical ethics crisis in the state. Clinicians across the state time and again underscored the impossibility of prioritizing patient care under the state’s draconian laws and the many harms this untenable situation results in for pregnant Louisianans. Patients, clinicians, and community-based organization all emphasized that the bans exacerbate the state’s preexisting maternal health crisis, with particularly severe results for historically marginalized communities including Black, Indigenous, and other people of color, people living on low incomes, and people living in rural areas. The bans also undermine the reproductive freedom of these same communities and perpetuate a legacy of reproductive oppression in the state. These harms constitute serious violations of existing federal guarantees—including constitutional rights—as well as international human rights laws. Further, the bans are exacerbating a public health crisis in the state by worsening determinants of health in marginalized communities, impeding access to care and clinicians’ ability to adhere to basic

medical and ethical standards, and contributing to health care worker shortages and health care deserts in the state.

This section provides a brief description of the U.S.’ obligations under federal and international human rights law and how Louisiana’s abortion bans run counter to them. It also sets out how the bans contravene public health guidance and lead to violations of clinicians’ medical ethical standards.

1. Louisiana’s Abortion Bans Undermine Federal Obligations Under U.S. Law

The U.S. has enacted federal legislation that creates individual entitlements and government responsibilities at the federal, state, and local levels.

This research demonstrates the profound harm that Louisiana’s abortion bans are causing, despite nominal exceptions for medical necessity and federal statutes protecting access to emergency care, patient privacy, and constitutional rights to equality and liberty. As

Emergency Medical Treatment and Labor Act (EMTALA)

In 1986, Congress enacted EMTALA to ensure public access to emergency medical treatment without regard to a person's ability to pay for the care they receive.¹⁰⁴ EMTALA provides rights to any person who presents at a hospital emergency room in a Medicare-participating hospital and requests treatment.¹⁰⁵ This law requires hospitals to provide all patients with an appropriate medical screening, examination, stabilizing treatment, and transfer, if needed. Because abortion care is medically indicated, stabilizing treatment in some cases, state abortion bans conflict with this federal protection. In July 2022, the U.S. Department of Health and Human Services (HHS) issued new guidance and communications clarifying that EMTALA preempts state bans and protects access to life- or health-saving abortion services in emergency situations.¹⁰⁶ Abortion opponents and the state of Texas sued the Biden administration to prevent the guidance from taking effect in that state. In January 2024, a federal appeals court sided with Texas.¹⁰⁷ In another lawsuit farther north, the U.S. Department of Justice (DOJ) sued Idaho, arguing that its near total abortion ban violates EMTALA. While a lower court agreed with the DOJ in August 2022 and blocked the ban as it applies to patients who fall under EMTALA, in January 2024 the U.S. Supreme Court reinstated the abortion ban.¹⁰⁸ The Supreme Court will hear the Idaho case later this term. Until then, Idaho and Texas hospitals are not obligated to provide abortions to stabilize pregnant people, and the Supreme Court's ultimate ruling could have implications for pregnant people nationwide.

Health Information Portability and Accountability Act (HIPAA)

HIPAA creates requirements for the use, disclosure, and protection of personal health information by health plans and health care providers.¹⁰⁹ Protected information includes information related to abortion and other sexual and reproductive health care.¹¹⁰ Health plans and health care providers can use or disclose a patient's personal health information without their authorization but only as expressly permitted or required by HIPAA under narrow exceptions.¹¹¹ Under a proposed rule issued in April 2023 in response to the *Dobbs* decision, HHS would modify and strengthen the confidentiality

of a person's personal reproductive health information as protected under HIPAA.¹¹² One of the modifications would prohibit the release of personal health information where certain criteria are met and the request for information is sought for the "criminal, civil, or administrative investigation or proceeding against an individual, regulated entity, or other person for seeking, obtaining, providing, or facilitating reproductive health care."¹¹³

The United States Constitution

The U.S. Supreme Court decision in *Dobbs* reversed nearly 50 years of precedent, concluded that there is no federal constitutional right to abortion, and—for the first time in U.S. history—took away a right grounded in personal liberty. The *Dobbs* decision is wrong. The reasoning in *Dobbs* undermines the very purpose of the Fourteenth Amendment to the U.S. Constitution, which was ratified after the American Civil War to address discrimination and inequality and prohibits states from violating a person's multiple and interdependent rights to life, liberty, due process, and equal protection of the laws.¹¹⁴ For decades, the Supreme Court has interpreted liberty interests to include personal decisions and privacy rights involving bodily integrity, abortion, contraception, procreation, sexual conduct, marriage, family relationships, and childrearing.¹¹⁵

Instead of considering what the Fourteenth Amendment's promise of freedom and equality means for the lives of women and all who can become pregnant, the *Dobbs* decision sets forth a radically narrow interpretation of the U.S. Constitution that reinforces the historical subordination of marginalized people. But as the dissent in *Dobbs* powerfully explains, the right to reproductive autonomy is deeply grounded in the U.S. Constitution and must be extended to cover historically marginalized groups.¹¹⁶ *Roe v. Wade* was correct to hold that decisions about pregnancy and childbearing rise to the level of constitutional importance, and that the right to abortion is part of the liberty guaranteed by the Fourteenth Amendment.

the *Dobbs* decision, Louisiana’s abortion bans, and the Supreme Court’s decision to intervene in EMTALA litigation demonstrate, the U.S. legal landscape has dramatically changed and continues to shift. Our findings illustrate the resulting fear, confusion, and deprivation of reproductive health care and autonomy that patients, clinicians, and communities in Louisiana are facing. Nevertheless, these drastic developments are also a reminder that laws can and do change.

The Louisiana legislature has the power to address the findings captured in this report by repealing the bans. The Supreme Court’s decimation of precedent requires a rebuilding of legislation and jurisprudence to align with the promise of the U.S. Constitution. While the Fourteenth Amendment’s guarantee against state deprivation of liberty—including a right to privacy and to control one’s body—must remain a core pillar of reproductive autonomy, it should not be the only pillar. Multiple legal rights establish that government restrictions on reproductive autonomy constitute sex, race, and economic discrimination, and that such restrictions can deny people their lives, as well as their ability to live their lives with dignity.⁹⁸ International human rights law can serve as a guide in this endeavor to build a more equitable and inclusive legal framework.

2. Louisiana’s Abortion Bans Violate the U.S.’ International Human Rights Obligations

While the U.S. Supreme Court and Louisiana state government have rolled back abortion rights, international human rights law is clear that access to abortion care is an integral part of peoples’ ability to live with dignity and enjoy their most essential freedoms. Over the last 30 years, international and regional human rights bodies have developed strong standards on the right to sexual and reproductive health, including abortion. Human rights bodies have condemned the U.S. Supreme Court’s ruling in

Dobbs and the subsequent criminalization of abortion in U.S. states.

The U.S. has ratified three international human rights treaties that recognize and protect sexual and reproductive health and rights: the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), and the Convention Against Torture (CAT).⁹⁹ The U.S. is obligated to respect, protect, and fulfill the rights enshrined in these treaties. This framework prohibits the U.S. from taking actions that violate a person’s human rights, but also requires it to remove existing barriers, and to proactively create an environment that enables human rights.

In addition to the three human rights treaties that the U.S. has ratified, the U.S. has also signed onto, but not ratified, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Rights of People with Disabilities (CRPD), all of which protect reproductive rights.¹⁰⁰ As a signatory to CEDAW, ICESCR, and the CRPD, the U.S. is obligated to not defeat the treaties’ object and purpose.¹⁰¹ At the regional level, the U.S. adopted the American Declaration of the Rights and Duties of Man, a non-binding declaration on a person’s fundamental human rights which the Inter-American Commission on Human Rights is tasked with interpreting.¹⁰² It has also signed, but not ratified, the American Convention on Human Rights.¹⁰³

The international human rights treaties that Congress signs onto and ratifies create human rights obligations for all levels of government—federal, state, and local. While the national government is ultimately responsible for reporting to human rights treaty monitoring bodies on how the U.S. is meeting those obligations, state and local governments play a critical role in ensuring that the U.S. fulfills its international human rights commitments.

Rights to Life and Health

The Human Rights Committee, which is tasked with interpreting the right to life under the ICCPR, has recognized that while governments can regulate abortion, they cannot adopt measures that “jeopardize [pregnant peoples’] lives, subject them to physical or mental pain or suffering ... discriminate against them or arbitrarily interfere with their privacy.”¹¹⁷ The Committee explicitly prohibited governments from imposing “criminal sanctions to women and girls who undergo abortion or to medical service providers who assist them in doing so.”¹¹⁸ Instead, governments should remove existing barriers to effective access to abortion and refrain from introducing new barriers.

The right to health as articulated by the Committee on Economic, Social and Cultural Rights requires governments to ensure that health information, goods, and services are: available in sufficient quantities; accessible to everyone, especially to vulnerable people and communities facing multiple and overlapping forms of discrimination; acceptable to patients and respectful of their culture and of medical ethics; and of good quality, meaning they must be scientifically and medically appropriate.¹¹⁹ The right to health is understood expansively to include sexual and reproductive health, which recognizes the right of every person to make decisions about their body and sexual and reproductive health free of violence, coercion, or discrimination.¹²⁰ It entitles them to access the information, goods, and services to meaningfully exercise this right, including access to abortion, maternal health care, contraception, and comprehensive sex education.¹²¹ It also recognizes that a person’s ability to enjoy this right is deeply affected by social determinants of sexual and reproductive health, including access to safe and potable water, adequate sanitation, food, and housing, and a safe and healthy working environment.¹²²

Right to Equality and Non-Discrimination

The right to equality and non-discrimination is indivisible from other human rights. In the context of the right to sexual and reproductive health, everyone should be able to “enjoy equal access to the same range, quality and standard of sexual and reproductive health facilities, information, goods and services, and to exercise their rights to sexual and reproductive health without experiencing any discrimination.”¹²³ Beyond obligations to ensure

equal treatment under the law, human rights bodies have also recognized that people and communities that experience multiple forms of discrimination in their everyday lives may experience similar intersectional discrimination in the context of sexual and reproductive health.¹²⁴ Governments must then take special measures to address the distinct sexual and reproductive health needs of these particular groups and the unique barriers they face.¹²⁵

Right to Privacy

Human rights bodies have made clear that the right of every person “to make autonomous decisions about [their] own body and reproductive functions is at the very core of [their] fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity” and is a “precondition for the enjoyment of other rights.”¹²⁶

Right to Information

The right to freedom of expression, including to seek, impart, and receive information, is protected under human rights law.¹²⁷ Human rights bodies have consistently emphasized that access to information is critical to sexual and reproductive health, and that governments have an obligation to ensure it is made available.¹²⁸ They have called on governments to remove barriers to information and care and to ensure that medical professionals can share accurate, evidence-based information with patients.¹²⁹

Right to be Free from Torture and other Cruel, Inhuman or Degrading Treatment

Human rights bodies have repeatedly affirmed that people who are denied access to abortion due to abortion bans may endure anguish and mental and physical suffering so severe that it implicates the prohibition on torture and other ill-treatment.¹³⁰ A UN expert on torture and other cruel, inhuman or degrading treatment or punishment has noted that “the denial of safe abortions and subjecting women and girls to humiliating and judgmental attitudes in such contexts of extreme vulnerability and where timely health care is essential amount to torture or ill-treatment.”¹³¹ To prevent these types of human rights violations, governments must “reform restrictive abortion legislation that perpetuates torture and ill-treatment.”¹³²

Louisiana's abortion bans disregard the U.S.' binding legal obligations and violate a constellation of human rights that protect reproductive health and autonomy. The rollback of abortion rights in the U.S. and in Louisiana specifically has led to a human rights crisis that undermines public health and the very practice of medicine. It has also made the U.S. an outlier as countries around the world are increasingly reforming their laws to recognize abortion as a right.

By allowing states like Louisiana to ban abortion, the current U.S. legal framework fails to respect, protect, and fulfill peoples' rights to reproductive health and autonomy. The findings presented in this report document multiple human rights violations, including to the rights to life, health, equality and non-discrimination, privacy, information, and to be free from torture and other cruel, inhuman or degrading treatment or punishment. It is not only pregnant people seeking reproductive health care who are harmed, but also the health care providers who are threatened with civil and criminal punishment for providing patients with essential health care.

The bans endanger the life and health of pregnant patients by delaying or denying time-sensitive care and undermining quality care. The research captured in this report indicates that it has become more difficult to access early prenatal care in Louisiana because of the abortion bans. For pregnant patients who want and need care earlier in pregnancy, this delay raises concerns. When pregnant patients experience complications such as miscarriage or preterm premature rupture of the membranes, they face unnecessary risks because of Louisiana's abortion bans. For example, this research supports other published findings after Texas' 2021 six-week abortion ban, which showed increased maternal health complications when clinicians were required to use expectant management, or watch and wait, instead of being able to offer immediate care to patients presenting with PPROM before 22

weeks' gestation.¹³³ The research findings also indicate that clinicians are waiting to intervene in pregnancy complications until the patient's condition has worsened and can be clearly documented.¹³⁴ Clinicians indicated that they were uncertain about when they could provide abortion care and information to pregnant patients with emergent conditions, as well as those with serious but slower progressing conditions, such as cancer. These research findings are comparable to other studies and reports from states with severe abortion restrictions across the U.S..¹³⁵

Pregnant patients in Louisiana who seek abortion care for a myriad of reasons unrelated to pregnancy complications also face risks to their health. Under the bans, most pregnant patients are forced to either continue their pregnancy or travel long distances to access care in states where abortion is legally protected.¹³⁶ A pregnant person struggling to surmount these logistical barriers may run up against gestational bans and increased procedure costs, and ultimately miss the window of time to obtain abortion care altogether. For patients who experience health complications or who learn of fetal complications later in pregnancy, every day of pregnancy spent attempting to access abortion care comes with health implications for the pregnant person. Whether they are delayed in accessing abortion care or denied completely, pregnant patients in Louisiana are being subjected to physical and mental health risks that they would otherwise not experience if abortion was legal and accessible in the state.

Louisiana's abortion bans perpetuate inequality and discrimination by disproportionately impacting communities that have been denied equal access to power, resources, and opportunities, and people that experience intersectional discrimination, including on the basis of race and gender.¹³⁷ While Louisiana's abortion bans apply to everyone, they most harm people who already face discrimination in accessing health care: Black, Indigenous, and other people of color, people with disabilities,

people in rural areas, young people, immigrants and undocumented people, LGBTQ people, and people living on low incomes.¹³⁸ Clinicians, patients, and representatives of community-based organizations consistently indicated that these communities disproportionately experience adverse reproductive health outcomes and are subjected to structural discrimination within and beyond Louisiana's health care system, making it nearly impossible to overcome Louisiana's many barriers to accessing abortion.

Access to information is critical to safeguarding patients' rights to informed consent and reproductive rights.¹³⁹ The chilling effect in the provision of information caused by the bans is of particular concern to pregnant patients who already face discriminatory barriers to accessing health care, including Black, Indigenous, and other people of color.

Human Rights Bodies Have Condemned the U.S. Supreme Court's Ruling and Subsequent Criminalization of Abortion in Some U.S. States

Human rights experts have widely condemned the *Dobbs* decision and the wave of state abortion bans, like Louisiana's, which it allowed to take effect. In August 2022, the Committee on the Elimination of Racial Discrimination (CERD) conducted a review of the U.S. and noted deep concerns about the backsliding on reproductive rights. CERD recommended that the U.S. address the disparate impact *Dobbs* would have on racial and ethnic minorities, Indigenous people, and those living on low incomes.¹⁴⁰ In October 2023, the Human Rights committee echoed these concerns and recommendations, stating that it was "alarmed at the increase in legislation, barriers and practices at the state level that impeded women's access to safe and legal abortion."¹⁴¹ The Human Rights Committee called on the U.S. to "put an end to the criminalization of abortion by repealing laws that criminalize abortion, including laws under which criminal sanctions may be imposed on women and girls who undergo abortion[s], health service providers who assist women and girls to undergo abortion[s] and persons who assist them."¹⁴² The U.S. legal framework has also been criticized by the Inter-American Commission on Human Rights, which in November 2023 recognized that the *Dobbs* and state abortion bans were causing great harm to pregnant people, in violation of their rights to life, health, equality and non-discrimination, and to be free from cruel, inhuman or degrading treatment or punishment.¹⁴³

3. Louisiana's Abortion Bans Contravene Public Health Guidance

Louisiana's abortion bans disregard evidence showing the safety of abortion procedures in the U.S. and demonstrating the significant harm that can be caused when reproductive health care is delayed or conditions such as gynecologic cancer, pregnancy loss, ectopic pregnancy, and abortion.¹⁴⁴ They also run counter to evidence

showing that laws that delay or deny pregnant patients access to abortion are harmful to pregnant patients. The Turnaway Study, for example, found that people who were denied an abortion reported increased life-threatening pregnancy complications, including eclampsia and infections, compared to those who received requested abortion care.¹⁴⁵ Other studies also estimate an increase in maternal mortality from total abortion bans and early gestational age limits on abortion.¹⁴⁶

World Health Organization Abortion Care Guideline

In 2022, the leading global public health expert body published an updated Abortion Care Guideline recognizing abortion as an essential health service necessary for the realization of human rights and calling on governments to remove access barriers.¹⁴⁷ Specifically, the Guideline urges that “all norms, standards and clinical practice related to abortion should promote and protect individuals’ health and human rights, informed and voluntary decision-making, autonomy in decision-making, non-discrimination (including intersectional discrimination) and equality, confidentiality and privacy, adequate referral mechanisms, and the continuum of care.”¹⁴⁸ Equality and non-discrimination are at the heart of the Guideline, which notes that the regulation of abortion should have the objective of “meeting the particular needs of marginalized

persons” and takes special note of women with few financial resources, young people, women with disabilities, migrant women, transgender and non-binary persons, and women from ethnic and racial minorities.¹⁴⁹ The Guideline makes seven law and policy recommendations to governments. Among these is the full decriminalization of abortion, including “removing abortion from all penal/criminal laws, not applying other criminal offences (e.g., murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.”¹⁵⁰ It also recommends that abortion be available on the request of the pregnant person and not restricted by grounds such as the life or health of the pregnant person.¹⁵¹

Louisiana's abortion bans contravene public health guidance and are harming the state's health care infrastructure, with dire consequences for Louisiana's access to reproductive health care and pregnant patient's maternal health outcomes. The bans are leading some OB-GYNs to delay prenatal care to pregnant patients until after the first trimester, notwithstanding public health guidance that such care is critical early in a pregnancy. They also contribute to a deferral of care in rural hospitals with dangerous consequences for pregnant patients who experience pregnancy complications, including miscarriages. Practicing under the risk of civil, criminal, and professional penalties appears to have left many clinicians reconsidering their choice to work in the state and medical students unsure about pursuing OB-GYN residencies in the state. This possible loss of clinicians and medical students would heighten barriers to health care in the state and exacerbate already poor maternal health outcomes for pregnant people in Louisiana. As the suppression and stigmatization of reproductive health escalates, pregnant people are further isolated from the information, support, and dignified care they need to exercise their human rights.

4. Louisiana's Abortion Bans Mandate Violations of Clinicians' Medical Ethics Obligations

The primary ethical duty of clinicians is to promote the health and well-being of patients. In the World Medical Association's (WMA) 1948 Declaration of Geneva, physicians pledge that "the health and well-being of my patient will be my first consideration."¹⁵² The Code of Ethics of the American Congress of Obstetricians and Gynecologists (ACOG) states that treatment decisions should be made "in accordance with the best interest of the patient, respecting a [person's] autonomy to make health care decisions."¹⁵³

Louisiana's abortion bans **prevent physicians from adhering to the principles enshrined in these and other professional codes of ethics**, including their four core principles:

- ▶ **Beneficence**, or the duty to provide beneficial care to patients;
- ▶ **Nonmaleficence**, or the duty to "do no harm" to patients;
- ▶ **Respect** for patient autonomy; and
- ▶ **Justice** or fair distribution of benefits and burdens.¹⁵⁴

To adhere to the principle of beneficence, it is incumbent on clinicians to, in the words of the American Medical Association's (AMA) Code of Ethics, "place patients' welfare above the physician's own self-interest or obligations to others."¹⁵⁵ The related principle of nonmaleficence requires physicians to seek to ensure that a patient they treat will be no worse off physically, emotionally, or otherwise after treatment than before.¹⁵⁶ In accordance with these principles, physicians must elicit, consider, and respect patients' own preferences and values.

The principle of respect for patient autonomy requires clinicians to uphold the rights of patients who have decision-making capacity to make decisions regarding the treatment they receive, even when their decisions go against their clinicians' recommendations.¹⁵⁷ It is the obligation of clinicians to provide clear, complete information about the patient's medical condition, treatment options, and recommendations, but ultimately the patient makes the decision about the care they receive. The principle of justice requires clinicians to

treat all patients equally, equitably, and without discrimination.

Codes of ethics further affirm clinicians' duty to protect patients' human rights. The WMA International Code of Medical Ethics states the obligation of physicians to pledge not to use "medical knowledge to violate human rights and civil liberties, even under threat."¹⁵⁸

Furthermore, Principle I of the AMA Code of Ethics affirms that, "[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."¹⁵⁹ Ethical codes from the AMA and other medical associations affirm that respect for these ethical principles requires clinicians to act in accordance with patients' human rights, including by avoiding complicity in torture, discrimination, or the denial of autonomy. As outlined above, failure to adhere to these principles infringes on the human rights of patients, including their rights to life, health, equality and non-discrimination, privacy, information, reproductive self-determination, the benefits of scientific progress, and freedom from torture and other cruel, inhuman or degrading treatment.

Louisiana's abortion bans harm patients by preventing clinicians from providing the proper standard of medical care and acting in accordance with the core ethical obligations that define health care professions. As described in the findings section above, the threat of civil and criminal charges under the bans prevents clinicians from meeting these ethical duties in several ways:

- ▶ forcing them to delay or deny necessary medical care, including life- and health-preserving abortions, resulting in the severe physical and mental suffering of pregnant patients;
- ▶ requiring pregnant patients with serious preexisting health conditions or who are diagnosed with severe fetal impairments

to continue their pregnancies while experiencing risks to their physical and mental health; and

- ▶ hindering clinicians' abilities to respect patients' autonomy by prohibiting them from acting in accordance with patients' preferences and rights.

Louisiana's bans further undermine clinicians' ethical duty to provide comprehensive, accurate, and evidence-based information on all treatment options available to patients. Many clinicians reported that the prospect of civil and criminal consequences prevented them from providing information or referrals for abortion services legally available in other states, an essential part of comprehensive pregnancy options counseling. Since providing information on abortion care is incorrectly seen as a violation of Louisiana's abortion bans, clinicians might withhold information that they are mandated by professional ethical codes to share with patients. For example, the AMA Code of Medical Ethics states that "[e]xcept in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient's knowledge or consent is ethically unacceptable."¹⁶⁰

ACOG has recognized this principle while unequivocally opposing impediments to accessing abortion care because "any efforts interfering in this relationship harm the people seeking essential health care and those providing it."¹⁶¹ Honesty, trust, and transparency are paramount to the clinician-patient relationship. These are all eroded by laws that strip physicians of their ability to use their own medical discretion and to take patients' autonomy, preferences, needs, values, and rights into account in medical decision-making.

Prior to the enactment of the trigger bans, Louisiana clinicians could provide medical care consistent with well-established standards of care and based on an individualized assessment of the patient's medical needs and

preferences, as well as by using their medical knowledge and experience—all while adhering to their extensive obligations as medical professionals. Since the enactment of these bans, that is no longer the case. This has grave implications for the health of Louisianans and the reproductive health care workforce if providers leave the state because they are unable to meet their medical and ethical obligations.

Health Care Providers are Human Rights Defenders

Health care professionals, including abortion providers, are recognized as human rights defenders under international human rights law when they serve on the frontlines of delivering essential health care and work to ensure that patients can exercise their rights.¹⁶² They often operate under risk of harassment, violence, and criminalization that aims to delegitimize, stigmatize, and undermine their delivery of care.¹⁶³

In 1998, the UN General Assembly adopted the Declaration on Human Rights Defenders, which described the rights of human rights defenders promoting and protecting human

rights and created government obligations to ensure that human rights defenders work in a safe, enabling environment.¹⁶⁴ Despite these international protections Louisiana's abortion bans target health care professionals and force them to operate under threat of civil and criminal penalties. Instead of recognizing health care providers as central to ensuring that people and communities can meaningfully exercise their reproductive rights, the state's abortion bans bind their hands, undermine their ability to meet their medical and ethical obligations to patients, and ultimately harm Louisianans seeking care.



Conclusion and Recommendations

The research captured in this report illustrates the manifold harms Louisiana’s abortion bans are causing Louisianans. Painful experiences shared by patients, clinicians, and representatives of community-based organizations demonstrate how the bans have led to delays and denials of health care. Pregnant patients with preexisting life-threatening conditions or who experience pregnancy complications receive delayed care, are subjected to unnecessary medical interventions, or are denied abortion care altogether. While some are able to reach abortion care in another state, many others are unable to surmount the barriers the bans have created and are forced to continue their pregnancy against their wishes. The bans have also led to delays in prenatal care access for patients in their first trimester as OB-GYNs seek to avoid the risk of treating a patient who miscarries. Although the fallout from the bans threatens the lives, well-being, and reproductive autonomy of all Louisianans, pregnant patients who already face poor access to health care and experience health inequities, including high rates of maternal morbidity and mortality, are disproportionately impacted.

The findings also exemplify how threats of legal and professional penalties cause clinicians to face dual loyalty and suffer moral injury for being unable to provide patients with the standard of care. Time and again, multiple

clinicians recounted how the bans prevented them from providing safe and patient-centered care when patients’ medical conditions did not fall within the ban’s narrow, allowed exceptions for medical emergencies or “medically futile” fetal conditions. The risk of prosecution has also chilled some clinicians’ confidence in providing patients with requested abortion information and support when they seek abortion care in another state. The threat of civil and criminal penalties under the bans will likely lead some of them to stop practicing in the state. It may likewise contribute to medical students choosing not to do their OB-GYN residency in Louisiana. This loss of clinicians will exacerbate the state’s frayed health infrastructure with adverse impacts on its pregnant patients who already struggle to access timely reproductive health care, including prenatal and abortion care.

Louisiana’s abortion bans raise serious federal, human rights, public health, and medical ethics concerns, including relating to violations of the rights to life, health, equality and non-discrimination, privacy, information, and freedom from torture and other cruel, inhuman or degrading treatment. The findings in this report make clear what regional and international human rights mechanisms have affirmed: that abortion is a fundamental right and that laws that criminalize abortion care are incompatible with human rights and

evidence-based, ethical, and patient-centered health care.

In light of the urgent harms caused by Louisiana's abortion bans, Lift Louisiana, Physicians for Human Rights, Reproductive Health Impact, and the Center for Reproductive Rights make the following recommendations:

To the Louisiana Legislature:

As these research findings illustrate, the laws and policies enacted by the Louisiana legislature have undermined the health and interests of pregnant people, women, and their families, and have reduced access to critical health care services. To comply with federal and human rights law, the legislature must:

1) Repeal Louisiana's abortion bans, as well as all other restrictive laws and regulations that effectively obstruct access to abortion in the state. This includes enacting legislation that would:

- a. **Decriminalize abortion** and remove professional, civil, and criminal penalties for health care workers who provide abortion care to patients.
- b. **Repeal laws that could be used to prosecute or penalize people for having an abortion**, including a self-managed abortion, assisting another person to access abortion care, or for pregnancy outcomes.
- c. **Remove all medically unnecessary requirements** for provision of abortion care, such as mandatory waiting periods and biased counseling.
- d. **Amend and adopt legislation to ensure access to the full spectrum of sexual and reproductive health care**, including comprehensive sexual health education, contraception, abortion, maternal health care, and perinatal mental health care without discrimination. This includes:

- i. **Refer a constitutional amendment to affirm the right of every Louisianan to make and carry out their own reproductive decisions**, including but not limited to decisions about abortion, contraception, fertility treatment, miscarriage care, and continuing their pregnancy.
- ii. **Address the state's maternal mortality and morbidity crisis by enacting laws and policies that increase access to prenatal, peri-partum, and postpartum care for historically marginalized communities and those disproportionately impacted by maternal mortality and morbidity**, including through regulatory and funding measures that facilitate access to and coordination between nurse midwives and surgical centers.
- iii. **Invest in full-spectrum health care centers and providers**, including birthing centers and birth workers, who are committed to the reproductive justice framework and offer care in chronically underserved areas, particularly rural and low-income communities.
- iv. **Enact Medicaid reforms that would expand access to full spectrum reproductive health care**, including contraception, abortion, pregnancy, and postpartum care.
- e. **Take steps to address social determinants of health that contribute to health inequities in maternal mortality and morbidity**—such as unequal access to income, nutrition, housing, clean water, healthy environments, transportation, paid family and medical leave, and affordable childcare.

To the Louisiana Executive Branch:

1) The Governor opposes abortion rights and, despite his substantial authority, is unlikely to use it to protect abortion care in the state. The Governor has broad authority to:

- a. **Support the enactment of legislation** that protects reproductive health care in the state;
- b. **Veto legislation** that would further restrict access to reproductive health care, including abortion access; and
- c. **Adopt executive orders** to ensure such care can be provided and received without fear of investigation, harassment, or civil or criminal penalties.

2) The Attorney General has substantial power to protect abortion care in the state that she is unlikely to wield because of her opposition to abortion rights. The Attorney General has authority to:

- a. **Rescind** the Office's letter of June 29, 2022; and
- b. **Decline** to prosecute abortion-related charges.

3) The Louisiana Department of Health should adopt policies that expand Louisianians' access to health care and engage with clinicians, hospitals, medical colleges, and medical associations to understand and address the impacts of abortion bans on Louisiana's public health and health care system.

To the Federal Executive Branch:

1) Integrate the World Health Organization's newly issued Abortion Care Guideline into the whole-of-government approach to ensure access to abortion. This Guideline makes evidence-based law and policy recommendations, including that all countries fully decriminalize abortion, refrain from enacting laws that permit abortion only in certain circumstances, and remove non-evidence based pharmaceutical restrictions on abortion medications. To that end:

- a. **Ensure that the U.S. Food and Drug Administration maintains authority to approve and regulate drugs used in medication abortion in an evidence-based manner.**
- b. **Exercise the power of the Department of Justice to actively promote and defend the right to reproductive autonomy,** including protecting the constitutional right to travel in order to obtain abortion care in states where it is legal, ensuring that all forms of violence and harassment against clinicians and health facilities for provision of abortion are investigated and prosecuted to the full extent of the law, and advising federal agencies and Congress on policies and actions that secure broad access to abortion and other reproductive health care.
- c. **Monitor the impact of abortion bans on the provision of reproductive health care and on health inequities,** including by employing the U.S. government's authority to investigate discrimination in programs and services funded by the Department of Health and Human Services.
- d. **Scrutinize, propose, and finalize updates to regulatory language to strengthen the effectiveness of relevant legislative measures,** including the Emergency

Medical Treatment and Labor Act (EMTALA), in order to secure access to abortion in life-threatening situations even in states where abortion is banned, and the Health Insurance Portability and Accountability Act (HIPAA), in order to protect sensitive personal health information disclosed when seeking or receiving abortion care.

- d. **Veto any legislation that seeks to limit access to reproductive health care.**

To the U.S. Congress:

- 1) Enact the Women’s Health Protection Act (WHPA)**, which establishes a statutory right for health care professionals to provide abortion care and for patients to receive care, and other positive measures to ensure meaningful access to abortion and other reproductive health care information and services without discrimination.
- 2) Eliminate the Hyde Amendment**, which restricts federal funding for abortion care except in very limited circumstances under Medicaid, and other harmful legislation that creates barriers to abortion access, in particular for Black, Indigenous, and other people of color, people with limited financial resources, and people with disabilities.
- 3) Enact the Equal Access to Abortion Coverage in Health Insurance (EACH) Act**, which would ensure that every person who receives health care or insurance through the federal government will have coverage for abortion care.
- 4) Support legislation that prohibits clinicians’ civil or criminal liability, disbarment, loss of license, or other retribution or reprimanding measures** where clinicians provide life- or health-preserving abortion care.

To Louisiana’s Hospitals and Health care Professionals:

- 1) Speak out against laws criminalizing abortion or otherwise restricting access to abortion**, including by raising awareness of the harm caused to patients and health care systems and ensuring clinicians are not prohibited by their medical institutions from speaking out against such laws.
- 2) Assist clinicians in navigating abortion bans and restrictions and providing patients with the standard of care**, including by providing them with accurate and up-to-date legal guidance as well as guaranteed and timely legal support for abortion-related investigations or legal proceedings. Louisiana’s hospitals and health care providers must better ensure that staff and clinicians in clinical settings adhere to the recommendations that the American Medical Association, the American College of Obstetricians and Gynecologists, and other medical professional organizations have issued affirming ethical and professional obligations to provide patients with abortion care.
- 3) Continue to support clinicians and medical students to attend trainings on abortion and other reproductive health care**, including clinical training and ethical guidance.
- 4) Lead and support efforts to build knowledge of and access to the full range of evidence-based reproductive care among patients and communities**, including those experiencing greater health inequities.

To State and National Medical Associations:

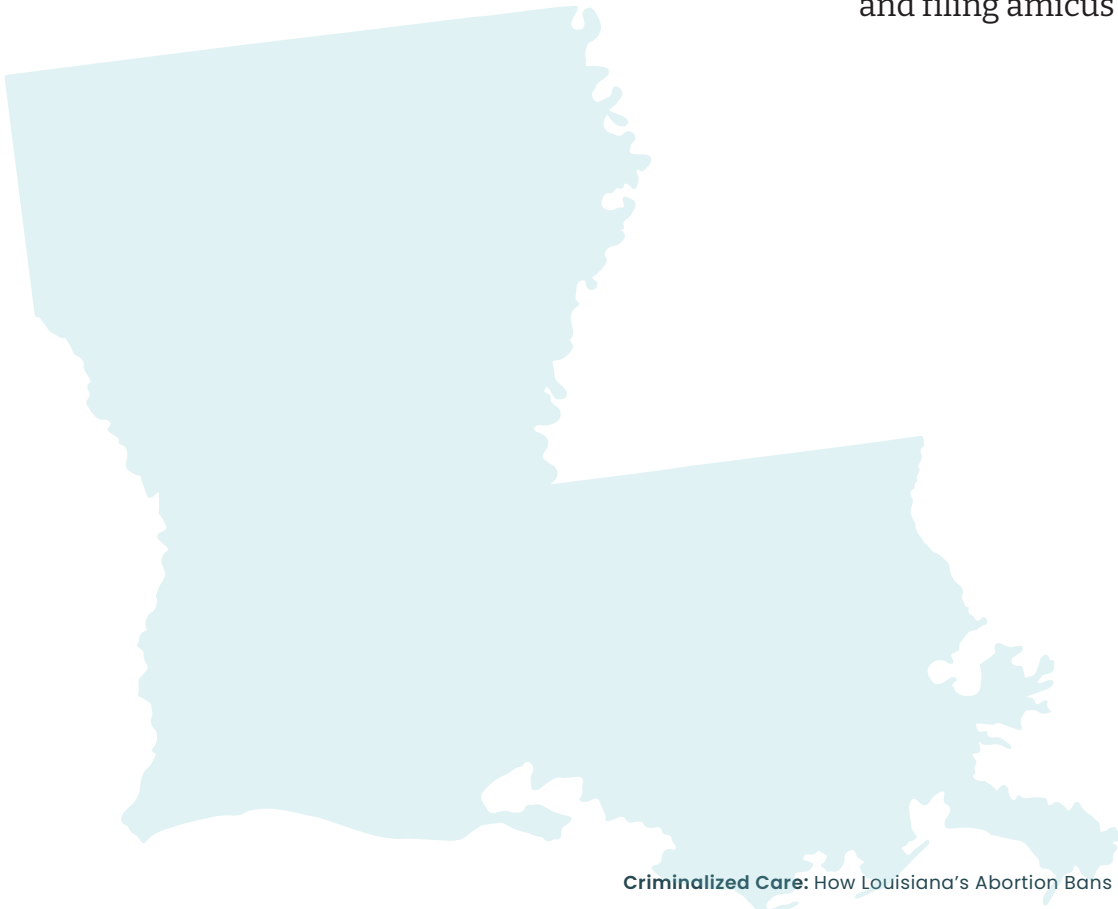
- 1) Vigorously advocate for the repeal of abortion bans and restrictions and continue to speak out against the range of injuries—criminal, civil, and moral—caused by**

abortion bans and restrictions, including citing evidence of how such laws lead to violations of ethical obligations, interfere with professional duties of care, and exacerbate existing health inequities.

- 2) **Advocate for increased access to abortion and other reproductive health care in Louisiana and beyond**, including measures that protect the safety and security of clinicians providing reproductive health care, patient data confidentiality, patients' ability to travel for abortion care, and telehealth abortion.
- 3) **Provide financial and practical support to allow Louisiana clinicians and medical students to access clinical training on abortion care**, including out of state.
- 4) **Raise patient awareness of their rights under the bans**, including their rights to travel to another state to access abortion care.

To International and Regional Human Rights Mechanisms, including UN Treaty Monitoring Bodies, UN Special Procedures, and the Inter-American Commission on Human Rights:

- 1) **Undertake independent, impartial human rights monitoring visits to the U.S.** to document the ongoing scope and nature of human rights violations occurring and monitor compliance with recommendations issued to the U.S. government post-*Dobbs*.
- 2) **Prioritize scrutiny of the U.S.' reproductive health record**, including in periodic review processes and relevant follow-up by the Human Rights Committee, the Committee Against Torture, the Committee on the Elimination of Racial Discrimination, and the UN Human Rights Council.
- 3) **Actively support legal challenges to abortion bans and other reproductive health care restrictions**, including by issuing joint statements of condemnation and filing amicus briefs.



Endnotes

1 *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 231 (2022).

2 *See id.*

3 *Id.*; *Roe v. Wade*, 410 U.S. 113, 152–53, 163 (1973).

4 *See generally* 2023 State Legislative Wrap-up, Ctr. for Reprod. Rts., <https://reproductiverights.org/2023-state-legislative-wrap-up-report/> (last visited Feb. 5, 2024).

5 *After Roe Fell: Abortion Laws by State*, Ctr. for Reprod. Rts., <https://reproductiverights.org/maps/abortion-laws-by-state/> (last visited Jan. 16, 2024).

6 *See* La. R.S. § 40:1061.

7 *See* La. R.S. §§ 14:87.7, 14:87.8.

8 Att'y Gen. Jeff Landry (@AGJeff Landry), X (formerly Twitter) (June 29, 2022, 3:46pm), <https://twitter.com/AGJeffLandry/status/1542233093729312768>.

9 La. R.S. §§14:87.1(1)(b)(v), 14:87.1(1)(b)(vi).

10 The first captive Africans arrived in Louisiana in 1719. By 1795, the population of enslaved Africans was close to 20,000 people and by the start of the Civil War in 1860, the number had grown to over 330,000. Even after slavery was outlawed, the Reconstruction Era saw the establishment of restrictive laws, called “Black codes,” which prevented newly freed Black people from voting, holding public office, or owning property. *See Justice Can't Wait: Oppression and Resistance: Slavery to Mass Incarceration in Louisiana*, Amistad Rsch. Ctr. (Feb. 18, 2021), https://artsandculture.google.com/story/LQVhVU_PJRY-LA.

11 From the state's founding, Louisiana's civil code established that “women are by their sex alone, rendered incapable of various civil engagements and functions.” *See* Armantine M. Smith, *The History of the Woman's Suffrage Movement in Louisiana*, 62 La. L. Rev. 509, 523 (2002), <https://digitalcommons.law.lsu.edu/cgi/viewcontent.cgi?article=5926&context=lalrev>. Despite the 19th Amendment's passage in 1920, Louisiana refused to ratify it until 50 years later in 1970. *See Louisiana and the 19th Amendment*, Nat'l Parks Serv. (July 8, 2020), <https://nps.gov/articles/louisiana-and-the-19th-amendment.htm>. And when Louisianan women were finally allowed to exercise their right to vote in the 1920s, it was limited to white women. *See id.* Louisiana has also still not ratified the federal Equal Rights Amendment (ERA), a proposed amendment to the U.S. Constitution designed to guarantee equal rights for Americans regardless of sex. The bill has failed to pass every time it has been introduced in the state legislature, despite the adoption of a state ERA in 1973. *See ERA Ratification Info by State*, ERA, <https://www.equalrightsamendment.org/era-ratification-map> (last visited Feb. 5, 2024); Katie Hawkinson & Sadie Logerfo-Olsen, *The State of State Equal Rights Amendments: A National Roundup*, Ms. Magazine (Aug. 25, 2022), [\[rights-amendments-era-tracker/\]\(https://reproductiverights.org/2023-state-legislative-wrap-up-report/\).](https://msmagazine.com/2022/08/25/state-equal-</p></div><div data-bbox=)

12 *See generally* Brief of Reproductive Justice Organizations as Amici Curiae in Support of Respondents, *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022) (No. 19-1392), <https://reproductiverights.org/wp-content/uploads/2021/09/Reproductive-Justice-Organizations-Brief.pdf>.

13 Racial segregation and redlining policies in the early 20th century, including classifying neighborhoods as mortgage risks and not loaning to Black people, have resulted in highly segregated neighborhoods and disparities in Black wealth and homeownership. In 2019, there was a 27.8 percent gap in homeownership between Black and white people in the state. *See generally* Kristen Lewis, *A Portrait of Louisiana 2020*, Measure of Am. of the Soc. Sci. Res. Council (Oct. 29, 2020), <https://measure-of-america.org/louisiana2020/>; *The Black homeownership gap in Louisiana*, Stacker (Feb. 10, 2022), <https://stacker.com/louisiana/black-homeownership-gap-louisiana>.

14 Louisiana has the highest incarceration rate in the country. *See* Hassan Kanu, *Louisiana's over-incarceration is part of a deeply rooted pattern*, Reuters (Feb. 1, 2023), <https://reuters.com/legal/government/louisianas-over-incarceration-is-part-deeply-rooted-pattern-2023-02-01/>. Sixty-four percent of the state's incarcerated population is Black, close to double their representation in the general population. *See id.*

15 Environmental racism is “a form of systemic racism whereby communities of colour are disproportionately burdened with health hazards through policies and practices that force them to live in proximity to sources of toxic waste such as sewage works, mines, landfills, power stations, major roads and emitters of airborne particulate matter.” Peter Beech, *What is environmental racism and how can we fight it?*, World Econ. F. (July 31, 2020), <https://www.weforum.org/agenda/2020/07/what-is-environmental-racism-pollution-covid-systemic/>; *see also* Tristan Baurick et al., *Welcome to “Cancer Alley,” Where Toxic Air is About to Get Worse*, ProPublica (Oct. 30, 2019), <https://www.propublica.org/article/welcome-to-cancer-alley-where-toxic-air-is-about-to-get-worse>.

16 *2023 Scorecard on State Health System Performance*, The Commonwealth Fund (June 22, 2023), <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>.

17 *See, e.g., No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma*, Physicians for Hum. Rts., Okla. Call for Reprod. Just., & Ctr. for Reprod. Rts. (Apr. 2023), <https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf>.

18 *See After Roe Fell: Abortion Laws by State > Louisiana*, Ctr. for Reprod. Rts., <https://reproductiverights.org/maps/state/louisiana/> (last visited Feb. 2, 2024).

19 Elizabeth Nash, *Louisiana Has Passed 89 Abortion Restrictions Since Roe: It's About Control, Not Health*, Guttmacher Inst. (Feb. 11, 2020), <https://www.guttmacher.org/article/2020/02/louisiana-has-passed-89-abortion-restrictions-roe-its-about-control-not-health>.

20 *See* 2022 La. Act 545; 2022 La. Act 548.

21 *See* 2022 La. Act 545. The statute contains limited exceptions, including saving the life or preserving the health of the fetus, a case of ectopic pregnancy, preventing the death of the pregnant person, and if the fetus is “medically futile.” La. R.S. § 14:87.1(1)(b). The statute defines a “medically futile” pregnancy

as one where “in reasonable medical judgment as certified by two physicians, the unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth.” *Id.* § 14:87.1(19)(a).

22 See La. R.S. § 14:87.1(18).

23 Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S. States, 2017-2019*, Ctrs. for Disease Control & Prevention (2022), <https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf>.

24 La. R.S. §14:87.8.

25 Courtney N. Phillips, *List of Conditions that shall deem an unborn child “Medically Futile”*, La. Dep’t of Health: Off. of Pub. Health (Aug. 1, 2022), https://ldh.la.gov/assets/oph/Rulemaking/ER/LDH_ER_List_of_Conditions_that_Shall_Deem_an_Unborn_Child_Medically_Futile_CLV_Signed_and_Dated_1_August_2022.pdf.

26 La. Admin. Code tit. 48, pt. I, § 401 (2023), <https://www.doa.la.gov/media/150dwaqn/48v01.pdf>

(list of conditions that would make meet the “medically futile” exception).

27 See Julie O’Donoghue, *Louisiana Health Department Declines to Answer Doctor’s Questions on Abortion Law*, La. Illuminator (Nov. 1, 2022), <https://lailluminator.com/2022/11/01/louisiana-health-department-declines-to-answer-doc-tors-questions-on-abortion-law/>.

28 See *id.*

29 *Id.*; see also Att’y Gen. Jeff Landry, *supra* note 8.

30 See, e.g., H.B. 461, 2023 Leg., Reg. Sess. (La. 2023); see also Julie O’Donoghue, *Louisiana lawmakers reject measures aimed at clarifying medical exceptions to abortion ban*, La. Illuminator (May 16, 2023), <https://lailluminator.com/2023/05/16/louisiana-lawmakers-reject-measures-aimed-at-clarifying-medical-exceptions-to-abortion-ban/>.

31 See H.B. 813, 2022 Leg., Reg. Sess. (La. 2022); see also Greg Larose, *Abortion would be punishable as murder under new Louisiana proposal*, La. Illuminator (May 4, 2022), <https://lailluminator.com/2022/05/04/abortion-would-be-punish-able-as-murder-under-new-louisiana-proposal/>; Kevin McGill, *No more murder charge for women in Louisiana abortion bill*, AP (May 12, 2022), <https://apnews.com/article/abortion-us-supreme-court-health-religion-louisiana-b73a7cfb0afc-29c30d106a85c80c7c50>.

32 La. R.S. § 40:962.2.

33 *Id.* § 40:962.2(D)(1).

34 See *2023 Louisiana Survey Shows Support for Legal Abortion Grows*, La. State Univ. (June 1, 2023), <https://www.lsu.edu/manship/news/2023/june/la-survey-shows-support-for-legal-abortion-grows.php>.

35 All abortions are banned in Arkansas except to save the life of a pregnant person in a “medical emergency.” Ark. Code Ann. § 5-61-304. The statute excludes from its definition of “abortion” acts to save the life or preserve the health of the “unborn child,” treat a miscarriage, or remove an ectopic pregnancy. *Id.* § 5-61-303(1). All abortions are banned in Mississippi except to preserve the life of the pregnant person or when the pregnancy is caused by rape, as long as the crime has been reported to the police. Miss. Code Ann. § 41-41-45. The statute as-

serts that “[a]s used in this section, the term “abortion” means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth or to remove a dead fetus.” *Id.* In Oklahoma, all abortions are banned except when “necessary to preserve” the pregnant person’s life. Abortion is criminalized and providers can be found guilty of a felony and be imprisoned from two to five years. Okla. Stat. Ann. tit. 21, § 861; S.B. 1555, 58th Leg., 2 Regular Session (Okla. 2022). Recently, the Oklahoma Supreme Court determined that the state’s constitution “creates an inherent right of a pregnant woman to terminate a pregnancy when necessary to preserve her life.” See *Oklahoma Supreme Court Rules the Right to Abortion is Protected in Life-Threatening Situations*, Ctr. for Reprod. Rts. (Mar. 21, 2023), <https://reproductiverights.org/oklahoma-supreme-court-limit-ed-right-abortion/>. There are other ongoing legal challenges to Oklahoma’s abortion restrictions. See Sean Murphy, *Oklahoma Supreme Court keeps anti-abortion laws on hold while challenge is pending*, AP (Nov. 14, 2023), <https://apnews.com/article/oklahoma-supreme-court-abortion-8e6160880139b86d654dd0531831e945> (describing CRR’s legal challenge). Though not binding, the Attorney General of Oklahoma released guidance for law enforcement in 2022 asserting that Oklahoma law prohibits aiding and abetting the commission of an “unlawful abortion,” which may include advising a pregnant person to obtain an “unlawful abortion.” Okla. Att’y Gen., *Guidance for Oklahoma law enforcement following Dobbs v. Jackson Women’s Health Org.* (Aug. 31, 2022), https://www.oag.ok.gov/sites/g/files/gmc766/f/memo_to_law_enforcement_following_dobbs_8.31.22.pdf. In 2023, the Attorney General issued further guidance stating that a person who seeks an abortion or self-induces an abortion cannot be prosecuted under state law. Okla. Att’y Gen., *Attorney General Opinion 2023-12* (Nov. 21, 2023), https://www.oag.ok.gov/sites/g/files/gmc766/f/documents/opinions/2023/ag_opinion_2023-12.pdf. All abortions are banned in Texas and anyone who performs or helps someone access abortion care is subject to civil penalties. Tex. Health & Safety Code Ann. § 170A.002(a). The only exceptions to this prohibition are cases in which the pregnant person is at risk of dying or suffering substantial impairment of a major bodily function. *Id.* § 170A.002(b). Texas allows private citizens to bring a civil claim of no less than \$10,000, as well as costs and attorney’s fees, against those who violate its restrictions. Tex. Health & Safety Code Ann. § 171.208.

36 See generally *After Roe Fell*, *supra* note 5. Providers in Colorado, Massachusetts, New York, Vermont, and Washington who offer abortion care via telemedicine to a patient physically outside of those states are entitled to the full range of shield protections if they are (1) licensed in the shield state, (2) physically present in that state at the time care is provided, (3) the care is lawful under the law of the shield state, and (4) the care meets the professional standards of care. See Colo. Rev. Stat. Ann. § 12-30-121; 2022 Mass. Acts. Ch. 127; S.B. 1066B, 2023 Leg. Reg. Sess. (N.Y. 2023), *amending* N.Y. Civ. Prac. Law §§ 3102, 3119, N.Y. Crim. Pro. Law §§ 140.10, 570.17, N.Y. Educ. Law § 6531-b, N.Y. Exec. Law § 837-x, N.Y. Ins. Law § 3436-a, *adding* N.Y. Civ. Prac. Law § 4550; Wash. Rev. Code § 18.130.450(1); Wash. Rev. Code §§ 7.115.010, 7.115.020, 7.115.030, 7.115.040, 7.115.050; Vt. Stat. Ann. tit. 1, § 150(b)(1)(B).

37 See generally *After Roe Fell*, *supra* note 5. North Carolina enacted a 12-week abortion ban on July 1, 2023, including additional burdensome restrictions to accessing care. N.C. Gen. Stat.

§ 90-21.81B(2). South Carolina is enforcing a six-week abortion ban after the state Supreme Court declared the ban constitutional on August 23, 2023. S. 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023); *Planned Parenthood S. Atl. v. South Carolina*, No. 2023-000896 (S.C. Aug. 23, 2023) (vacating the preliminary injunction and declaring the act constitutional), *Planned Parenthood S. Atl. v. South Carolina*, No. 2023-000896 (S.C. Aug. 29, 2023) (denying request for rehearing). Georgia is enforcing a six-week abortion ban after the state Supreme Court allowed it to remain in effect on October 24, 2023. Ga. Code Ann. § 16-12-141; *State of Georgia v. SisterSong Women of Color Reprod. Just. Collective*, No. S23A0421 (Ga. Oct. 24, 2023). Florida elected officials passed a six-week ban that would go into effect 30 days after the state Supreme Court rules on the state constitutional right to privacy in a case challenging the current 15-week ban. S.B. 300, 2023 Leg., Reg. Sess. (Fl. 2023), *to be codified at Fla. Stat. § 390.0111*; *Florida v. Planned Parenthood of S.W. and Central Florida*, No. 1D22-2034 (Fla. 1st Dist. Ct. App. Jul 21, 2022).

38 Marlo Lacen & Carolyn Roy, *These are the nearest states to Louisiana with protected abortion rights*, K TAL News (Jun. 25, 2022), <https://www.ktalnews.com/news/louisiana/these-are-the-nearest-states-to-louisiana-with-protected-abortion-rights/>; see also Caitlin Myers et al., *Abortion Access Dashboard*, <https://experience.arcgis.com/experience/6e360741bfd84db79d5db774a1147815/page/Page/?views=-Dashboard--October-10> (last visited Jan. 23, 2024).

39 See Myers et al., *supra* note 38; see also *Parental Involvement in Minors' Abortions*, Guttmacher Inst. (Sept. 1, 2023), <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions>.

40 See *Louisiana Parishes*, Louisiana.gov, <https://www.louisiana.gov/local-louisiana/> (last visited Jan. 23, 2024).

41 See *Louisiana: 2020 Census*, U.S. Census Bureau (Aug. 25, 2021), <https://www.census.gov/library/stories/state-by-state/louisiana-population-change-between-census-decade.html>.

42 *Id.*

43 *Id.*

44 See *Data for Louisiana*, March of Dimes, <https://www.marchofdimes.org/peristats/data?reg=99&top=14&stop=128&lev=1&slev=4&obj=18®=22> (last visited Jan. 23, 2024).

45 *Louisiana Quick Facts*, U.S. Census Bureau (Jul. 1, 2022), <https://www.census.gov/quickfacts/fact/table/LA#>.

46 Mohamad Moslimani et al., *Facts About the U.S. Black Population*, Pew Rsch. Ctr. (Mar. 2, 2023), <https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population/?tabId=tab-013779b8-6126-40a3-a78f-92695d8fe46d>; *Louisiana Quick Facts*, *supra* note 45.

47 *Poverty in the United States: Explore the Map*, Ctr. for Am. Progress, <https://www.americanprogress.org/data-view/poverty-data/poverty-data-map-tool/> (last visited Jan. 23, 2024); *Louisiana Quick Facts*, *supra* note 45. The federal poverty line is an economic metric used to determine whether an individual or family qualifies for federal benefits and programs. In 2023, that number was \$30,000 for a household of four. See *Poverty Guidelines*, U.S. Dep't of Health & Hum. Servs., <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> (last visited Feb. 4, 2024).

48 *Data for Louisiana*, *supra* note 44.

49 *Poverty Rate by Race/Ethnicity*, KFF, <https://www.kff.org/>

[other/state-indicator/poverty-rate-by-raceethnicity/?current-Timeframe=0&selectedRows=%7B%22states%22:%7B%22Louisiana%22:%7B%7D%7D%7D&sort-Model=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?current-Timeframe=0&selectedRows=%7B%22states%22:%7B%22Louisiana%22:%7B%7D%7D%7D&sort-Model=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (last visited Jan. 23, 2024).

50 *U.S. Census: Poverty and Inequality in Louisiana*, La. Budget Project (Sept. 27, 2019), <https://www.labudget.org/2019/09/u-s-census-poverty-and-inequality-in-louisiana/>.

51 Lewis, *supra* note 13.

52 See Megan Wisniewski, *What Is the Gender Wage Gap in Your State?*, U.S. Census Bureau (Mar. 1, 2022), <https://www.census.gov/library/stories/2022/03/what-is-the-gender-wage-gap-in-your-state.html>.

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54 See *Funding Lies: An Investigation into Louisiana's Alternatives to Abortion Initiative*, Lift La. 7 (2022), <https://static1.squarespace.com/static/64b951a07cb4e21d8a4f0322/t/6543dd04f210e472625b23be/1698946310392/Funding+Lies+-+Louisiana%27s+Alternatives+to+Abortion+Initiative+Report+2022.pdf>.

55 *2023 Scorecard on State Health System Performance*, The Commonwealth Fund (June 22, 2023), <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>.

56 *Health Professional Shortage Areas: Primary Care, by County, 2024 – Louisiana*, Rural Health Info. Hub, <https://www.ruralhealthinfo.org/charts/5?state=LA> (last visited Jan. 23, 2024). As of 2021, Louisiana had 160 hospitals. Of these 43 were non-profit, 56 were government run, and 64 were for-profit; Jenny Yang, *Number of hospitals in Louisiana 2021, by ownership type*, Statista (Nov. 30, 2023), <https://www.statista.com/statistics/202844/number-of-hospitals-in-louisiana-by-ownership-type/>.

57 Louisiana has fewer public transportation options than other states, and people without access to a car are disproportionately Black, Latino, and Indigenous. See *Rankings: Transportation*, U.S. News & World Rep., www.usnews.com/news/best-states/rankings/infrastructure/transportation (last visited Jan. 23, 2024); *Car Access: United States vs. Louisiana*, Nat'l Equity Atlas, https://nationalequityatlas.org/indicators/Car_access (last visited Nov. 2, 2023). Even with access to a car, driving conditions are poor in Louisiana. A report found that the state has the 11th worst road infrastructure nationwide, with many of its roads and bridges deemed unsound. See *Report Card for Louisiana Infrastructure 2017*, Am. Soc. of Civ. Eng'rs (2017), https://infrastructurereportcard.org/wp-content/uploads/2021/07/Louisiana-FullReport-LA_2017.pdf.

58 *Contraceptive Access in Louisiana*, Power to Decide (Dec. 2022), <https://powertodecide.org/what-we-do-information/resource-library/contraceptive-access-louisiana>. Reasonable access is measured as at least one health center or provider for every 1,000 women in need of publicly funded contraception. The full range of contraceptive methods refers to all FDA-approved method categories, including IUDs and implants. See *Tip Sheet: Understanding Contraceptive Deserts*, Power to Decide, <https://powertodecide.org/sites/default/files/2022-02/Understanding%20Contraceptive%20Deserts.pdf> (last visited Jan. 23, 2024).

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- 60 See *2021 Report*, *supra* note 57.
- 61 See Jessica Arons, *The Last Clinics Standing*, ACLU, <https://www.aclu.org/issues/reproductive-freedom/abortion/last-clinics-standing> (last visited Jan. 23, 2024); see also *State Facts About Abortion: Louisiana*, Guttmacher Inst., <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana#1> (last visited Jan. 23, 2024).
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- 63 See *Medicaid State Fact Sheets*, KFF (June 29, 2023), <https://www.kff.org/interactive/medicaid-state-fact-sheets/>.
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