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Michael S. Sinha

Anna Krotinger

Maya A. Phan

Louise P. King

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Michael S. Sinha

Saint Louis University-School of Law

Anna Krotinger

*3rd year medical student- Harvard Medical School
Graduate- Harvard Medical School Center for Bioethics*

Maya A. Phan

3rd year law student- Saint Louis University-School of Law

Louise P. King

Harvard Medical School Center for Bioethics

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REPRODUCTIVE RIGHTS AND MEDICO-LEGAL EDUCATION POST-DOBBS: A FIRESIDE CHAT

MICHAEL S. SINHA, ANNA KROTINGER, MAYA A. PHAN, & LOUISE P. KING*

ABSTRACT

The Supreme Court's 2022 decision in Dobbs v. Jackson Women's Health Organization was a pivotal moment that reshaped the landscape of abortion policy and delivery of abortion care in the United States. To create a space for critical reflection on the implications of Dobbs for the teaching and learning of abortion care in both medical and legal education, the authors engage in a dialogue highlighting the varied perspectives of professionals and professionals-in-training in both the medical and legal professions. As new attacks on reproductive autonomy continue at both state and federal levels, we foreshadow a tumultuous landscape for abortion policy in the next several decades and describe the impact and ramifications of widespread restrictions on abortion care at all levels of medical training and practice; collaboration between physicians and attorneys will be essential to forge a path ahead.

* Michael S. Sinha, MD, JD, MPH, Assistant Professor, Center for Health Law Studies, Saint Louis University School of Law. Anna Krotinger, MBE, third year medical student, Harvard Medical School, and 2021 MBE graduate, Harvard Medical School Center for Bioethics. Interested in applying into OB/GYN residency. Maya A. Phan, BS, third year law student, Saint Louis University School of Law, Health Law Concentration. Louise P. King, MD, JD, Assistant Professor, Harvard Medical School Center for Bioethics.

I. INTRODUCTION

The United States Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*¹ was a pivotal moment that reshaped the landscape of abortion access. *Roe v. Wade*, the landmark 1973 Supreme Court decision, laid the foundation for legal frameworks governing abortion access.² In contrast, the subsequent *Dobbs* decision erased decades of progress in addressing women's reproductive issues. Our goals are to shed light on the varied perspectives and experiences within the medical and legal communities since *Dobbs*, and to create a space for critical reflection on the implications of the case for teaching and learning in both medical and legal education. Two years post-*Dobbs*, this dialogue shares our reflections on the evolving landscape surrounding abortion care and its integration into both legal and medical curricula.

For the "Teaching *Dobbs*" issue, our initial plan was to include four distinct opinion pieces offering insights from the perspective of a medical student (Anna Krotinger), a medical school professor (Louise King), a law student (Maya Phan), and a law school professor (Michael Sinha). Early discussions made clear that there would be considerable overlap between the four opinion pieces and that readers would benefit more from a dialogue highlighting the varied perspectives of professionals and professionals-in-training in both the medical and legal professions.

In the dialogue transcribed below, each contributor highlights the effects of the *Dobbs* decision on their teaching or learning experiences, emphasizing crucial considerations within their respective realms. Together, these diverse viewpoints form a tapestry of insights that enrich our understanding of the ongoing discourse surrounding abortion and reproductive rights in the aftermath of *Dobbs*.

II. DISCUSSION

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

² *Roe v. Wade*, 410 U.S. 113, 154 (1973), *overruled by* *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022) (holding that the Fourteenth Amendment's substantive due process right of personal privacy includes the right to an abortion decision).

How did you find out about the decision in *Dobbs*?

Maya Phan: At the time the decision was handed down, I was interning at Health Law Advocates, a health law public interest firm based out of Boston, Massachusetts.³ The political climate there is largely pro-access for everything health-related, so the decision was incredibly disheartening for everyone, including me. We had known about the leaked decision a month beforehand, but I think everyone was clinging to hope for a different outcome.

Michael Sinha: I co-authored a piece with a law student on abortion policy⁴ the year before the *Dobbs* decision as part of an annual symposium at Boston University School of Law.⁵ As we were revising our piece prior to publication, cases were making their way up through the courts, and it became clear that our article would need to address the very real possibility that the Supreme Court would overturn *Roe*. The leaked opinion all but confirmed our worst fears, so we revised our final draft accordingly.

Louise King: I found out about the decision when all Americans did—as it was announced and reported by the media. But I knew for years that *Dobbs* was inevitable. It was predictable, given the political changes and judicial appointments that preceded the decision.⁶ Even though I expected the outcome, I still felt shocked and dismayed when I listened to oral arguments and especially when I read the decision itself, which so sweepingly removes bodily autonomy as a right shared by all Americans.

Anna Krotinger: I remember having several conversations with the Obstetrics and Gynecology (OB/GYN) faculty members about *Dobbs* before the decision was announced. It was clear that they had been anticipating the fall of *Roe* for quite a while. Among students, as well, there was a growing sense of dread around the decision that came to a head when the opinion was leaked.

³ “Health Law Advocates (HLA) is a 501(c)(3) public interest law firm whose mission is to provide pro bono legal representation to residents in low-income situations experiencing difficulty accessing or paying for needed medical services.” *What We Do: Mission*, HEALTH L. ADVOCES., <https://www.healthlawadvocates.org/about/what-we-do> (last visited Feb. 20, 2024).

⁴ Cassandra LaRose & Michael S. Sinha, *EACH Person’s Right: The Importance of Federal Abortion Care Funding Health Care Reform*, 48 AM. J. L. & MED. 266, 266 (2022).

⁵ *AJLM Symposium: Reproductive Health Policy*, BOS. UNIV. SCH. OF L., <https://www.bu.edu/law/2022/01/12/ajlm-symposium-2022/> (last visited Feb 18, 2024).

⁶ See, e.g., ILYSE HOGUE & ELLIE LANGFORD, *THE LIE THAT BINDS* (Troy Miller et al. eds., 2020); MARY ZIEGLER, *DOLLARS FOR LIFE: THE ANTI-ABORTION MOVEMENT AND THE FALL OF THE REPUBLICAN ESTABLISHMENT* (2022).

How does the current medical curriculum address the evolving legal landscape surrounding reproductive rights and healthcare?

Louise King: Our curriculum at Harvard Medical School (HMS) does not directly address the legal landscape for any topic in any great detail. We look at the ethics of abortion in the first- and third-year courses, and we speak about clinical aspects of abortion care and reproductive rights during clinical rotations in year three.

Anna Krotinger: The OB/GYN core clerkship provides the most comprehensive exposure to reproductive care. During the core rotation, we learned procedural techniques, as well as how to guide difficult conversations about abortion and other reproductive decisions. We also had the option to spend time in a family planning clinic. As mentioned, we also got some exposure to this content in our preclinical courses as well, but only a half-day was dedicated to pregnancy and reproductive health in the first year. While we did get a chance to discuss reproductive ethics briefly, it was often assumed in these sessions that all students were pro-choice, so there wasn't much exploration of other viewpoints or any discussion of how legal limitations on abortion affect practice around the country.

Louise King: We try to make space for a variety of views, but based on survey data, eighty-five percent⁷ of Americans—and likely the same percentage of students at HMS—think abortion should be legal. Given this, we do assume people share these views, as they are the most typical. Exploring other opinions around the ethics of abortion is important. We all need to be able to talk about this topic in a nuanced way. That said, from a clinical standpoint, HMS follows the lead of the American Medical Association (AMA)⁸ and the American College of Obstetricians and Gynecologists (ACOG),⁹ ensuring all medical students understand that abortion is essential healthcare. We see no need to explore, for example, the fairly extreme conservative view that providing abortion care is not part of ensuring the health of our populace. This simply isn't supported by science or ethical analysis. Exploring why that is the case, even if you believe an embryo or fetus has some degree of moral status, is an important conversation that we do explore.

Anna Krotinger: This approach feels like a relief in many ways—we came to medical school to learn the clinical standard of care, how the evidence supports the proper standard, and how to provide care to patients consistently and compassionately. However, we spend very little time thinking about how to provide care to patients seeking or requiring abortion services when the

⁷ *Abortion*, GALLUP, <https://news.gallup.com/poll/1576/abortion.aspx> (last visited Feb. 22, 2024).

⁸ The AMA advocates for medical institutions to provide clinical training on reproductive health services, including medical and procedural abortions. Kevin B. O'Reilly, *AMA Holds Fast to Principle: Reproductive Care is Health Care*, AM. MED. ASS'N (Nov. 17, 2022), <https://www.ama-assn.org/delivering-care/public-health/ama-holds-fast-principle-reproductive-care-health-care>.

⁹ The ACOG views abortion as an “essential component of comprehensive, evidence-based health care.” *Abortion Policy*, AM. COLL. OBSTETRICIANS AND GYNECOLOGISTS, <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy> (last visited Feb. 22, 2024).

standard of care violates state law.¹⁰ With respect to abortion and reproductive health, the discrepancy between what we learn in the classroom and what happens in practice extends to other aspects of our education as well. In our ethics courses, we learn the concept of shared decision-making, where patients and physicians work together to formulate a treatment or medication plan that is informed by and aligned with patients' values and goals. For so many pregnancy-capable patients, seeking reproductive care that aligns with their goals is simply no longer an option in anti-abortion states. From the early stages of our medical training, we are presented with some significant contradictions between theory and practice that are challenging to navigate, even as students.

Louise King: This is an excellent point. We are still unsure how best to navigate restrictive laws around the provision of abortion care, and in this setting of uncertainty it is difficult to teach. But we should share our uncertainties about how best to proceed with our learners.

Michael Sinha: In medical schools, I worry that if we discuss ethics before science, some students may opt-out of essential scientific education because they have already deemed it morally objectionable. This has already started happening at some institutions. Even if a physician-in-training plans to opt out of providing abortion care as a practicing physician, they must understand the science so that they can recognize when such care is needed and refer the patient to another physician in a timely fashion.

Louise King: We've tried it both ways; each has pros and cons. We try to achieve a balance by teaching about abortion care in the setting of desired pregnancy during our first-year introductory ethics courses and then expand the discussion in later years after students gain more knowledge and clinical experience. While learners can "opt out" of participation in some forms of abortion care, training on how to perform an abortion remains a required part of OB/GYN residency.¹¹ Moreover, all medical students are required to possess knowledge of the science and medicine pertaining to the procedure and care of patients undergoing an abortion.¹²

What about the legal curriculum? Does it more adequately cover reproductive rights?

Maya Phan: Constitutional Law typically covers these cases, but reproductive rights are only discussed within the context of due process and equal protection. Constitutional Law is taught in two semesters at Saint Louis University School of Law (SLU Law). Constitutional Law I is mandatory, but Constitutional Law II, which provides a more in-depth examination of reproductive

¹⁰ Carmel Schachar et al., *Whose Responsibility Is It to Define Exceptions in Abortion Bans?*, 331 JAMA 559, 559–560 (2024).

¹¹ The Review Committee for Obstetrics and Gynecology, part of the Accreditation Council for Graduate Medical Education, has clarified that programs "must provide training or access to training in the provision of abortions" regardless of if student may opt out of "training in or performing induced abortions." *See Clarification on Requirements Regarding Family Planning and Contraception*, AGCME (June 2017), https://www.acgme.org/globalassets/pfassets/programresources/220_obgyn_abortion_training_clarification.pdf.

¹² *Id.*

rights cases, is not required. Additionally, there are multiple professors for the same Constitutional Law course, so students often do not have the same exposure as their classmates. Even with these types of cases integrated into the legal curriculum, students may not have opportunities to engage in discussions regarding reproductive rights. Most law school classes are not discussion-based. Constitutional Law is one course that I believe should be more discussion-based since it is so fundamental to what we observe in our day-to-day lives and what we will encounter in our legal careers.

Michael Sinha: Every law school is different, but the typical law school curriculum will usually touch on reproductive rights issues in the context of Constitutional Law, a class every law student is required to take. The classic casebook by Professor Erwin Chemerinsky¹³ covers *Roe v. Wade* and *Planned Parenthood v. Casey* in its chapter on “Fundamental Rights Under Due Process and Equal Protection.” Future editions of the casebook may curtail discussion of both cases to make room for *Dobbs*, but they will likely still be included in some form. That said, the depth of coverage of this topic in a Constitutional Law course is often up to the faculty member teaching the course. It may be especially difficult to cohesively teach reproductive rights in Constitutional Law at larger law schools with multiple sections of students. Another course where these issues often arise is Bioethics and the Law, a health law elective offered at many law schools. I spend a week on reproductive rights as part of my Public Health Law class, and many law schools, including ours, now offer seminars in Reproductive Rights and Reproductive Justice. Of course, each of these are elective courses geared toward students with interest in these topics; they may also be subject to enrollment caps.

Maya Phan: I took Bioethics and the Law last year. I was both surprised and disappointed that our class did not touch on the topic of reproductive rights or abortion at all, especially since it is all over the news. I imagine that some professors may not feel comfortable bringing it up, either for personal reasons or because others may feel uncomfortable in class. I took Professor Sinha’s Public Health Law class, which was the most discussion that I’ve experienced regarding reproductive rights in any class, in law school or elsewhere. Again, most law school classes tend to prioritize lectures over discussions, making it challenging for students to have candid conversations about topics like reproductive rights. While there are opportunities for students to proactively seek out additional knowledge, such as involvement in related organizations like If/When/How¹⁴ or through volunteer work at clinics, the current law school curriculum is not as comprehensive as it could be. Additionally, most of my non-bar classes have been health law related, but students pursuing other areas of law might not be exposed to reproductive health in any way while at SLU Law.

How can medical and law school faculty create safe spaces for students to discuss and engage with sensitive issues like abortion in their classes?

¹³ Erwin Chemerinsky, *CONSTITUTIONAL LAW* (Frederick MD: Aspen Publishing, 6th ed. 2020).

¹⁴ *Student Organizations*, SAINT LOUIS UNIV. SCH. OF L., <https://www.slu.edu/law/student-services/student-organizations.php> (last visited Feb. 13, 2024).

Louise King: Safe BRAVE spaces are needed.¹⁵ A Safe space implies that we will avoid triggers and will make room for all views.¹⁶ A BRAVE space incorporates not only compassion and a desire to validate differing viewpoints, but also an agreement to push against each other and challenge each other.¹⁷ Mediation techniques are essential to creating both safe and BRAVE spaces. For example, if a student says that they feel abortion is the killing of a child, or even murder, and thus should not be legal or part of health care, we will make space to hear that view. But we must then counter with basic principles of ethics—you have, under their framework, two full persons in front of you; one does not wish to take on the risks of pregnancy for the benefits of the other. In no other scenario can we force one human being to take risks for another, even in situations after someone's death or if it is their child. So how can you then say that this person *must* continue a pregnancy even if they do not wish to take on those risks? There is a lot to debate there, but students must defend their views against these counterpoints if they want to present them. Similarly, a student who feels abortion is health care and may not believe that personhood attaches during early embryonic or fetal development must be ready to listen and understand that their colleague sincerely believes abortion constitutes the killing of another human being. We won't get anywhere if we can't go to these spaces and have these difficult conversations. The result in most discussions I have with medical students when we truly discuss this as an agreement that if you believe abortion is killing, you absolutely should not be involved in the provision of that care, but you cannot require others to hold the same view. In addition, you must understand that for most of us, the life and rights of the pregnant person will be seen as superior to those of the embryo or fetus—even presuming the attachment of some level of moral status or personhood. You cannot and must not prevent us from providing compassionate care to our patients, just as we cannot force you to provide care you feel is unethical.

Anna Krotinger: I think this understanding—that you can opt out of providing abortion care if you so choose but that you cannot restrict other physicians from offering it—would ideally serve as a foundation for all discussions about abortion in medical school. *Dobbs* changed things, though. The new reality post-*Dobbs* is one where anti-abortionists are empowered to and actively do restrict abortion by physicians who deeply believe in the importance of providing such care. This new power dynamic necessitates more sensitivity from both pro-choice and anti-abortion medical students and faculty. A successful conversation about abortion should acknowledge these new power dynamics in an attempt to create a safer environment for open discussion.

Michael Sinha: One option may be to host a school-wide public forum for such difficult conversations. This may be a better approach than assuming (or hoping) that certain topics are covered at some point in the law school curriculum. When I taught at Northeastern University School of Law, the Dean and interested faculty often hosted open forums to discuss contentious topics, like the appointments of Justices Brett Kavanaugh and Amy Coney Barrett or repercussions

¹⁵ DIANA ALI, SAFE SPACES AND BRAVE SPACES: HISTORICAL CONTEXT AND RECOMMENDATIONS FOR STUDENT AFFAIRS PROFESSIONALS 3 (NASPA Policy and Practice Series Issue Two, Oct. 2017).

¹⁶ *Id.*

¹⁷ *Id.*

of the Supreme Court decision in *Dobbs*. All community members in attendance were welcome to engage and participate; no viewpoints are excluded. This sort of contemporaneous dialogue can translate nicely into classroom discussions, though, by necessity, those in-class conversations would be more limited in nature.

Maya Phan: While advocating for open dialogues, it's also pertinent to acknowledge that varying degrees of openness exist among law students and institutions. Some communities might find it more challenging to comfortably engage in such discussions. Therefore, fostering an inclusive environment where all viewpoints are welcomed and respected becomes imperative for productive conversations. One potential strategy is to incorporate these discussions directly into the classroom, given time constraints on extracurricular activities. However, considering the potential challenges arising from deeply entrenched viewpoints, a targeted approach may be more successful. For instance, one possible solution is hosting separate forums for health law students, non-health law students, and a mixed audience. Aligning these discussions with ongoing open forums hosted by faculty or institutions would provide the basis for subsequent classroom conversations, which can foster a more inclusive learning environment.

How can reproductive health issues be better integrated into various law and medical school courses to provide a more comprehensive education?

Louise King: One of my research goals is to create a roadmap of when these topics (and other central ethical topics) can and should arise in both basic science and clinical experiences in medical school. In this way, students and faculty will be aware that these are central topics to be addressed and should not be punted down the road or avoided. For example, in cardiovascular physiology, we should discuss cardiovascular disease as the primary driver of maternal mortality and how that relates to policy issues around universal healthcare access, as well as access to contraception and abortion.

Anna Krotinger: The unfortunate reality is that, regardless of our opinions on abortion, physicians often have the least say and the least power in determining what services we can and cannot provide as we are largely subject to the whim of federal and state politicians or the Supreme Court. Rather than having relatively sparse education on reproductive health issues such as abortion during preclinical courses, dedicating more curricular time to both the medical and legal aspects of reproductive health would help students better understand the reality of how medicine translates from the classroom to the clinic. Furthermore, we know nearly one in four women will have an abortion in their lifetimes,¹⁸ yet we spend far more time in class learning about rare diseases. Spending more time introducing abortion as essential health care alongside the impact of *Dobbs*

¹⁸ *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates*, GUTTMACHER INST. (Oct. 19, 2017), <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>. The term pregnancy capable individuals captures the fact that up to fifteen percent of persons with uteri are infertile and a large proportion of those persons are not able to access infertility care. The one in four women statistic does not account for the number of persons who cannot get pregnant—and thus would never need an abortion—in denominator.

would also help decrease the sense of otherness that abortion already carries, both for future physicians and as patients ourselves.

Michael Sinha: I may be biased because I teach health law, but covering these issues in reasonable depth should be an expectation of all Constitutional Law courses. There are other important areas of law where reproductive law and policy could be addressed, such as criminal law, criminal procedure, family law, and employment law, to name a few. These issues should not automatically be siloed into health law.

Maya Phan: I agree with the importance of consistently teaching all law students as part of being well-informed as lawyers. If anyone, lawyers should know about the *Dobbs* decision and its implications. Most law school courses are taught in an extremely rigid format, and it's usually not discussion-based unless you're in a classroom setting of less than fourteen people—and even then, it may not always be discussion-based. I would love to see more discussion-based classes in law school, with more focus on future implications of law instead of just historical background. It might require a good deal of effort for some professors to modify their course content or syllabi, but it's worth it, especially if the goal is to make us better informed law students and future lawyers. By avoiding these important topics, students won't be prepared to address these topics in practice after graduation.

Michael Sinha: Most law school courses can have a discussion component if we are intentional about creating space for those conversations. Policy issues permeate all areas of law, and it is our job as law faculty to provide students the opportunity to understand the nuances of our areas of legal expertise.

Can Teaching *Dobbs* be done in a balanced way?

Michael Sinha: I'm not convinced that balance is a necessary component here. I might try to assign readings that are more objective and evidence-based, but two sides of a contentious issue need not be given the same emphasis or class time. This is especially true for the professions of medicine and law, where duties arise to patients and clients, respectively, and those interests will often supersede our own.

Maya Phan: I think the word "balance" is a loaded and dangerous descriptor in the context of reproductive health. Reproductive access is incredibly politicized and considering a "balanced" approach only furthers the politicization of reproductive health. There are two sides to every issue, but it seems like the only issue that calls for "balance" is reproductive health and access. I don't hear calls for "balance" in the approach to immigration issues or education reform. Reproductive health done in a balanced way would do it a disservice and give power to a narrative that doesn't have a basis in fact, law, or medicine.

Michael Sinha: This perspective makes a lot of sense to me. Those who wish to insert “balance” into a conversation are often seeking to elevate the importance of a minority opinion. That may well be the case in the context of reproductive rights and ethics. Only one perspective here truly values the lived experiences of pregnant persons seeking reproductive care—the other seeks to impose values on those directly affected.

Anna Krotinger: I agree that aiming for “balance” could be dangerous in this conversation, particularly in light of the four pillars of medical ethics: autonomy, beneficence, nonmaleficence, and justice. In navigating difficult medical decisions, we strive to balance these principles, but the buck stops with patient autonomy. We do not force decisions on patients. The idea of “balance” in abortion education does not map on to these ethical pillars. We can argue all day about whether we think offering or denying access to abortion violates our oath to do no harm, but there is no balance to be found in restricting a patient’s right to make decisions about their own body.

Louise King: Many issues don't have “balance” or equally justifiable “sides” of debate. There is no ethical justification for slavery, abuse, or inequitable outcomes. While those who provide conscientious abortion care see the inherent value in potential life, they also recognize the inherent value in existing life. Forcing any human being to be subjugated for the benefit of another is never justifiable even if it is “natural.” So, we don't seek “balance” or “equal time” or “equal attention” in our discussions of abortion and a human's right to bodily autonomy. We instead seek open discussion and open, respectful sharing of viewpoints.

How can medical students in different parts of the country ensure equal exposure to reproductive and abortion care prior to residency applications and career choice?

Anna Krotinger: For many students hoping to apply into OB/GYN residencies or those interested in reproductive health, elective rotations in family planning prior to medical school graduation are an essential part of choosing a career path and deciding how and where to apply for residency. For some students, these electives can happen at hospitals affiliated with their medical school. For medical students in restrictive states, away rotations at hospitals in non-restrictive states are now their only opportunities for exposure to this essential part of healthcare and career decision-making tool. Securing an away rotation as a medical student is already a competitive process. Now, with the number of non-restrictive states, there simply won't be enough spots for interested students.

Louise King: Unfortunately, some medical schools and residency programs can't ensure equal access to exposure given restrictive laws. We must change the restrictive laws in part to ensure that they can. Students will have to choose the right state to train and practice in. If they are courageous enough to practice in states with restrictive laws, we would all be so grateful—but it's a lot to ask of anyone. ACOG and AMA have excellent guidance, as will residency directors. Given the ever-changing landscape here, students should not walk too far into the abyss. We recommend you seek guidance as you make these decisions about your future.

Are there career risks to law and medical faculty for teaching reproductive health policy?

Michael Sinha: I would argue that in most law schools, teaching or writing about reproductive law and policy is a major plus. Law schools are often looking to hire faculty that can teach courses in reproductive rights and ethics. In some states, like Texas and Florida, politics have recently clouded the issue—the standing of a law professor teaching at a public university may no longer be as stable. For example, Idaho recently passed the “No Public Funds for Abortion Act,” which would potentially subject a professor like me—one who teaches, discusses, or writes about abortion—to up to fourteen years of imprisonment.¹⁹

Louise King: I teach ethics and medicine in Massachusetts. I have not experienced any career risks—but nor have I experienced substantial benefits from teaching reproductive health policy. I have experienced heavier critiques and risks to my career by criticizing my discipline for gaps in training and quality. If, however, I worked and taught in a restrictive state, my freedom of speech would be severely curtailed both in my care for my patients and in how I educate learners. This outcome seems uniquely un-American.

Michael Sinha: I have had the privilege of teaching at three different law schools, each of which centers social justice and public interest as core missions and values. Other professors teaching contentious topics are being sanctioned.²⁰ If I taught in Florida, Texas, or Idaho, I might change the way I address these topics. And that is the point of those restrictive state laws: censorship.

¹⁹ Elizabeth Gyor, *Idaho Wants to Jail Professors for Teaching About Abortion*, ACLU (Aug. 8, 2023), <https://www.aclu.org/news/reproductive-freedom/idaho-wants-to-jail-professors-for-teaching-about-abortion>.

²⁰ A Texas A&M University Professor was placed on administrative leave and investigated for discussing issues related to how a lack of infrastructure limits Texas’ ability to respond to the opioid crisis. Kate McGee & James Barragán, *Texas A&M Suspended Professor Accused of Criticizing Lt. Gov. Dan Patrick in Lecture*, TEX. TRIB. (July 25, 2023), <https://www.texastribune.org/2023/07/25/texas-a-m-professor-opioids-dan-patrick/>.

What about career risks to students?

Anna Krotinger: OB/GYN residency is known to be highly competitive, with many new MD graduates across the country not matching into residency programs at all. Post-*Dobbs*, the number of OB/GYN residency programs in states with preserved access to abortion has shrunk dramatically, while the prospect of training or practicing as an OB/GYN in restrictive states now poses intensified legal, ethical, and moral challenges. In fact, working in a restrictive state, for some students, would diminish their very purpose for entering the OB/GYN field in the first place. If most medical students applying into OB/GYN share this perspective—and data referenced earlier in our conversation show that they do—we will likely see increasing competition at programs in non-restrictive states and a drop in applications to programs in restrictive states. This shift creates a problem for medical students, residency programs, and patients alike.

Michael Sinha: In the 2023 residency application cycle, OB/GYN applications dropped by 10.5% in states that enacted abortion bans.²¹ The downstream effect of these laws will be less access to all essential reproductive care—not just abortion care—and even perhaps a decrease in the quality of health care available in general.²²

Louise King: Not long ago there was a Twitter “drama” around a study of “unprofessional” social media content by medical students.²³ The authors of a controversial opinion article noted that posting images of oneself in a bikini was, by definition, unprofessional.²⁴ The response on Twitter was a wonderful barrage of photos of happy professionals in bikinis including one resuscitating someone on a beach while “scantily clad.” The “drama” was named #MedBikini and the article was pulled.²⁵ What many didn’t discuss, and perhaps simply accepted, is that the article also identified any social media discussion of abortion and reproductive rights as unprofessional.²⁶ Discussing one of the most common and essential procedures in our disciplines, as well as the

²¹ Fenit Nirappil & Frances Stead Sellers, *Abortion Ban States See Steep Drop in OB/GYN Residency Applicants*, THE WASH. POST (Apr. 21, 2023, 6:00 AM), <https://www.washingtonpost.com/health/2023/04/21/abortion-ban-states-obgyn-residency-applications/>.

²² See, e.g., *NRMP Celebrates Match Day by Publishing the Results of a Record-Breaking 2023 Main Residency Match*, NRMP (Mar. 17, 2023), <https://www.nrmp.org/about/news/2023/03/nrmp-celebrates-match-day-by-publishing-the-results-of-a-record-breaking-2023-main-residency-match/>. In the 2023 Main Residency Match, there were 42,952 applicants, including 1,239 couples who collectively represented 5.7% of the overall applicant pool. *Id.* An inhospitable practice environment for a prospective OB/GYN resident may also mean that their partner, who may specialize in a different area of medicine such as pediatrics or psychiatry, will also not prioritize residency positions in that state. *Id.*

²³ Emma Goldberg, *Women Doctors Ask: Who Gets to Decide What’s ‘Professional’?*, N.Y. TIMES (Aug. 2, 2020), <https://www.nytimes.com/2020/08/02/us/women-doctors-medbikini-professional-gender-bias.html>.

²⁴ Scott Hardouin et al., *Prevalence of Unprofessional Social Media Content Among Young Vascular Surgeons*, 72 J. OF VASCULAR SURGERY 667, 669 (2020).

²⁵ Lauren M. Johnson & Alisha Ebrahimji, *A Medical Journal Apologized After an Article Prompted Health Professionals to Post Images of Themselves in Bikinis*, CNN (July 25, 2020, 5:01 PM), <https://www.cnn.com/2020/07/25/cnn10/medbikini-backlash-and-apologies-trnd/index.html>.

²⁶ Nina Shapiro, *Viral #MedBikini Response to Controversial Manuscript Leads Editor to Retract Article*, FORBES (July 25, 2020, 3:51 PM), <https://www.forbes.com/sites/ninashapiro/2020/07/25/viral-medbikini-response-to-controversial-manuscript-leads-editor-to-retract-article/?sh=1bccbcb1f47d>.

political issues around provision of that care, is the essence of professional discourse on social media (when done well). Yet, I can't deny that some residency programs may look to social media and judge applicants as "too political" or "edgy" for engaging in such discussions. It's an unfortunate truth that we hope to change.

Maya Phan: I feel like it's generally understood that law students will have exposure to a wide variety of topics, including those related to reproductive rights. As much as I would like to say it wouldn't hinder job prospects, recently, in discussions concerning the Israel/Palestine/Hamas crisis, some prominent law firms withdrew job offers from new graduates who publicly supported Palestinians.²⁷ It's unclear whether this was due to political alignment, or a perception of unprofessionalism associated with expressing such views. Moreover, the rescinding firms are among those that set professional culture and compensation trends in the industry. As a result, expressing certain opinions publicly could potentially have consequences affecting job prospects not only at these firms, but also at the firms that emulate such prominent firms.

Michael Sinha: Given the recent rescinding of law firm job offers due to political engagement while in law school,²⁸ I would not rule out the possibility that abortion policy work could limit certain job opportunities for recent law graduates. I ask law students whether they are comfortable with an abortion-related publication on their CVs before they engage in reproductive rights/justice scholarship with me. Most say yes, but it's an important discussion to have upfront. That said, if a law firm declined to hire someone because of an article they wrote as a law student, I would consider that a major red flag. When law firms show you who they are, believe them. There are more traditionally conservative domains of law like tax, bankruptcy, or antitrust, but health law is not usually thought of as a conservative field.

What ethical risks might physicians encounter when engaging with reproductive health care cases? How does one deal with the moral distress caused by state laws that run counter to core ethical principles and values in medicine?

Louise King: From an ethics perspective, if you train or practice in a restrictive state, you will likely experience moral distress if you are unable to provide the standard of care for your patients without risking legal liability. I, frankly, can't imagine how difficult this must be for physicians. If you are capable of being pregnant yourself, you will also have medical risks that in turn may compromise not only your life but also the care you can provide your patients.²⁹ Depending on

²⁷ Karen Sloan, *Law Firm Davis Polk Revokes Job Offers to Harvard, Columbia Students Over Israel Statements*, REUTERS (Oct. 18, 2023), <https://www.reuters.com/legal/litigation/davis-polk-revokes-jobs-harvard-columbia-law-students-over-statements-israel-2023-10-17/>.

²⁸ Yasmeen Altaji, *'Career on the Line': US Students Fear Job Backlash for Protesting Israel*, ALJAZEERA (Nov. 2, 2023), <https://www.aljazeera.com/news/2023/11/2/advocacy-or-a-career-us-students-fear-employer-backlash-amid-war-in-gaza>.

²⁹ For example, if a physician in a restrictive state without exceptions experienced a complication with their pregnancy that compromised their health but could not be treated medically or surgically due to restriction, they would have to wait for their health situation to escalate to an emergency—maybe while caring for other patients—to get the care they need. These risks are not experienced by doctors in nonrestrictive states.

their view of the issues, law students may experience moral distress as they explore the cases of delayed care. People are already suffering greatly. One of the great tragedies of the politicization of abortion in this country is that the real stories of people who seek abortion care aren't at the forefront of the discussion. When you sit with people who have had abortions and they share their stories, invariably you can identify with the decisions they made. Katie Watson wrote a wonderful book about this,³⁰ and others have as well. Some authors, namely Watson and Joyce Arthur, have written that conservatives—who frequently seek abortion even while they protest its legality—believe that the “only moral abortion is [their] abortion.”³¹

Anna Krotinger: In medical school, we are taught about growing moral distress and burnout amongst healthcare workers stemming from a variety of factors. One such factor is the inability to provide the best care—the standard of care—to your patients, due not to lack of medical capability, but instead to extrinsic financial, administrative, political, and legal restrictions.

Louise King: Most Americans know and understand that abortion is healthcare.³² It is a rational, ethical option in any pregnancy. We would all much rather focus on our need for better preventative healthcare so people can come to pregnancy healthy, and in some cases, be able to continue desired pregnancies. Consider, for example, a patient who finds their cardiovascular disease requires an abortion, but they may have been healthier and better able to continue their pregnancy, if they could access better health care. Support systems like family leave, early childcare, excellent public education, better minimum wage, and universal healthcare—all publicly-available benefits in most modern countries—would allow many people to build the families they wish to have, but who, now, for a variety of reasons, choose not to begin that process. There is moral distress that comes with working on frustrating cases, such as the cases recently brought in Texas, where women were denied abortion care for preterm rupture of membranes or for lethal fetal anomalies—brutal, insensitive denials of standard of care.³³ Working on these cases is so important but must also feel frustrating.

Michael Sinha: We often talk about burnout in medicine and health care, but moral injury is perhaps the more appropriate term.³⁴ State-imposed restrictions on the evidence-based practice of medicine, especially restrictions that physicians are morally opposed to, epitomizes moral injury,

³⁰ KATIE WATSON, *SCARLET A: THE ETHICS, LAW, AND POLITICS OF ORDINARY ABORTION* (2018).

³¹ Joyce Arthur, “*The Only Moral Abortion is My Abortion*”, JOYCE ARTHUR’S PAGE (Sept., 2000), <https://joycearthur.com/abortion/the-only-moral-abortion-is-my-abortion/>.

³² See, e.g., *Public Opinion on Abortion*, PEW RSCH. CTR. (May 17, 2022), <https://www.pewresearch.org/religion/fact-sheet/public-opinion-on-abortion/>; *Where Do Americans Stand on Abortion?*, GALLUP (July 7, 2023), <https://news.gallup.com/poll/321143/americans-stand-abortion.aspx>.

³³ Plaintiff’s Second Amended Verified Petition at 6–68, *Zurawski v. Texas*, No. D-1-GN-23-000968 (Tex. D. Ct., Travis County, Nov. 14, 2023).

³⁴ Simon G. Talbot & Wendy Dean, *Physicians Aren’t ‘Burning Out.’ They’re Suffering from Moral Injury*, STAT NEWS (July 26, 2018), <https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/>.

a term the authors describe as “[the inability] to provide high-quality care and healing in the context of health care.”³⁵

How can medical students and physicians best prepare themselves to advise other physicians, patients, and support organizations effectively?

Anna Krotinger: I think that as students and physicians, listening to our patients is the best thing we can do to prepare ourselves to be effective advocates. We are training to step into a role that is unique in its capacity to empower patients, while also being limited by legal and insurance-related restrictions. Before we graduate, we can practice amplifying the stories and voices of our patients as we develop our medical knowledge, setting ourselves up to be the best possible guides for our patients through challenging, and often confusing, health-related decisions. We can also work to build relationships with our peers and with faculty mentors to learn about any support or volunteer organizations with which we could get involved or to which we can refer patients in need of specific services.

Louise King: I agree with this. Being knowledgeable about medical facts, ethics, and politics is helpful. Being open to having conversations about this topic is essential. Sticking to the facts is usually the best way to ensure a productive discussion. It’s also acceptable to step away from a conversation if it’s clearly not going to be productive. Taking time to ensure that the voices of patients and physicians remain at the forefront of this issue is also essential. There are opportunities in all national medical societies to advocate for appropriate and compassionate abortion care. The opportunities are obvious in some, like ACOG. In others, there are few advocates, but taking the time to ensure each society is aware of and supportive of abortion as essential healthcare is time well spent.

Michael Sinha: When I was a medical student, I found an advocacy home at the AMA. I wrote resolutions and passed policies that had a national impact. Legal policy writing lends itself nicely to resolution writing, and as a postdoctoral fellow, I wrote the comprehensive gender equity policy that passed at both the Massachusetts Medical Society and American Medical Association House of Delegates in 2018.³⁶ I’ve continued to do this work through the American Medical Women’s Association (AMWA), most recently through the founding of their allies membership branch, the “AMWA Action Coalition for Equity.”³⁷

³⁵ *Id.*

³⁶ *Gender Parity/Women in Medicine, Gender Equity*, MASS. MED. SOC’Y (Apr. 28, 2018), <https://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Gender-Equity-Policies/>; Kevin B. O’Reilly, *Physicians Adopt Plan to Combat Pay Gap in Medicine*, AM. MED. ASSOC. (June 13, 2018), <https://www.ama-assn.org/delivering-care/health-equity/physicians-adopt-plan-combat-pay-gap-medicine>; *Advancing Gender Equity in Medicine, Resolutions*, AM. MED. ASSOC. (2018), <https://policysearch.ama-assn.org/policyfinder/detail/comprehensive%20gender%20equity%20policy?uri=%2FAMADoc%2Fdirectives.xml-D-65.989.xml>.

³⁷ *AMWA Action Coalition for Equity*, AM. MED. WOMEN’S ASSOC., <https://www.amwa-doc.org/amwa-action-coalition-for-equity/> (last visited Mar. 3, 2024).

How can law students and lawyers best prepare themselves to advise clients, physicians, policymakers, and politicians effectively?

Maya Phan: This can be difficult for some law students because, in the standard course of law school, we don't have the opportunity to speak with physicians, policymakers, or politicians. Law students should aim to put themselves in positions where they can learn about the stories and experiences others have to think about how policies could change. I'm enrolled in a Grassroots Advocacy class focusing extensively on practical experiences. This class allows us to draft bills, engage in discussions with politicians, and hone our policy memo-writing skills. The hands-on nature of this class is immensely rewarding and informative. Our law school also has extracurricular opportunities focusing on health law that provide opportunities to deploy practical skills.

Michael Sinha: I will often design midterm assignments for my health law classes that allow opportunities for advocacy. Students have written public comments to federal agencies, like the Food and Drug Administration and the Centers for Disease Control and Prevention, and op-eds geared toward state and federal policymakers. I am beginning to engage the Directors of the Saint Louis City and Saint Louis County Departments of Health so that our law students can be directly involved in policy work at a local level. Because health lawyers often work with health officials in some capacity, the Directors come to class to discuss important issues with the law students in my Public Health Law class. And because SLU Law is in St. Louis, Missouri, which is a relatively progressive city within a state with highly restrictive abortion policies, I expect issues relating to reproductive rights to be central to local policymaking. Access to reproductive care does exist in the Greater St. Louis Metro Area, but only at reproductive health centers across the Mississippi River in Illinois towns like Fairview Heights and Granite City.³⁸

Are there risks associated with NOT teaching this content in law or medical school?

Michael Sinha: I am concerned that students will come out of their education uninformed and unprepared to deal with issues relating to reproductive rights if this content is not taught in law and medical schools.

Maya Phan: I think there are serious risks associated with not teaching this content in law school. Students would have to teach themselves these topics, but as lawyers, we should be the most versed in such issues. Some people are willfully blind to these issues, and students' legal exposure before law school is highly variable. While some students have had exclusively abstinence-based sex education, others have not received any sex education at all. Students from rural communities may

³⁸ Ray Sanchez, *An Illinois 'Oasis' Opens a Window into America in a Post-Roe v. Wade era*, CNN (June 24, 2022), <https://www.cnn.com/2022/05/15/us/illinois-abortion-oasis-roe-wade/index.html>.

not get exposed to these topics frequently, if at all,³⁹ but lawyers should be informed about these issues, even if they disagree. We learn about many different types of discrimination in Constitutional Law,⁴⁰ and I fail to see how reproductive rights should be any different just because they are politicized.

Anna Krotinger: Abortion affects everyone. No matter what specialty medical students choose to enter, they will inevitably be caring for a patient who either will have or has already had an abortion. Even in restrictive states, we know that limiting access to legal abortion does not mean that no abortions will take place. It is crucial, then, for all medical students to have a foundational understanding of abortion, the legal challenges facing both patients and physicians across the country, and the ethical and medical risks of restricting abortion access.

Louise King: I agree. I can't think of any discipline in medicine where abortion care is not, at some point, a part of the clinical picture. In some cases, of course, it is more obvious. Efforts to define medical care in a way that excludes abortion care are dishonest and a disservice to students and patients.

How can law and medical schools foster stronger collaboration to ensure that future legal professionals and physicians are well-prepared to address reproductive healthcare issues?

Louise King: We need more legal education in medical school and more medical education in law school; perhaps cross enrollment or shared faculty?

Anna Krotinger: I totally agree! Some understanding of the legal landscape and the career risks to doctors is essential for our education. I would love to have joint sessions with law students to discuss abortion and other pertinent topics with both medical and legal implications.

Michael Sinha: Opportunities to integrate law and medicine. At Southern Illinois University, we hosted a Professional Responsibility Day that gathered first-year law and medical students in mixed groups to discuss ethical issues. Why not extend the discussion to reproductive justice? Combined degree programs, like the JD/MPH or JD/MHA at SLU, can allow for co-listing or cross-enrollment of certain classes. For example, students pursuing a PhD in Health Care Ethics at SLU often enroll in Bioethics and the Law at SLU Law. Fourth-year medical students from SLU Medicine come to the law school for a day of case-based discussion on medical malpractice, which highlights that it can be done at our institution.

³⁹ See, e.g., Jo Valentine et al., *Improving Sexual Health in U.S. Rural Communities: Reducing the Impact of Stigma*, SPRINGER (Aug. 26, 2021), <https://link.springer.com/article/10.1007/s10461-021-03416-4>; Mackenzie Piper, *Connecting Rural Youth to Sexual and Reproductive Health*, HEALTHY TEEN NETWORK (Aug. 18, 2022), <https://www.healthyteennetwork.org/news/connecting-rural-youth/>.

⁴⁰ See, e.g., *Brown v. Bd. of Educ.*, 347 U.S. 483, 495 (1954) (holding discrimination based on race in public schools violated the Equal Protection Clause); *United States v. Virginia*, 518 U.S. 515, 534 (1996) (holding discrimination on the basis of sex in excluding all women from citizen-soldier training at a public institution violated the Equal Protection Clause).

Maya Phan: Bringing in physicians who specialize in reproductive health as guest speakers would offer invaluable insights and discussion. Mixed-cohort classes, which both law and medical students take together, could be extremely valuable. For example, the Bioethics and Law course at SLU Law is an ideal setting for medical students to enroll alongside law students. The outcome could be a more unified and holistic understanding of these issues.

Michael Sinha: Medical schools are gradually adopting health systems science curricula, which often includes aspects of bioethics.⁴¹ I agree that there are opportunities to better integrate bioethics conversations in both medical and legal curricula.

What strategies do you use to stay up-to-date outside of the classroom?

Anna Krotinger: I use news sources, discussions with hospital faculty, and lectures in reproductive care. National organizations like ACOG and research institutes like Guttmacher and Pew also provide clear and valuable resources.

Maya Phan: I use news sources such as NPR or the New York Times, along with podcasts⁴² and documentaries,⁴³ to stay updated with any new developments. I also attend guest speaker lectures revolving around reproductive healthcare and stay involved with student organizations that place an emphasis on it, such as If/When/How. Additionally, taking courses on bioethics and public health law adds to my growing knowledge of reproductive rights and healthcare.

Michael Sinha: I use social media and rely on health law and reproductive justice scholars for up-to-date info on emerging case law and controversies. I also follow advocates for information about access and availability of abortion care across the United States. I ask students to share articles or social media posts that they find so that we can discuss these topics in class. I use these methods for all topics I teach, not just reproductive rights.

Louise King: I avoid American news sources as they seem highly influenced by our tendency towards “hot topics” and “both side-ism.” I instead rely on European outlets and other news sources like the AP wire. Additionally, I serve on the boards of reproductive justice and civil rights organizations, as well as in national roles for ACOG and AMA. I get updates on legislative topics directly from those sources.

⁴¹ *AMA Health Systems Science Learning Series*, AMA, <https://edhub.ama-assn.org/health-systems-science> (last visited Apr. 13, 2024); Jed D. Gonzalo et al., *Health Systems Science in Medical Education: Unifying the Components to Catalyze Transformation*, 95 AAMC 1362, 1362 (2020); SUSAN SKOCHELAK, *HEALTHSYSTEMS SCIENCE* (2d ed. 2024).

⁴² See, e.g., MORE PERFECT, WNYC STUDIOS, <https://podcasts.apple.com/us/podcast/more-perfect/id1117202653>; STRICT SCRUTINY, CROOKED MEDIA, <https://podcasts.apple.com/us/podcast/strict-scrutiny/id1469168641>; The Ezra Klein Show, *The Dobbs Decision Isn't Just About Abortion. It's About Power*, N.Y. Times (June 26, 2022), <https://podcasts.apple.com/us/podcast/the-dobbs-decision-isnt-just-about-abortion-its-about-power/id1548604447?i=1000567732834>.

⁴³ REVERSING ROE (Netflix 2018); AMEND: THE FIGHT FOR AMERICA (Netflix 2021).

Where do you think the landscape of reproductive rights will be a generation from now?

Michael Sinha: A bright future is a way away, and there will be a lot of harm caused before we get there. The last several years have seen a sea change in state legislatures and the Supreme Court—a ripe combination for further draconian policy change related to reproductive health.

Maya Phan: Change might not happen overnight, particularly considering the long tenures of Supreme Court Justices. However, I have faith in the upcoming generation's commitment to carry forward the legacy of advocating, educating, and vocalizing matters concerning reproductive health. The groundwork laid in fighting for these issues will hopefully continue to be upheld and progressed by the next generation.

Anna Krotinger: No matter what the law is, abortions will continue to happen.⁴⁴ There is no question that increasing access to abortion—a safe and reliable procedure—will improve patient health and empower patient autonomy. I hope we make meaningful strides toward this goal over the coming generations, with state protections likely coming before any federal action.

Louise King: I agree. I would add that with the law as it stands, we will see patients die and others suffer before change occurs. Abortion is the only medical procedure that is politicized and legislatively controlled to this extent. Doing so does not comport with the stated opinions of many Americans and is not consistent with compassionate medical care. Our convoluted elective procedures have allowed this to happen, and it will require us to all vote to overcome that system and have the will of the people prevail. So, if you do nothing else—vote.

⁴⁴ *Abortion*, WORLD HEALTH ORGANIZATION (Nov. 25, 2021), <https://www.who.int/news-room/fact-sheets/detail/abortion>.

III. CONCLUSION

The ripples of the *Dobbs* decision extend far beyond the courtroom, dramatically shaping the landscape of abortion access in our nation as well as abortion education in medical schools, training hospitals, and law schools. At the state level, we are seeing a surge in restrictive measures that further diminish access to abortion and other forms of reproductive care.⁴⁵ State actions, ranging from the imposition of gestational limits to the introduction of cumbersome procedural requirements, contribute to the complexity of challenges already faced by those seeking abortion care. Adding to this complexity is the confusion and fear abortion providers face in trying to determine the legal limits of their role.

Moreover, the Supreme Court does not appear to be done with restrictions on abortion rights. Cases surrounding mifepristone, a medication crucial for medication abortion, and the availability of abortion care under the Emergency Medical Treatment and Labor Act (EMTALA), are both slated to be heard by the Supreme Court this term.⁴⁶ Contrary to the Court's earlier assurance that *Dobbs* handed future decision-making regarding abortion access to states, the Supreme Court now looks to consider additional restrictions on access to safe and legal abortion care.

In light of these developments, collaboration between medical and law professionals is imperative to safeguard access to abortion. The intersection of legal and medical education thus becomes a powerful avenue for change. Whether through cross-enrollment initiatives, shared

⁴⁵ ASRM, CHANGES AHEAD: ABORTION POLICY PROPOSALS AFFECTING REPRODUCTIVE MEDICINE (Mar. 17, 2023), <https://www.asrm.org/advocacy-and-policy/reproductive-rights/summary-reports/changes-ahead-abortion-policy-proposals-affecting-reproductive-medicine/>.

⁴⁶ *All. for Hippocratic Med. v. U.S. Food & Drug Admin.*, 78 F.4th 210 (5th Cir. 2023), *cert. granted sub nom.* Food and Drug Administration v. All. for Hippocratic Med., 144 S. Ct. 537 (2023), and *cert. granted sub nom.* Danco Laboratories, L.L.C. v. All. for Hippocratic Med., 144 S. Ct. 537 (2023); *United States v. Idaho*, 82 F.4th 1296 (9th Cir. 2023), *cert. granted sub nom.* *Idaho v. United States*, 144 S. Ct. 541 (2024), and *cert. granted sub nom.* *Moyle v. United States*, 144 S. Ct. 540 (2024).

faculty programs, or integrated curricula, fostering a symbiotic relationship between the legal and medical disciplines will be vital for navigating the evolving reproductive rights landscape.

One clear takeaway from this insightful discussion is that staying informed, advocating for change, and actively participating in policy discussions is essential for current and future professionals in these fields. The challenges posed by *Dobbs* necessitate a united effort to safeguard patient rights and ensure equitable access to reproductive healthcare. Our collective commitment to advocacy, education, and collaboration will play a pivotal role in shaping a future that respects and upholds fundamental rights.