Abortion & Ambiguous Policy Language:

Examining Instances of Obstruction to
Reproductive Healthcare Access in a Post-*Roe* Legislative Climate

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Abstract

On June 24th, 2021 the US Supreme Court decided the case, Dobbs v. Jackson Women's Health Organization, overturning *Roe v. Wade* and *Planned Parenthood of Southeastern Pa. v. Casey* and revoking the constitutional right to abortion. Since the passing of *Dobbs,* twenty states have increased restrictions or posed complete bans on abortion, despite the fact that it has been deemed a human right by the World Health Organization.[1] Those working across the reproductive health field, including doctors, researchers, and other medical professionals continue to affirm that abortion is an essential health care practice. Medical professionals regularly observe that restricting access to this care is detrimental to the health and livelihoods of people with the ability to become pregnant, and disproportionately impacts marginalized communities.

With such fast-moving developments in reproductive health legislation, researchers have suggested that changes in the maternal mortality rate can help us understand the severity of this decision. The maternal mortality ratio is defined as the number of maternal deaths in a given time period, region, etc, per 100,000 live births in the same period. This framing only captures deaths resulting "from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy."[2] While a helpful and important unit of measurement, the maternal mortality rate has not been constructed to encompass all of the discrepancies and obstructions of care that may occur in light of *Dobbs;* nor is there sufficient data at this juncture for this metric to fully capture the severity of the issue, as the MMR is published on a 1-4 year delay. As this is

[1]Bearak et al., "Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion."
[2] "Maternal Mortality Ratio (per 100 000 Live Births)."

a fast-moving issue which requires immediate examination, I plan to focus on instances of maternal morbidity as a way of better understanding the damage of confusing and restrictive legislation in real-time. The maternal morbidity refers to "any health condition attributed to and/or aggravated by pregnancy and childbirth that has negative outcomes to the [pregnant person's] well-being."[3] Interpreting the relationship between this new legislation and maternal morbidity allows for a wider net to be cast in regards to the impact of *Dobbs*.

One year after *Dobbs*, there are already numerous narratives of medical professionals frustrated or confused by the gaps and steps now in place to conduct proper care, all under the threat of losing one's medical license, fines, or jail time. I will investigate how the post-*Dobbs* legislative climate, including ambiguous policy language and confusing restrictions, has led to disparities in care, thus impacting instances of maternal morbidity. I plan to analyze the language used in restrictive abortion policies and interview public health professionals on how their work has been affected by the *Dobbs* decision. In order to bring into focus the access discrepancies that have resulted due to new legislation, I will be deploying a reproductive justice framework within my work, which can be defined as "the right to have a child… the right not to have a child… [and] the right to parent the children we have, as well as to control our birthing options."[4] Additionally, I will be focusing specifically on how this impacts marginalized communities. I anticipate finding that in states where abortion has been restricted in the wake of Dobbs are observing an uptick in maternal morbidity, principally in people of color and those with low socioeconomic status. By assessing these narratives of discrepancy in relation to a detailed policy analysis, I aim to provide a holistic understanding of how these restrictions are causing harm,

[3] "What Are Maternal Morbidity and Mortality? | Office of Research on Women's Health."
[4] Ross, SisterSong, et al, *Reproductive Justice Briefing Book*

reinforce clarity in this aspect of public health communication and create suggestions of how to best prevent and fight against disparities in care.

Introduction and Statement of Problem

Through this work, I have produced an extensive analysis of the impact of the language, of phrases, words, within the actual abortion legislation in states where it has become more restricted after *Dobbs v. Jackson Women's Health Organization.* As opposed to comparing where policies are more or less restrictive, this work instead hones in on states where abortion is legal in certain circumstances, but the vague language makes it difficult to provide proper care. Abortion care is a fast-moving and polarized issue, which is greatly reflected in the legislation which has formed after *Roe.* The organization, ANSIRH (Advancing New Standards in Reproductive Health), published the Texas Policy Evaluation Project out of the University of California San Francisco, and detailed the epitome of this issue. Policy makers and practitioners are not on the same page: "[b]ecause the exceptions drafted by legislators are often conflicting and use non-medical terminology, they sow confusion around what kinds of care and procedures health care providers can legally offer when a pregnancy threatens a person's health or life."[5] This confusion is manifesting across states with restrictive legislation, creating "a duality in which providers feel they must serve as agents of the state—reporting any suspicious pregnancy-related issues—or have their license called into question, all while trying to best help their patients."[6] I have decided to focus on the production of this confusion, highlighting the consequences for both patients and providers. Because of the pace with which the legislative climate is shifting and how recent the changes have been passed across the United States, I have

[5] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."
[6] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."

elected to examine the policies themselves as they allow us to better understand the experience of those in this space and intervene in the discourse while working in an evolving situation.

Literature Review

Over the past year, the right to abortion care has been exclusively protected or restricted by state legislatures, despite the fact that the World Health Organization deems access to safe reproductive care a human right.[7] Without this access, those seeking this care are at risk, especially those from marginalized communities.[8] Since the passing of *Dobbs* 25 states have increased restrictions or posed complete bans on abortion.[9] This literature review examines the impact of reproductive health legislation on public health in the US through the analysis of discrepancies of care. It will explore how reproductive health care legislation arrived at this juncture and the disproportionate impact of a post-*Roe* climate.

Historical Understandings & Legislative Incidence

Dobbs v. Jackson, while it is already beginning to produce ramifications, is the product of decades of polarizing discourse surrounding reproductive care. Researcher Caronline Hymel illustrates this political and social climate by periodizing the "*Roe* era," in which abortion was a constitutional right, in Louisiana. To fully interpret this historical period as well as the present, it is necessary to understand the language used by different groups. There are two principle sides explained in this work, the pro-choice movement and the pro-life movement. The pro-choice movement, as its name suggests, believes a person should have the right to choose to be pregnant and/or to care for a child. The pro-life movement believes that life begins at conception, and therefore abortion can be described as murder. It should also be noted that pro-choice activists

[7]Bearak et al., "Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion."
[8] Brandi and Gill, "Abortion Restrictions Threaten All Reproductive Health Care Clinicians."
[9] "Abortion Laws by State - Center for Reproductive Rights."

and researchers, including Hymel, will also describe the pro-life movement as anti-choice or anti-abortion, as the utilization of life has been viewed as a propagandizing force.[10]

Hymel describes three phases of what she describes as "the Abortion Wars," in which anti-abortion (or pro-life) movement participants, including those in state power, reacted to the practicing of and participating in legal abortion care, championed principally by the pro-choice movement. The phases can be broken down into periods categorized into what is described as legislative reactions and direct action. The period 1973-1980 was categorized by legislative action, with the "Abortion War" taking place principally in courthouses between those with political power, mainly, anti-abortion Louisiana state politicians and the federal government. Between the 1980s-1994 however, prevention disseminated to a local level, as direct action became the focal point of the movement.[11] This period is categorized with violence and protest tactics against the clinics themselves and all who participate in this movement. 1994-2016 is specific, as it is a response to *Planned Parenthood v. Casey,* which reaffirmed the right to abortion and brought into question the "undue burdens" associated with abortion restrictions, including waiting periods and parent or partner consent.[12] Because of the new legislation, in addition to direct tactics, there is a resurgence of legislative action. In tracing the reactionary nature of the *Roe*-era Abortion Wars, patterns of legislative action and change are more clearly identifiable.[13] However, the narrative has now shifted, as there is now a state responsibility to uphold abortion care, not the federal government. In June 2022, Louisiana state officials revoked the right to abortion, and it is now criminalized.

[10] "The Hypocrisy of the 'Pro-Life' Movement."
[11] Hymel, "Louisiana's Abortion Wars."
[12] "Last Five Years Account for More Than One-Quarter of All Abortion Restrictions Enacted Since Roe."
[13] Hymel, "Louisiana's Abortion Wars."

The Impact of Criminalization

Abortion is currently criminalized, or has a near-total ban, in twelve states: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia.[14] Researcher Katrina Kimport suggests that the criminalization of abortion will increase surveillance in all populations, but exacerbate surveillance in marginalized groups. Public health is an intersectional issue, and the legislative inhibiting of what is defined as a medical procedure provides different implications for different populations.[15]

Studies from the American Public Health Association suggest that the impact of this criminalization disproportionately harms Black and socially marginalized communities. Taylor Riley from the University of Washington argues that because of the structural racism within the medical industrial complex, which they recognize as a public health crisis, the criminalization of abortion care further exacerbates discrepancies. Riley illustrates that the criminalization of these practices is rooted in white supremacy, as it exacerbates state control and further reinforces medical vulnerability.[16]

Abortion Restrictions: From Mortality to Morbidity

A study conducted by the US Commonwealth Fund found that in 2020, maternal death rates were 62% higher in states with restrictive abortion laws than in states where abortion was more accessible.[17] In the months after *Dobbs,* seven doctors from across the United States published an article explaining the historical correlation between the criminalization of abortion and the maternal mortality rate, urging for state level protections on behalf of their patients.[18]

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[14] "An Overview of Abortion Laws."
[15] Kimport, "Abortion after Dobbs."
[16] Riley et al., "Abortion Criminalization."
[17] Declercq et al., "The U.S. Maternal Health Divide."
[18] Ruha et al., "Criminalization of Abortion Will Lead to Increased Poisoning Illness and Deaths."

This correlation has been further suggested by the International Reproductive Health Journal, which published a study tracing the connection between state-level abortion restrictions and the maternal mortality rate from 1995 to 2017. This study found that the maternal mortality ratio was higher in states with more restrictions than in states with protections and states with neutral legislation.[19] Analysis of data pre-*Dobbs* allows health professionals across the United States to better prepare for the disproportionate impact the loss of constitutional abortion protections is already beginning to have.

One year later, these restrictions are already having notable impacts, both in the United States and globally. Risa Kaufman, the director of Human Rights at the Center for Reproductive Rights, suggests that this decision undermines and threatens other constitutional frameworks across the world. Modern constitutional frameworks create precedents, and the dismantling of a decision spanning five decades is suggested to create reverberating impacts.[20]

There is already an immediate crisis in the availability and accessibility of abortion care. Literature has suggested that social support and social capital are primary factors in the ability to obtain an abortion. Barriers to accessing this care are being exacerbated disproportionately due to discrepancies brought on by restrictions. Those in marginalized groups and those with lower socioeconomic status are at a greater risk of not receiving care due to the current importance of one's social network and economic support in accessing abortion.[21] By surveying 6,674 people across the United States, researchers at the Guttmacher Institute found that abortion patients in restricted states continue to encounter more situational and financial barriers to accessing care.[22]

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[19] Addante et al., "The Association between State-Level Abortion Restrictions and Maternal Mortality in the United States, 1995-2017."
[20] Kaufman et al., "Global Impacts of Dobbs v. Jackson Women's Health Organization and Abortion Regression in the United States."
[21] Dickey et al., "They're Forcing People to Have Children That They Can't Afford."
[22] Jones, Kirstein, and Philbin, "Abortion Incidence and Service Availability in the United States, 2020."

In addition to availability concerns, confusion as to what kind of care can be accessed and where is another Dobbs-era difficulty in obtaining care. There are already many narratives, from both those obtaining reproductive care and those conducting it, of confusion and frustration in relation to how, when, and what kind of care can be provided. In a study of preliminary findings produced by the Texas Policy Evaluation Project, health care providers shared experiences of concern when treating ectopic pregnancies, miscarriage, obstetric complications, and fetal anomalies due to the new legal climate. In each narrative, their ability to administer proper care was hindered due to the possible risk of criminal charges for both the patient and the health professional.[23]

The Supreme Court decision, *Dobbs v. Jackson* has further exacerbated discrepancies in reproductive healthcare across the United States, most principally impacting those in marginalized groups and those with low socioeconomic status.[24] Analyzing the history of reproductive legislation provides clear insight into the polarized nature of our current legislative climate. In addition, from a healthcare perspective, this analysis further outlines the importance of access to safe abortion care and the increased potential for grave health outcomes due to policy restriction. The confusion and limitations of care administration within current state policies suggests there should be further analysis of language as a site of further legislative harm.[25]

Methodology: Researched Policy Analysis & Interviews

Establishing a Problem Definition

As of August, 2023, the Center for Reproductive Rights published a map examining the legislative decisions made throughout the United States post-*Dobbs.* In this study, ten states were

[23] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."
[24] Kimport, "Abortion after Dobbs."
[25] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."

listed as having hostile abortion laws and fifteen where abortion is illegal. The states are as follows: Arizona, Utah, Wyoming, Nebraska, Iowa, Wisconsin, Ohio, Pennsylvania, Virginia, Georgia; and Texas, Oklahoma, Louisiana, Arkansas, Missouri, Tennessee, Mississippi, Louisiana, Alabama, Kentucky, West Virginia, Illinois, South Dakota, North Dakota, and Idaho.[26] The reproductive health legislative climate is fast-paced and currently-shifting in hostile states, and it became quickly apparent that an examination of both categories was necessary.

In order to encompass the extent to which the *Dobbs* decision has impacted medical care, this analysis was conducted in combination with findings from interviews with those on the frontlines of this work. I have elected to include a small series of interviews with frontline medical providers in order to better depict how this legislation is impacting the experience of those providing these services in different restricted states. These interviews were used to identify the qualitative trends within many recent legislative changes and inform my analysis. After conducting these interviews, I was able to cultivate a problem definition for this analysis, which can be surmised as vague or suggestive language which has the possibility of obstructing care.

The three people I spoke with are actively working in the field of abortion care in three different states. Each of the states they practice in have been impacted by these restrictions, and each reported a significant change in their experience of the work. Because of the intense polarization of reproductive care in US culture today, for the safety of these three frontline workers their location, specific practice, and identities will be anonymous. Instead, I have selected to refer to them as Frontline Worker A, B, and C. The states selected to be a part of this case study have no connection to the worker's selected, their interviews merely inform the general trends witnessed across restricted states.

[26] "Abortion Laws by State - Center for Reproductive Rights."

With this information, I analyzed the policies within the twenty-five states which have been labeled hostile or illegal since the *Dobbs* decision. Given that this policy has already been placed in effect, this research follows a retrospective policy analysis model. This policy analysis model examines the interpretation of policy already in place and evaluates its success, allowing for a holistic inspection of the recent changes. However, with the rapid changes and recent establishment of the laws, its effects can only be observed in prospective analysis. In order to produce a retrospective analysis, more information on the impact of *Dobbs* over time would need to have been published. As the decision was only made last year, this study is limited to a prospective examination.[27] However, highlighting the pitfalls already present in the legislation can aid in the instigation of changing these policies, as it provides clear, definable reasons why they may be unsustainable. Since abortion care is such a politicized and polarized topic in the current US social climate, being able to point out instances where legislation is actively hindering care is important not only for governing bodies or medical professionals, but for everyone in a community.

Evaluation Criteria

The problematic language found in this legislation is enabled within a wider mechanism that carries the propensity to obstruct the attainment of abortion care. Most principally, I witnessed instances where exclusionary categories (like gender) are combined with medically imprecise language in a punitive framework, which has the possibility to hinder the ability or proclivity to provide care. In this analysis, I flagged instances where abortion care was technically legal (albeit incredibly restricted), but due to the vague legislation, there is potential for medical providers to be wary, confused, or unsure if they are legally able. In order to define what kinds of obstructions are possible, I consulted ANSIRH's Texas Policy Evaluation Project.

[27] Patton and Sawicki, *Basic Methods of Policy Analysis and Planning*.

This case study documents several narratives from providers and patients where restrictive policy led to harmful obstructions of care.[28] From their narratives, researchers at UCSF were able to outline seven categories in which a majority of the narratives were produced:

1. Obstetric complications in the second trimester prior to fetal viability, including preterm prelabor rupture of membranes, hemorrhage, cervical dilation, and hypertension;
2. Ectopic pregnancy, including cesarean scar ectopic;
3. Underlying medical conditions that made continuing a pregnancy dangerous;
4. Severe fetal anomalies;
5. Early miscarriage;
6. Extreme delays in obtaining abortion care;
7. Delays obtaining medical care unrelated to abortion.

Each of these categories have the propensity to severely increase one's risk for maternal morbidity.[29] Interpreting instances of a higher possibility of maternal morbidity acknowledges a wider range of interactions with the new legislation which would not have been captured by the mortality rate. It should be noted that mortality rate is an important measurement and is integral to the fight against restrictive legislation. However, at this juncture, capturing how these policies disrupt a larger spectrum of experiences, like how a law may further delay obtaining care, can help us better understand the scope of this issue.

While these categories encompass a wide variety of medical situations, they have all been at risk in different states. With these in mind, it became clear that the language patterns that should be flagged in the analysis fell into three categories: language surrounding the health of the pregnant person, language surrounding the health of the fetus, and language surrounding the

[28] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."
[29] "What Are Maternal Morbidity and Mortality? | Office of Research on Women's Health."

responsibility of the provider. As this study focuses specifically on obstruction, examining words or phrases which may delay obtaining abortion care was of course integral.

In discussing outcomes of reproductive care, it is crucial that these instances are viewed through a reproductive justice framework. The reproductive justice framework, defined by Black women and Sister Song Women of Color Reproductive Health Collective, "analyzes how the ability of any [person with the ability to get pregnant] to determine [their] own reproductive destiny is linked directly to the conditions in [their] community… Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny."[30] Rates of morbidity and mortality are disproportionately worse for those in marginalized communities, most principally Black women and Black trans people, meaning that the instances of obstruction in care disproportionately impact marginalized communities at higher rates.[31] It is through a reproductive justice framework that this discrepancy can be best understood, analyzed, and center those most impacted by this legislation.

Case Study Examples:

Case Study Demographics

According to the Guttmacher Institute, Utah houses 812,000 women* of reproductive age (ages 15-49), where Oklahoma houses 903,000, and Mississippi houses 677,000. It should also be noted that 10% of Utah's population of women in this range were born outside of the United States, 8% of Oklahoma's population, and only 3% of Mississippi's population. In Utah, 25% of women* in this state have "incomes below 200% the federal poverty level," where in Oklahoma 38% are below, and in Mississippi a staggering 43% are below the federal poverty level. In Utah, 75% of the population is White, with the next highest being the Black population, at 15%. In

30 Ross, SisterSong, et al, *Reproductive Justice Briefing Book*

31 "Abortion Bans Cause Outsized Harm for People of Color."

Oklahoma, 59% of the population is White, 18% is Black and 13% is Hispanic. In Mississippi, 52% of the population is White, and 40% is Black.[32]

When examining a piece of legislation, it is essential to understand how it may affect different communities and populations. Examining disruptive language within legislation without acknowledging the discrepancies in care already existing would be an insufficient analysis of this impact. Economic status alone is a significant barrier to accessing care, and further limiting this disproportionately impacts those in a state where 40% of the population of women is below the poverty line as opposed to a quarter. Additionally, people of color, most principally Black women and Black trans people, continue to have experience disparities in access and quality of care across the board, including when measuring maternal morbidity. Women of color are more likely to require life saving abortion care because of the discrepancies in access.[33] This discrepancy is essential to center in discussions of morbidity, as instances of aggravated or produced health conditions in pregnant people often lie at intersections of marginalized identities and access. Utah, Oklahoma, and Mississippi have each enacted severe abortion restrictions, yet these constraints are being thrust upon a diverse array of communities differing widely in terms of gender, race, and socioeconomic status.

With intense consideration, I have deduced that it would not be helpful, nor particularly informative, to include the full analysis of all twenty-five states. In order to fully depict what this legislation looks like and how it can be interpreted, I wanted to provide three examples of restrictive or illegal legislation that has the potential to be obstructive. From the twenty-five states, I have selected Utah, Oklahoma, and Missouri. These states depicted have each scored hostile or illegal on the scale created by Center for Reproductive Rights and thus house similar

[32] "An Overview of Abortion Laws."
[33] "Abortion Bans Cause Outsized Harm for People of Color."

restrictive legislation, despite the fact that they are regionally and demographically different.[34] These states have informed how I have come to understand the effects of ambiguity, despite a diversity of circumstances.

Case Study 1: Utah's Abortion Policy

On June 24th, 2022 Title 76 7a of the Utah Criminal Code went into effect, banning all abortion excepting cases of rape, incest, or the threat to the life of the pregnant person. This policy was a "trigger law" established in 2020, meaning that it was already passed by a legislative body, but could not go through until *Roe* was overturned.[35] This policy has been labeled as hostile by the Center for Reproductive rights due to its restrictions in care.[36]

Utah's legislation includes examples of exclusionary/politicized language, medically vague language, and targeting/blame-focused language. Exclusionary and politicized language within these policies are not only medically inaccurate, but can be construed as politically suggestive. Utilizing words that personify or give personhood to the fetus alters the narrative surrounding abortion. This is a practiced anti-choice tactic, and should be regarded within this context. Additionally, utilizing words like "mother" or "woman" in relation to the pregnant person erases those who do not identify as women. This language creates another barrier to accessing care, namely for members of the queer community, which are already facing disproportionate discrepancies in care.[37]

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[34] "Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision."
*It should be noted that "women" is the word used by the Guttenmacher Institute in this report. The utilization of "women" (and not persons with the ability to become pregnant) conflates sex and gender and is thus exclusionary to those who do not identify as women but still have the capacity to become pregnant. I have selected to include "women" as I do not know the scope of who was interviewed or if they provided another option for people to select. As researchers in such an already polarized field, we must do better to encompass all who are impacted, especially and most principally those already pushed to the margins in our society.
[35] "Abortion Laws by State - Center for Reproductive Rights."
[36] "Utah Code Part 76-7a-2."
[37] "The Hypocrisy of the 'Pro-Life' Movement - NARAL Pro-Choice America."

Frontline Worker B, who practices in Utah, has allowed me to disclose the state they work in for this project. In our conversation, they expressed increasing concern for the language used in this policy, as it was incompatible with the actual procedures being performed and was overall insufficient in encompassing the wide-ranging reasons for requiring abortion services. For instance, the term "incompatible with life" in reference to the fetus, has the potential to produce a line of doubt. "Minutes? Hours? Days?" B asked rhetorically in our discussion, "that's really hard. [Policy makers] can't create exceptions [like "incompatibility], [they] have to allow for medical expertise."[38]

Additionally, the phrase, "serious physical risk" also creates a dynamic in which the medical professional must decide what the legislators are considering "serious" or "dangerous" for their patients under threat of criminal charges. Given the fact that most hostile policies only allow abortion in the most medically extreme cases, patients are already on a delay to receive care, meaning that the barometer for what would have been considered a serious risk has shifted without a blueprint. In other words, the question is now what constitutes a serious *enough* risk to perform potentially life-saving care? Frontline Worker B also speculated that "physical" was specific and intentional in the policy, in order to block exceptions for mental health.[39] It is especially interesting to flag this specificity, as the rest of the policy is shrouded in vague language that is obstructing care.

Case Study 2: Oklahoma's Abortion Policy

On March 21st, 2023, in the case Oklahoma Call for Reproductive Justice v. Gentner Drummond (the Attorney General of OK), the Oklahoma Supreme Court recognized that "the

38 Frontline Worker B. "Interview with Frontline Worker B." Jasmine Gates

39 Frontline Worker B. "Interview with Frontline Worker B." Jasmine Gates

Oklahoma Constitution creates an inherent right of a pregnant woman to terminate a pregnancy when necessary to preserve her life." This decision protects the right to abortion in life-threatening situations, which had previously been under threat due to the state's abortion bans, S. B. 612, which had been enacted in 2022.[40] However, this decision upholds the policy that abortion is illegal and punishable with criminal charges, excepting specific circumstances.[41]

Oklahoma's legislative policy is more restrictive than the policy in Utah, however the language used remains similar. Unlike in Utah, Oklahoma legislation also explicitly cites that the risk must be physical and not mental. Additionally, the phrase "serious risk" is used in this legislation, as it was in Utah, despite a difference in policy. This vague wording, compounded with "reasonable medical judgment" can be seen in different policies across restrictive states, each with the potential to alarm and confuse abortion providers.

In Oklahoma, the term "child" is used when describing the fetus, which imposes personhood onto the fetal stage of development. Additionally, the term "woman" is utilized in some sections of this legislation, including 63-1-732. Viable Fetus- Grounds to Abort Procedure- but is not used in sections prior. This inconsistency is interesting to note, especially considering that this section was added in the last two years, whereas in the section added in 2010, uses of the term "female." The term woman was also used in even earlier legislation, added in the 1970s.[42] The inconsistencies in this wording alone is alarming. Sex, which references biological variables, and gender, which references social and cultural experiences and factors, are separate terms, and should not be conflated. The social construct and experience of being a woman cannot and should not exclusively encompass those that have female sex traits.[43] The United States has a

[40] "Attorney General O'Connor Releases Guidance for Law Enforcement After Newest Abortion Law Takes Effect | Oklahoma Attorney General."
[41] Oklahoma Abortion Statues 1979, 2010, 2021
[42] Oklahoma Abortion Statues 1979, 2010, 2021
[43] Krieger, "Genders, Sexes, and Health."

long history of violence against queer and trans persons, but considering the current uptick in legislative erasure of trans persons and healthcare flagging this change in language is especially necessary. Medical practitioners have advised that gendered language, like the use of "woman" or "man" can be harmful and exclusionary in medical settings and should not be included or used as the default, as it furthers the erasure, harm, and isolation of trans patients[44]. Whether or not this discrepancy was politically charged or purposeful, the switching back and forth between the use of the gendered term"woman" and biological term "female" is surprising to view in state-wide legislation.

Case Study: Mississippi Abortion Policy

On June 27th, 2023 the Attorney State General certified Mississippi Code Title 41. SB 41-41-45, banning all abortion except in the case of (reported) rape or incest, or to save the life of the pregnant person. Violation of this code can result in civil and criminal charges for both the practitioner and the patient, including being charged with murder. This was a trigger law initially enacted in 2007.[45]

As viewed in Utah and Oklahoma, Mississippi legislation exclusively utilizes the terms "woman" and "mother" when referring to the pregnant person. The term child is also exclusively used when discussing the fetal stage of development. Unlike in previous examples, in Mississippi there are also terms of blame/targeted language against the pregnant person. Words like "reckless" in regards to the pregnant person fall within the anti-choice narrative crafted to paint those seeking abortion care as "immature" or otherwise socially dissolute.[46] While Frontline Worker A does not work in this state, they have encountered similar restrictions and found this narrative promotes barriers to other life-saving forms of reproductive care, like

[44] Hagen and Galupo, "Trans* Individuals' Experiences of Gendered Language with Health Care Providers."
[45] "Mississippi - Center for Reproductive Rights."
[46] "The Hypocrisy of the 'Pro-Life' Movement - NARAL Pro-Choice America."

instances of fetal complication, which were not "intended" to be hindered by anti-chocie politicians.[47] In similar conversations, Frontline Worker B echoed A's frustration and confusion. B, who works in Utah under similar, albeit less restrictive, constraints to those in Mississippi, viewed this specificity as a mechanism for policy makers attempting to "distinguish between what they think of as the 'good women' and the 'bad women,' further leading to alienation and exclusion.[48]

Mississippi has historically been on the forefront of harsh abortion restrictions, leading the charge on abortion bans, making it no surprise the extremes with which patients in this state are now facing. Mississippi was one of six states to have only one clinic in 2017. Four of the six other states which had one clinic, Kentucky, Missouri, North Dakota, South Dakota, and West Virginia, have all banned abortion post-*Dobbs* (the Center for Reproductive Rights labels Virginia abortion law as "unprotected").[49] When tracing policy, it is essential to contextualize the language within the polarized history it was brought forth.

Analysis: Frontline Workers in Conversation

There is no denying that the landscape of abortion care in the United States is and has historically been, problematic. Despite the varying demographics of each of these states, they are all utilizing exclusionary language and blame-focused rhetoric on top of already restrictive policies. It is already incredibly difficult, if not impossible to attain care, yet marginalized and targeted groups are continuing to be effaced.

In conversation with Frontline Worker A, they noted the impact of restrictions as "people are showing up later than they should be [to attain abortion services]." This narrative is

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47 Frontline Worker A in conversation with Jasmine Gates

48 Frontline Worker B in conversation with Jasmine Gates

49 "The Last Clinics Standing."

particularly notable, as a delay in care is one of the premier factors in the cause of morbidity. According to Worker A, their colleagues across state lines in "sanctuary states," or states with less restrictive policies closest to states where abortion is illegal, are experiencing an uptick in those with what they described as "desired" pregnancies who require termination but were unable to acquire one in their home state.[50] Frontline Worker C echoed the observation of A, noting that their patient volume has doubled in a year.[51] With this observed increase in the delay of care, the toll of morbidity, including hospitalizations, economic burdens, and psychological distress, have the propensity to increase significantly.

Given the threat of criminal and civil penalties to performing an illegal abortion, the vagueness of the legislation surrounding the ability to make these choices is cause for alarm. Frontline Worker B expressed observing an increase in consultation with other providers or specialists before providing care because of the fear, stress, and threat of jail time. "They expect us to do the right thing," B warns, "but a threat of jail time has people wanting to… we have yet to see the full effect of this."[52]

Frontline Worker C affirmed B's observation, noting that "doctors and hospital systems are risking death for their patients where they were previously not risking death." Noting that because of the restrictive policy and lack of clarity, providers are forced into "putting patients lives at risk in a way that was unimaginable in the past."[53]

Among the examples provided, it is clear that the trends with vague language within legislation produce serious effects. Through this analysis in conjunction with the small series of interviews, it is clear that ambiguity has the potential to be utilized as a strategy of exclusion for

50 Frontline Worker B in conversation with Jasmine Gates

51 Frontline Worker C in conversation with Jasmine Gates

52 Frontline Worker B in conversation with Jasmine Gates

53 Frontline Worker C in conversation with Jasmine Gates

those seeking care, and a technique to assign responsibility and liability for providers of this care. Essentially, the vague language, most specifically when involving the "safety" of the pregnant person, creates a dynamic in which medical practitioners are being forced to work in an ambiguous zone, unsure if their practices would be considered legal in the eyes of the law, despite possible violation of the Hippocratic Oath.

Despite that each of the interviewees work in different states and are experiencing the impacts of restrictive policy in different ways, the interviews feel as though they are in communication with one another. It was the similarities in their responses, both in frustration and insights, that grounded my tracing of the trends within the legislation across all states experiencing intense restrictions.

Frontline Worker B expressed that one invisible issue spurred by this vague legislation, is that as providers are those actually having to experience the policy, they are also those best equipped to combat it. Frontline Worker B and their colleagues have all testified against this language in state-level committee hearings because of the harmful and inconsistent wordage, which takes time away from their work at hand.[54] Frontline Worker C echoed this sentiment, expressing frustration at the fast-changing and consistently ambiguous legislation, noting that there are now many extra steps or checks that must be performed. C continued, describing that "it's very hard to balance what's reasonable and the law." Because of how quickly the legislation has been shifting and the intensity of the polarization of this work, Frontline Worker C added that the lawyers working with the practitioners often also don't know how or if a given procedure will meet requirements of the law, as much of the legislation is widely untested.[55]

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54 Frontline Worker B in conversation with Jasmine Gates

55 Frontline Worker C in conversation with Jasmine Gates

.By examining morbidity through the RJ lens, it's apparent that those most impacted by complications are those with access discrepancy. In our interviews, Frontline Worker A and Frontline Worker C echoed the disparities in care observed and highlighted in the Literature Review of this research. Both specifically detailed witnessing racial disparities in care and access in this field, and how these have been exacerbated by restrictive policy. Frontline Worker C detailed that a majority of their patients were African American, which further provided evidence towards the fact that these restrictions are politicized=In linking the impact of this policy to the historical surveillance and systemic medical harm towards Black people in the United States, they questioned, "Who are we really controlling? Who are we really oppressing?"[56] Frontline Worker A also touched on the continued disparity of access to these services, noting that "access is a problem, lack of access is a problem and it always has been. It's not new."[57]

Conclusion

Through this research project, I have turned to policy analysis and frontline narratives in order to argue that newly implemented abortion legislation can impact maternal morbidity. One of the central insights of this paper is that problematic language in newly passed abortion restrictions at the state level has the potential to obstruct the facilitation of reproductive health care and create instances of confusion and fear among providers and creates mechanism of exclusion for patients.This phenomenon may play out differently in various states, but is a part of an overall trend that, as my interviewees observe, resonates across state lines and regions. The implications of this for reproductive justice are severe, as it obstructs autonomy by restricting access to services while exacerbating the risk of morbidity, thus complicating the conditions with which reproductive rights can be achieved. Frontline Worker B surmised their frustration in their

56 Frontline Worker C in conversation with Jasmine Gates

57 Frontline Worker A in conversation with Jasmine Gates

concluding remark, warning, “you can’t legislate medicine [without practitioners]. They’re gonna hurt a lot of people.”[58]

58 Frontline Worker in conversation with Jasmine Gates

Bibliography

"Abortion Bans Cause Outsized Harm for People of Color." Accessed September 7, 2023. https://www.apa.org/monitor/2023/06/abortion-bans-harm-people-of-color.

"Abortion Laws by State - Center for Reproductive Rights." Accessed September 4, 2023. https://reproductiverights.org/maps/abortion-laws-by-state/.

Addante, Amy N., David L. Eisenberg, Mark C. Valentine, Jennifer Leonard, Karen E. Joynt Maddox, and Mark H. Hoofnagle. "The Association between State-Level Abortion Restrictions and Maternal Mortality in the United States, 1995-2017." *Contraception* 104, no. 5 (November 2021): 496–501. https://doi.org/10.1016/j.contraception.2021.03.018.

"Attorney General O'Connor Releases Guidance for Law Enforcement After Newest Abortion Law Takes Effect | Oklahoma Attorney General." Accessed September 4, 2023. https://www.oag.ok.gov/articles/attorney-general-o%E2%80%99connor-releases-guidance-law-enforcement-after-newest-abortion-law-takes.

Bearak, Jonathan, Anna Popinchalk, Bela Ganatra, Ann-Beth Moller, Özge Tunçalp, Cynthia Beavin, Lorraine Kwok, and Leontine Alkema. "Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates from a Comprehensive Model for 1990–2019." *The Lancet Global Health* 8, no. 9 (September 2020): e1152–61. https://doi.org/10.1016/S2214-109X(20)30315-6.

Brandi, Kristyn, and Puneet Gill. "Abortion Restrictions Threaten All Reproductive Health Care Clinicians." *American Journal of Public Health* 113, no. 4 (April 2023): 384–85. https://doi.org/10.2105/AJPH.2023.307239.

Declercq, Eugene, Ruby Barnard-Mayers, Laurie Zephyrin, and Kay Johnson. "The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions," 2022. https://doi.org/10.26099/Z7DZ-8211.

Dickey, Madison S., Elizabeth A. Mosley, Elizabeth A. Clark, Sarah Cordes, Eva Lathrop, and Lisa B. Haddad. "'They're Forcing People to Have Children That They Can't Afford': A Qualitative Study of Social Support and Capital among Individuals Receiving an Abortion in Georgia." *Social Science & Medicine (1982)* 315 (December 2022): 115547. https://doi.org/10.1016/j.socscimed.2022.115547.

Frontline Worker A in discussion with Jasmine Gates, June 2023.

Frontline Worker B in discussion with Jasmine Gates, June 2023.

Frontline Worker C in discussion with Jasmine Gates, June 2023.

Grossman, Daniel, Carole Joffe, Shelly Kaller,Katrina Kimport, Elizabeth Kinsey,Klaira Lerma, Natalie Morris, Kari White. *Care Post-Roe: Documenting Cases of Poor-Quality Care since the Dobbs Decision.*"Preliminary Findings, May 2023. Texas Evaluation Project with Advancing New Standards in Reproductive Health (ANSIRH). University of California San Francisco.

Guttmacher Institute. "An Overview of Abortion Laws," March 9, 2016. https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

Guttmacher Institute. "Last Five Years Account for More Than One-Quarter of All Abortion Restrictions Enacted Since Roe," March 18, 2016. https://www.guttmacher.org/article/2016/01/last-five-years-account-more-one-quarter-all-abortion-restrictions-enacted-roe.

Hagen, D. Brienne, and M. Paz Galupo. "Trans* Individuals' Experiences of Gendered Language with Health Care Providers: Recommendations for Practitioners." *International Journal of Transgenderism* 15, no. 1 (January 2, 2014): 16–34. https://doi.org/10.1080/15532739.2014.890560.

Hymel, Caroline. "Louisiana's Abortion Wars: Periodizing the Anti-Abortion Movement's Assault on Women's Reproductive Rights, 1973-2016." *Louisiana History: The Journal of the Louisiana Historical Association* 59, no. 1 (2018): 67–105.

Jones, Rachel K., Marielle Kirstein, and Jesse Philbin. "Abortion Incidence and Service Availability in the United States, 2020." *Perspectives on Sexual and Reproductive Health (University of Ottawa)*, November 20, 2022. https://www.guttmacher.org/article/2022/11/abortion-incidence-and-service-availability-united-states-2020.

Kaufman, Risa, Rebecca Brown, Catalina Martínez Coral, Jihan Jacob, Martin Onyango, and Katrine Thomasen. "Global Impacts of Dobbs v. Jackson Women's Health Organization and Abortion Regression in the United States." *Sexual and Reproductive Health Matters* 30, no. 1 (2022): 22–31.

Kimport, Katrina. "Abortion after Dobbs: Defendants, Denials, and Delays." *Science Advances* 8, no. 36 (September 9, 2022): eade5327. https://doi.org/10.1126/sciadv.ade5327.

Krieger, Nancy. "Genders, Sexes, and Health: What Are the Connections—and Why Does It Matter?" *International Journal of Epidemiology* 32, no. 4 (August 2003): 652–57. https://doi.org/10.1093/ije/dyg156.

"Maternal Mortality Ratio (per 100 000 Live Births)." Accessed September 4, 2023. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26.

"Mississippi - Center for Reproductive Rights." Accessed September 4, 2023.

https://reproductiverights.org/maps/state/mississippi/.

NARAL Pro-Choice America. “The Hypocrisy of the ‘Pro-Life’ Movement.” Accessed June 20, 2023. https://www.prochoiceamerica.org/campaign/the-hypocrisy-of-the-pro-life-movement/.

Oklahoma Abortion Statues, 1979, 2010, 2021.

Patton, Carl V., and David S. Sawicki. *Basic Methods of Policy Analysis and Planning*. 3rd ed. Upper Saddle River, N.J: Pearson, 2013.

Riley, Taylor, Yasaman Zia, Goleen Samari, and Mienah Z. Sharif. “Abortion Criminalization: A Public Health Crisis Rooted in White Supremacy.” *American Journal of Public Health* 112, no. 11 (November 2022): 1662–67. https://doi.org/10.2105/AJPH.2022.307014.

Ross, L., & SisterSong Women of Color Reproductive Health Collective. (2007). What is Reproductive Justice? In *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and social change*. essay.

Ruha, Anne-Michelle, Kavita Babu, Jennifer Carey, Andrew Stolbach, Meghan B. Spyres, Ayrn D. O’Connor, and Jeffrey Brent. “Criminalization of Abortion Will Lead to Increased Poisoning Illness and Deaths.” *Journal of Medical Toxicology: Official Journal of the American College of Medical Toxicology* 18, no. 3 (July 2022): 185–86. https://doi.org/10.1007/s13181-022-00902-6.

“The Hypocrisy of the ‘Pro-Life’ Movement - NARAL Pro-Choice America.” Accessed June 20, 2023.https://www.prochoiceamerica.org/campaign/the-hypocrisy-of-the-pro-life-movement/.

“The Last Clinics Standing.” Accessed September 4, 2023. https://www.aclu.org/issues/reproductive-freedom/abortion/last-clinics-standing.

“Utah Code Part 76-7a-2.” Accessed September 4, 2023. https://le.utah.gov/xcode/Title76/Chapter7A/76-7a-P2.html?v=C76-7a-P2_2020051220200512.

“What Are Maternal Morbidity and Mortality? | Office of Research on Women’s Health.” Accessed September 4, 2023. https://orwh.od.nih.gov/mmm-portal/what-mmm.

Appendix

***KEY**: Examples of exclusionary/politicized language (yellow), medically vague language (green), and targeting/blame-focused language (purple)*

Title 76 7a of the Utah Criminal Code[59]

Utah Code

Effective 6/24/2022

Part 2
Prohibition

76-7a-201 Abortion prohibition -- Exceptions -- Penalties.
(1) An abortion may be performed in this state only under the following circumstances:
(a) the abortion is necessary to avert:
(i) the death of the woman on whom the abortion is performed; or
(ii) a serious physical risk of substantial impairment of a major bodily function of the woman on whom the abortion is performed;
(b) subject to Subsection (3), two physicians who practice maternal fetal medicine concur, in writing, in the patient's medical record that the fetus has a fetal abnormality that in the physicians' reasonable medical judgment is incompatible with life; or
(c) the unborn child has not reached 18 weeks gestational age and:
(i)
(A) the woman is pregnant as a result of:
(I) rape, as described in Section 76-5-402;
(II) rape of a child, as described in Section 76-5-402.1; or
(III) incest, as described in Subsection 76-5-406(2)(j) or Section 76-7-102; or
(B) the pregnant child is under the age of 14; and
(ii) before the abortion is performed, the physician who performs the abortion:
(A) for an abortion authorized under Subsection (1)(c)(i)(A), verifies that the incident described in Subsection (1)(c)(i)(A) has been reported to law enforcement; and
(B) if applicable, complies with requirements related to reporting suspicions of or known child abuse.
(2) An abortion may be performed only:
(a) by a physician; and
(b) in a hospital, unless it is necessary to perform the abortion in another location due to a medical emergency.
(3) If the unborn child has been diagnosed with a fetal abnormality that is incompatible with life, at the time of the diagnosis, the physician shall inform the woman, both verbally and in writing, that perinatal hospice services and perinatal palliative care are available and are an alternative to abortion.
(4) A person who performs an abortion in violation of this section is guilty of a second degree felony.
(5) In addition to the penalty described in Subsection (4), the department may take appropriate corrective action against a health care facility, including revoking the health care facility's license, if a violation of this chapter occurs at the health care facility.
(6) The department shall report a physician's violation of any provision of this section to the state entity that regulates the licensing of a physician.
(7) A physician who performs an abortion under Subsection (1)(c) shall:
(a) maintain an accurate record as to the manner in which the physician conducted the verification under Subsection (1)(c)(ii)(A); and
(b) report the information described in Subsection (7)(a) to the department in accordance with Section 76-7-313.

Amended by Chapter 158, 2023 General Session

Page 1

Oklahoma Abortion Statues: 1979, 2010, 2021[60]

the life or health of the pregnant woman than another available method or technique.

E. An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for the child. During the performance or inducing of the abortion, the physician performing it, and subsequent to it, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the child, in the same manner as if the child had been born naturally or spontaneously. The requirement of the attendance of a second physician may be waived when in the best judgment of the attending physician a medical emergency exists and further delay would result in a serious threat to the life or physical health of the pregnant woman. Provided that, under such emergency circumstances and waiver, the attending physician shall have the duty to take all reasonable steps to preserve the life and health of the child before, during and after the abortion procedure, unless such steps shall, in the best medical judgment of the physician, present a significantly greater danger to the life or health of the pregnant woman.

F. Any person violating subsection A of this section shall be guilty of homicide.

Added by Laws 1978, c. 207, § 4, eff. Oct. 1, 1978; Amended by Laws 1997, c. 133, § 524, eff. July 1, 1999.

§63-1-733. Self-Induced Abortions

No woman shall perform or induce an abortion upon herself, except under the supervision of a duly licensed physician. Any physician who supervises a woman in performing or inducing an abortion upon herself shall fulfill all the requirements of this article which apply to a physician performing or inducing an abortion.

Added by Laws 1978, c. 207, § 5, eff. Oct. 1, 1978; Amended by Laws 1997, c. 133, § 525, eff. July 1, 1999.

§63-1-734. Live-born fetus - Care and treatment

A. No person shall purposely take the life of a child born as a result of an abortion or attempted abortion which is alive when partially or totally removed from the uterus of the pregnant woman.

B. No person shall purposely take the life of a viable child who is alive while inside the uterus of the pregnant woman and may be removed alive therefrom without creating any significant danger to her life or health.

C. Any person who performs, induces, or participates in the performance or inducing of an abortion shall take all reasonable measures to preserve the life of a child who is alive when partially or totally removed from the uterus of the pregnant woman, so long as the measures do not create any significant danger to her life or health.

D. Any person violating this section shall be guilty of homicide.

Added by Laws 1978, c. 207, § 6, eff. Oct. 1, 1978; Amended by Laws 1997, c. 133, § 526, eff. July 1, 1999.

§63-1-735. Sale of Child, Unborn Child or Remains of Child - Experiments

A. No person shall sell a child, an unborn child or the remains of a child or an unborn child resulting from an abortion. No person shall experiment upon a child or an unborn child resulting from an abortion or which is intended to be aborted unless the experimentation is therapeutic to the child or unborn child.

B. No person shall experiment upon the remains of a child or an unborn child resulting from an abortion. The term "experiment" does not include autopsies performed according to law.

Added by Laws 1978, c. 207, § 7, eff. Oct. 1, 1978.

§63-1-736. Hospitals - Advertising of Counseling to Pregnant Women

No hospital in which abortions are performed or induced shall advertise or hold itself out as also providing counseling to pregnant women, unless:

1. The counseling is done by a licensed physician, a licensed registered nurse or by a person holding at least a bachelor's degree from an accredited college or university in psychology or some similarly appropriate field;

2. The counseling includes factual information, including explicit discussion of the development of the unborn child; and

3. The counseling includes a thorough discussion of the alternatives to abortion and the availability of agencies and services to assist her if she chooses not to have an abortion.

Added by Laws 1978, c. 207, § 8, eff. Oct. 1, 1978.

§63-1-737. Hospitals Which May Perform Abortions

An abortion otherwise permitted by law shall be performed only in a hospital, as defined in this article, which meets standards set by the Department. The Department shall develop and promulgate reasonable standards relating to abortions.

Added by Laws 1978, c. 207, § 9, eff. Oct. 1, 1978.

§63-1-737.4. Requiring Signing in Abortion Facilities

A. Any private office, freestanding outpatient clinic, or other facility or clinic in which abortions, other than abortions necessary to prevent the death of the pregnant female, are performed, induced, prescribed for, or where the means for an abortion are provided shall conspicuously post a sign in a location defined in subsection C of this section so as to be clearly visible to patients, which reads:

Notice: It is against the law for anyone, regardless of his or her relationship to you, to force you to have an abortion. By law, we

[60] Oklahoma Abortion Statues 1979, 2010, 2021

a. the female upon whom an abortion was performed or attempted to be performed in violation of this section,

b. any person who is the spouse, parent, sibling, or guardian of, or current or former licensed health care provider of, the female upon whom an abortion has been performed in violation of this section,

c. a district attorney with appropriate jurisdiction, or

d. the Attorney General.

2. The injunction shall prevent the abortion provider from performing further abortions in violation of this section in this state.

3. Any person who knowingly violates the terms of an injunction issued in accordance with this section shall be subject to civil contempt and shall be fined Ten Thousand Dollars ($10,000.00) for the first violation, Fifty Thousand Dollars ($50,000.00) for the second violation, and One Hundred Thousand Dollars ($100,000.00) for the third violation and for each succeeding violation. The fines shall be the exclusive penalties for civil contempt pursuant to this paragraph. Each performance or attempted performance of an abortion in violation of the terms of an injunction is a separate violation. These fines shall be cumulative. No fine shall be assessed against the female upon whom an abortion is performed or attempted.

4. A pregnant female upon whom an abortion has been performed in violation of this section, or the parent or legal guardian of the female if she is an unemancipated minor, may commence a civil action against the abortion provider for any knowing or reckless violation of this section for actual and punitive damages.

D. An abortion provider who knowingly or recklessly performed an abortion in violation of this section shall be considered to have engaged in unprofessional conduct for which the certificate or license of the provider to provide health care services in this state shall be suspended or revoked by the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners.

E. In every proceeding or action brought under this section, the anonymity of any female upon whom an abortion is performed or attempted shall be preserved unless she gives her consent to such disclosure. The court, upon motion or sua sponte, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the female's identity from public disclosure. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone who brings an action under subsection B of this section shall do so under a pseudonym.

Added by Laws 2010, c. 46, § 1, emerg. eff. April 2, 2010.

§63-1-731.3. Detectable Heartbeat – Grounds to Abort

A. No person shall perform or induce an abortion upon a pregnant woman without first detecting whether or not her unborn child has a heartbeat. No person shall perform or induce an abortion upon a pregnant woman after such time as her unborn child has been determined to have a detectable heartbeat except if, in reasonable medical judgment, she has a condition that so complicates her medical condition that it necessitates the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition may be determined to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

B. A "detectable heartbeat" shall mean embryonic or fetal cardiac activity or the steady or repetitive rhythmic contract of the heart within the gestational sac.

C. "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

D. Any person violating subsection A of this section shall be guilty of homicide.

Laws 2021, HB 2441, c. 219, § 1, eff. November 1, 2021.

§63-1-732. Viable fetus - Grounds to Abort - Procedure

A. No person shall perform or induce an abortion upon a pregnant woman after such time as her unborn child has become viable unless such abortion is necessary to prevent the death of the pregnant woman or to prevent impairment to her health.

B. An unborn child shall be presumed to be viable if more than twenty-four (24) weeks have elapsed since the probable beginning of the last menstrual period of the pregnant woman, based upon either information provided by her or by an examination by her attending physician. If it is the judgment of the attending physician that a particular unborn child is not viable where the presumption of viability exists as to that particular unborn child, then he shall certify in writing the precise medical criteria upon which he has determined that the particular unborn child is not viable before an abortion may be performed or induced.

C. No abortion of a viable unborn child shall be performed or induced except after written certification by the attending physician that in his best medical judgment the abortion is necessary to prevent the death of the pregnant woman or to prevent an impairment to her health. The physician shall further certify in writing the medical indications for such abortion and the probable health consequences if the abortion is not performed or induced.

D. The physician who shall perform or induce an abortion upon a pregnant woman after such time as her unborn child has become viable shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child, unless he shall first certify in writing that in his best medical judgment such method or technique shall present a significantly greater danger to

Excerpt from Mississippi Code Title 41. SB 41-41-45:[61]

(1) As 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.

(2) No abortion shall be performed or induced in the State of Mississippi, except in the case where necessary for the preservation of the mother's life or where the pregnancy was caused by rape.

(3) For the purposes of this section, rape shall be an exception to the prohibition for an abortion only if a formal charge of rape has been filed with an appropriate law enforcement official.

(4) Any person, except the pregnant woman, who purposefully, knowingly or recklessly performs or attempts to perform or induce an abortion in the State of Mississippi, except in the case where necessary for the preservation of the mother's life or where the pregnancy was caused by rape, upon conviction, shall be punished by imprisonment in the custody of the Department of Corrections for not less than one (1) year nor more than ten (10) years.

[61] *Mississippi Code Title 41. SB 41-41-45*