From Constitutional Protections to Medical Ethics: The Future of Pregnant Patients' Medical Self-Determination Rights After *Dobbs*

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Abstract: This article argues that the Supreme Court's decision in *Dobbs* is likely to impact medical decision-making by pregnant patients in a variety of contexts. Of particular concern are situations where a patient declines treatment recommended for its potential benefit to the fetus and situations where treatment is withheld due to potential risk to the fetus. The Court's elevation of fetal interests, combined with a history of courts using abortion jurisprudence to guide their reasoning in compelled treatment cases, means that *Dobbs* has the potential to limit patient autonomy in a wide array of clinical settings. The article calls on professional medical associations to issue ethical guidance affirming the duty to respect the medical self-determination of pregnant patients.

Introduction

The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* is likely to dramatically limit pregnant patients' rights to direct the course of their medical care far beyond abortion. Because fewer legal protections exist for patient autonomy after *Dobbs*, the health care profession must establish clear ethical guidance affirming the duty to respect medical self-determination during pregnancy.

I: *Dobbs* and Medical Decision-Making

Pregnancy impacts the body in significant, sometimes unpredictable, and often long-lasting ways. It can strain otherwise healthy bodies and cause unexpected complications that pose risks to both maternal and fetal well-being. Pregnant people may also need care for routine ailments and acute conditions unrelated to pregnancy. By elevating the state's interest in potential fetal life, *Dobbs* could disrupt pregnant patients' medical decision-making in various contexts.

First, providers may rely on *Dobbs* to justify overriding a patient's refusal of medical treatment that might benefit the fetus, even if that treatment poses risks to the pregnant patient. This most often arises during labor and delivery when the physician and patient

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disagree about the value of interventions intended to expedite or manage labor, or whether to opt for cesarean surgery. Providers may also feel empowered by *Dobbs* to compel pregnant patients to unwanteduntil safe delivery of the fetus is possible.

Second, health care providers may prevent patients from accessing health care that involves risk to a fetus, or where there is unfounded perception of fetal risk. Given medical uncertainty in the largely untested domain of fetal risk, pregnant patients could be denied treatment, including cancer treatment,[1] addiction medicine,[2] x-rays,[3] or anesthesia.[4]

In both situations, providers may mistakenly perceive that the Court's view of potential fetal life requires them to either provide or withhold medical treatment from pregnant patients to protect fetal well-being. This, however, is a misreading of *Dobbs* and a misinterpretation of providers' legal and ethical obligations; *Dobbs* imposes no such requirement.

The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* will dramatically limit pregnant patients' rights to direct the course of their medical care far beyond abortion. Because fewer legal protections exist for patient autonomy after *Dobbs*, the health care profession must establish clear ethical guidance affirming the duty to respect medical self-determination during pregnancy.

II: The Influence of Abortion Jurisprudence in Compelled Treatment Cases

When conflicts arise regarding pregnant patients' right to refuse treatment, courts have frequently turned to abortion jurisprudence for guidance, relying on *Roe* and *Casey*[5] to conclude that the state's interest in fetal life trumps the woman's autonomy interests in determining her medical treatment. While these cases should not influence legal analysis regarding common law and constitutional rights of bodily integrity,[6] recognizing their influence illuminates *Dobbs'* likely impact on future disputes.

A. Misplaced Reliance on Abortion Law

As recognized by Professor Margo Kaplan over a decade ago, abortion jurisprudence and compelled treatment cases are an imperfect fit.[7] Kaplan convincingly argued that "the state interest in fetal life is not implicated in the same manner" in the two types of cases.[8] When a patient seeks an abortion, the purpose of the medical procedure is to terminate fetal life. In contrast, decisions about medical care during pregnancy involve "differences of opinion in how to achieve a live birth," as well as medical uncertainty regarding fetal risk.[9] In compelled treatment cases, both the mother and the physician have the fetus' interests in mind, but they disagree about how to balance those interests against competing concerns.[10] As a matter of ethical principles, abortion and treatment refusal cases differ in both intent and effect.

Some courts have relied on similar reasoning to reject the idea that abortion jurisprudence should impact their decisions. In *In re A.C.*, an appellate court disavowed a trial court's order to perform an involuntary Cesarean surgery on a patient with cancer, where the procedure resulted in the death of both patient and baby.[11] It wrote that abortion law was irrelevant because "[t]he issue … is not whether A.C. … should have a child but, rather, who should decide how that child should be delivered."[12] An Illinois appellate court in *In Re Baby Boy Doe* reached the same conclusion, holding that the state interest in regulating abortion to preserve the life of a viable fetus "does not translate into the proposition that the state may intrude upon the woman's right to remain free from unwanted physical invasion of her person [via Cesarean surgery] when she chooses to carry her pregnancy to term."[13] Likewise, in a case considering pregnancy limitations on advance directives for end-of-life treatment, the district court in *Almerico v. Denney* distinguished the Supreme Court's abortion decisions, which "only *limit* the choices of women who seek to terminate a pregnancy," from the Idaho statute that "*completely denies* the choices of women … and forces medical treatment on them."[14]

B. Roe's Impact in Compelled Treatment Cases

Nevertheless, many courts that have authorized involuntary treatment of pregnant patients rely on the principles established in abortion cases. Typically, the requested medical intervention is Cesarean surgery for delivery of a viable fetus, which courts justified under *Roe*, noting the state interest in protecting

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fetal life became compelling at viability. In *Jefferson v. Griffin Spalding Hospital*, for example, the Georgia Supreme Court considered a petition to compel treatment for a patient in her thirty-ninth week of pregnancy with complete placenta previa who refused on religious grounds to consent to a Cesarean or blood transfusion.[15] The court authorized the hospital to perform these treatments if needed, incorrectly citing *Roe* for the proposition that "a viable unborn child has the right under the U.S. Constitution to the protection of the State[.]"[16] The Superior Court of the District of Columbia adopted similar reasoning in *In Re Madyun* when it granted a hospital's petition to perform a Cesarean on a patient whose delivery was not progressing but who declined surgery due to religious beliefs.[17] A similar outcome resulted in Florida in *Pemberton v. Tallahassee Memorial Regional Medical Center* for a patient who sought vaginal birth after Cesarean. The court held that under *Roe*, "the state's interest in preserving the life of the fetus outweighs the mother's own constitutional interest in determining whether she will bear a child."[18] Notably, in all of these cases, the patients claimed not just a right to bodily integrity but also a constitutionally protected right to religious freedom.

More troublingly, *Roe* has been used to justify intervention even for pre-viable fetuses. In *Application of Jamaica Hospital*, a New York court ordered a blood transfusion for a patient who was eighteen weeks pregnant; both she and her fetus were at serious risk of death.[19] The court emphasized the state's "significant interest in protecting the potential of human life," finding that while the fetus was not yet viable, the state's "highly significant interest in protecting the life of a mid-term fetus [nevertheless] outweighs the patient's right to refuse[.]"[20]

C. The Implications of Dobbs *for Medical Self-Determination*

Dobbs strengthens fetal rights to a degree that will further restrict pregnant people's rights to make autonomous health care decisions. In distinguishing the right to abortion from other substantive due process rights (like contraception and marriage), the Court emphasized that only abortion "destroy[s] a 'potential life.'"[21] In doing so, the Court set a dangerous precedent for cases where patients refuse medical treatment recommended to reduce fetal risk. As the dissent noted, "The majority thinks that a woman has *no* liberty or equality interest in the decision to bear a child, so a State's interest in protecting fetal life necessarily prevails."[22] Other health care decisions that pose a risk of fetal harm could likewise be unprotected.[23]

Compelled treatment cases decided before *Roe* reflect the likely reality after *Dobbs*. In *Raleigh-Fitkin*, a hospital sought to compel a patient who was 32 weeks pregnant to receive a blood transfusion.[24] While recognizing that a competent adult has an interest in refusing treatment, the court held that "the unborn child is entitled to the law's protection" and ordered the transfusion, effectively subsuming the living woman under the interests of a 32-week fetus.[25]

Dobbs' impact on decision-making during pregnancy is likely to be even more expansive and deepen existing health inequity. First, new restrictions on abortion access will increase the number of complex pregnancies carried to term, as fewer people with medical conditions that make pregnancy risky will be able to abort. Access limitations will also impact patients with conditions that may not be identified until later in pregnancy — like lethal fetal anomalies, severe preeclampsia, or premature rupture of membranes. More patients will be faced with difficult decisions about how to balance protection of their own health and that of the fetus they hope to bring to term.

Second, these concerns are not limited to patients living in states with restrictive abortion laws. Even in states with strong legislative protections for reproductive rights, courts will be bound by the principles set by *Dobbs* — namely, that pregnant persons have no constitutional right to make choices about their bodies, and that the state's interest in fetal life may legitimately prevail over patients' wishes. Only in the few states that have enshrined the right to reproductive decision-making in their constitutions (or choose to do so by statute) will courts have a firm legal basis for prioritizing maternal autonomy over fetal interests in compelled treatment cases.

Finally, research on coercion and mistreatment in obstetrics suggests that *Dobbs* will infringe medical decision-making during pregnancy differently across racial, ethnic, and socioeconomic categories. The medical oppression of Black, Latina, Indigenous, and other patients of color has persisted since the antebellum period, particularly in the context of obstetric care and research.[26] Recent scholarship exploring U.S. birthing experiences reports more frequent mistreatment of Black patients and other patients of color.[27] And because providers' responses to patients who decline recommended treatment may vary based on race,[28] it is likely that requests for legal intervention will be disproportionately distributed as well.[29]

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III: Looking to Medical Ethics and Professional Guidelines for Autonomy Protections

Dobbs shifts the baseline for protection of pregnant people's health and safety, not only in terms of who will be forced to continue pregnancies but also in terms of patients' ability to make medical decisions that reflect their best judgment about the risks and benefits of treatment. With fewer legal protections to ensure that pregnant patients can exercise decisional autonomy, the responsibility will fall to health care professionals to follow medical ethics and protect patient rights.

Medical ethics dictate that physicians respect patients' autonomy interests in making medical decisions with intentionality, with substantial understanding, and free from controlling influences.[30] The American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics states that "[p]regnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life."[31] ACOG also "opposes the use of coerced medical interventions for pregnant women," including via judicial intervention.[32] Distinguishing between the "beneficence-based *motivations* toward the fetus of a woman who presents for obstetric care" and a "beneficence-based *obligation* to the pregnant woman who is the patient," ACOG notes that interventions on behalf of the fetus necessarily raise concerns about pregnant patients' bodily autonomy, as Joan Krause discusses in this symposium.[33]

Professional medical organizations and specialty associations — including, but not limited to, groups focused on oncology, emergency medicine, and anesthesia — should reaffirm their commitment to respect the autonomy of patients during pregnancy.[34] To establish that standard of care treatment prioritizes pregnant patients' interests over fetal interests, they should issue guidance opposing practices that withhold otherwise recommended treatment because it poses a risk to the fetus, and opposing compelled treatment for the benefit of the fetus. Clinical practice guidelines should clearly state that prognostic uncertainty makes it impossible to "determine with certainty when a situation will cause harm to the fetus" or "to guarantee that the pregnant woman will not be harmed by the medical intervention," and should recommend counseling that enables the pregnant person to balance potential risks and benefits informed by their own values and relational interests.[35] Defining the standard of care in this way will help protect physicians practicing in abortion-restrictive jurisdictions, especially if hospitals also adopt analogous institutional policies. While *Dobbs* permits states to sanction providers for participation in abortion, it does not directly speak to other medical decisions that pose only potential risks to the fetus.

Likewise, ACOG should revise its ethics opinions and develop specific guidance on navigating treatment refusals after *Dobbs*. For example, in a current opinion, ACOG explicitly states that the physician's "primary duty is to the pregnant woman" and provides as an illustration a pregnant woman with severe cardiopulmonary disease whose physician "may recommend terminating the pregnancy" in the face of a life-threatening condition.[36] Because physicians in abortion-restrictive jurisdictions may face legal risk if they offer such counseling, ACOG should offer clear guidance regarding the ethic of care, while being mindful of laws that penalize aiding and abetting abortions.

As Pasha et al. argue in their article for this symposium, health care providers should not encounter these ethical precepts for the first time in a clinical setting.[37] At an early stage in didactic teaching, residents must learn that pregnancy does not alter a physician's duty to respect patient autonomy or the ability of pregnant patients to exercise self-determination in medical decision-making. Instruction on this dimension of medical ethics should continue throughout medical school and residency — in specialties beyond obstetrics — as a fundamental component of preparing new physicians to serve their patients' best interests. Medical schools and educators should disentangle state-imposed restrictions on abortion care and counseling from physicians' ethical duty to promote patient autonomy by facilitating patients' informed consent to potential treatment. Variations in abortion laws increase the burden on health care professionals, and professional organizations should aid clinicians in navigating this complicated terrain.

Finally, state medical boards should support and enforce regulations that authorize disciplinary action against physicians who violate ethical norms, including the prohibition on treating patients without consent. Boards have authority to respond to complaints by patients who are compelled to accept unwanted treatment based on provider concern for fetal well-being or denied needed medical treatment due to provider concern about fetal risk. Such state disciplinary actions could strengthen providers' understanding that respect for the autonomy of pregnant patients is central to their ethical duty of care.

Conclusion

Courts have relied wrongly on *Roe* and *Casey* to justify overriding treatment refusals by pregnant women,

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and such fetal-consequentialist legal reasoning is likely to become more common after *Dobbs*. In light of these weakened legal protections, the medical profession has a duty to ensure that clinicians promote pregnant patients' rights to self-determination. Professional organizations must issue clear guidance about autonomy-enhancing approaches to medical treatment during pregnancy, and licensure boards must intervene when providers disregard autonomous decisions made by pregnant patients.

Note

The authors have no conflicts to disclose.

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13. 632 N.E.2d 326, 334 (Ill. App. 1994). See also *In re Brown*, 689 N.E.2d 397, 405 (Ill. App. 1997) (distinguishing between abortion and refusal of blood transfusion, and stating: "This is not an abortion case.").
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18. 66 F. Supp. 2d 1247, 1251 (N.D. Fla. 1999).
19. 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985).
20. *Id.*
21. 124 S.Ct. 2228, 2261 (2022).
22. *Id.* at 2323, note 1 (dissenting opinion).
23. This could extend to patients' dietary choices, choice of sleeping positions, and use of technology. See A.D. Lyerly et al., "Risk and the Pregnant Body," *Hastings Center Report* 39, no. 6 (2009): 34–42.
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35. *Id.*
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