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The Safety Gap: Why Maternal Health is Declining in Abortion-Restrictive States

Biology * Public Health

Introduction: The Interdependence of Reproductive Healthcare

In political discourse following the 2022 Dobbs v. Jackson Women's Health Organization ruling, pregnancy termination and assisted reproductive technologies such as In Vitro Fertilization (IVF) have frequently been treated as separate clinical domains. Yet empirical and legal evidence accumulated through 2026 demonstrates that abortion services cannot be excised from reproductive healthcare without inflicting systemic collateral damage. Synthesizing cohort data from Oregon Health & Science University (OHSU), workforce surveillance from the Association of American Medical Colleges (AAMC), and state jurisprudence, this report examines how statutory abortion restrictions -- specifically "fetal personhood" frameworks and Targeted Regulation of Abortion Providers (TRAP) laws -- degrade fertility care and maternal public health outcomes.[1][2]

The clinical infrastructure required to manage spontaneous miscarriage, resolve ectopic pregnancy, or preserve fertility prior to cancer therapy is identical to that used in induced abortion.[1][3] Pharmacological agents (mifepristone and misoprostol) and surgical uterine evacuation (dilation and curettage, or D&C; dilation and evacuation, or D&E) serve across both contexts. A landmark JAMA Health Forum study by OHSU researchers analyzing over 400,000 fertility-conceived births between 2012 and 2021 established that states with stringent TRAP laws and abortion restrictions had significantly higher rates of severe maternal morbidity, hemorrhage, and obstetrical complications.[1] Because IVF pregnancies carry higher baseline risks of multiple gestation, placenta previa, and gestational hypertension, criminalizing reproductive interventions directly imperils patients with highly desired pregnancies.[1][2]

Fetal Personhood and the Disruption of IVF Standards

The legal intersection between abortion restrictions and fertility medicine crystallized in February 2024 with the Alabama Supreme Court's ruling in LePage v. Center for Reproductive Medicine.[4][5] Following an incident in which a hospital patient entered an unsecured cryostorage room and dropped embryos preserved in liquid nitrogen, the Court held that Alabama's 1872 Wrongful Death of a Minor Act applies to "all children, born and unborn, without limitation," classifying eight-cell extrauterine embryos in "cryogenic nurseries" as legal minors.[4][9] Because standard IVF protocols inevitably involve cellular attrition during embryogenesis and thawing, the University of Alabama at Birmingham (UAB) and major state clinics immediately halted IVF operations to avoid felony homicide or wrongful-death liability.[4][5] Although the Alabama legislature subsequently enacted a civil and criminal immunity shield allowing clinics to reopen, the underlying constitutional personhood classification remains intact, creating

persistent regulatory instability.[4][7]

| Legal Framework | | Statutory Classification of Embryo | | Clinical Consequence for IVF Practice | | Provider Liability Exposure |

| Standard Medical Model | | Pre-implantation biological tissue; patient reproductive property. | | Routine cohort fertilization, blastocyst culture, PGT-A screening, and selective discard permitted. | | Low (Standard medical negligence / malpractice only). |

| Fetal Personhood (LePage Model) | | "Extrauterine child" possessing full legal personhood from zygote formation. | | Embryo discard or cryotank failure equates to wrongful death; routine IVF pauses. | | Critical (Civil wrongful-death and criminal homicide risk). |

| Statutory Immunity Shield | | Constitutional "child" paired with provider liability carve-out. | | Clinics operate under threat of statutory repeal or constitutional challenge. | | Moderate-High (Persistent legal and insurance uncertainty). |

| Strict Ban (No Exceptions) | | "Unborn human being" protected across gestation. | | Chilling effect on multifetal reduction, ectopic intervention, and miscarriage D&C. | | High (Felony prosecution and medical license revocation). |

Personhood statutes and strict abortion bans directly compromise three pillars of evidence-based reproductive endocrinology:[8][9]

* Preimplantation Genetic Testing for Aneuploidy (PGT-A): Biopsying trophectoderm cells allows embryologists to screen for abnormal numbers of chromosomes (aneuploidy, such as Trisomy 13 or 18) that cause implantation failure or lethal congenital anomalies.[8][9] Under personhood doctrines, discarding aneuploid embryos risks legal liability, pressuring clinics toward indefinite cryostorage fees or compassionate transfer of non-viable embryos.[8]

* Limited Insemination Protocols: To avoid generating surplus frozen embryos, defensive protocols restrict fertilization to only 2-3 retrieved oocytes per cycle. Because blastocyst conversion is a process of biological attrition, limiting cohort size sharply reduces cumulative live-birth rates and subjects patients to repeated $15,000-$30,000 ovarian stimulation cycles and Ovarian Hyperstimulation Syndrome (OHSS) risks.[10]

* Cryo-Shipping Barriers: Following LePage, major cryogenic transport carriers temporarily suspended Alabama shipments,[6] and interstate embryo relocation costs of $1,000 to $8,000 impose steep socioeconomic barriers.[11]

Maternal Morbidity, Mortality, and the Epidemiological Safety Gap

Post-Dobbs epidemiological surveillance across 2024-2026 quantifies the clinical toll of restrictive statutes. Isolating over 400,000 fertility-assisted deliveries, the OHSU study demonstrated that state TRAP laws and abortion restrictions significantly elevated rates of gestational hypertension, preeclampsia, severe obstetrical hemorrhage requiring blood transfusion, and peripartum hysterectomy.[1] When institutional familiarity with emergency uterine evacuation erodes, clinical teams hesitate during acute hemorrhagic crises.[1][2]

| Epidemiological Metric | | Restrictive (Ban) States | | Protective States | | Clinical & Demographic Mechanism |

| Maternal Mortality Risk | | ~2.0x higher pregnancy/postpartum death[12] | | 21% post-Dobbs decline[12] | | Delayed intervention; Black mortality 3.3x White rate.[12] |

| Second-Trimester Sepsis | | ~50% rise in pregnancy-loss sepsis (Texas)[13] | | Stable baseline incidence | | Mandatory expectant management until cardiac arrest.[13][14] |

| Infant Mortality Rate | | +11% above expected baseline[13] | | Baseline or declining | | Forced continuation of lethal congenital anomalies.[13] |

| MD Residency Applicants | | -6.7% to -10.0% application drop[16] | | Stable or increased volume | | Trainees avoid states lacking D&E training.[15][19] |

In states enforcing total bans, women face nearly double the risk of maternal death compared to peers in protective states, with Black women experiencing a 3.3-fold disparity.[12] Narrow statutory exceptions permitting termination only to prevent maternal "death" compel physicians to delay uterine evacuation during preterm premature rupture of membranes (PPROM) or inevitable miscarriage until frank sepsis or organ failure develops -- driving a 50% surge in maternal sepsis in Texas.[13][14] Simultaneously, infant mortality rose 11% above expected baselines as fetuses with lethal congenital anomalies (such as anencephaly or renal agenesis) were carried to term.[13]

Workforce Brain Drain, Oncofertility, and Socioeconomic Stratification

Restrictive laws are also eroding the obstetrical workforce pipeline. AAMC Electronic Residency Application Service (ERAS) data for 2023-2025 document a 6.7% to 10% drop in U.S. MD senior applications to residency programs in abortion-ban states.[15][16] Graduating OB/GYN residents who originally planned to practice in restrictive states were 8.5 times more likely to relocate to protective states post-Dobbs,[19] citing moral distress and criminal liability.[17][18] With 35% of U.S. counties already classified as maternity care deserts, the departure of Maternal-Fetal Medicine (MFM) and Reproductive Endocrinology (REI) subspecialists accelerates rural labor unit closures.[19]

In oncology, restrictions create life-versus-life conflicts for the ~750 pregnant patients diagnosed with cancer annually in ban states.[20][21] Because teratogenic chemotherapy and radiation cannot be administered early in gestation without pregnancy termination, legal barriers force treatment delays that raise maternal mortality risk by 13% per month.[21] Meanwhile, over 32,000 adolescent and young adult (AYA) cancer patients annually reside in states where personhood ambiguities complicate pre-chemotherapy embryo banking.[22][23] Because interstate travel and "fertility tourism" require substantial out-of-pocket costs,[24][25] low-income and minority populations -- where birth rates rose ~2.0% above expected baselines[13] -- bear the heaviest burden of under-resourced care.

Conclusion: The Indivisibility of Reproductive Medicine

The empirical record from 2022 through 2026 refutes the premise that abortion restrictions can be isolated from general obstetrics and fertility medicine. As OHSU co-author Dr. Molly Kornfield noted, "People with highly planned and desired pregnancies may not be who we typically think of when we discuss the impacts of abortion restrictions, but their health and safety are being considerably impacted."[1] From cryogenic IVF laboratories in Alabama and oncology wards in Texas to residency training programs nationwide, criminalizing core reproductive procedures and codifying embryonic personhood erodes the clinical infrastructure that protects maternal and neonatal life.[1][26]

Updates... (Nov 23, 2026): Clarified the print/issue vs. online publication date on Ref [21] (Gynecologic Oncology, Feb 2024; published online Nov 17, 2023), removed numbered section headings, and standardized the References section heading.

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