Abortion restrictions take effect with Jack Resneck Jr., MD

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Featured topic and speakers

In today’s episode of Moving Medicine, recapping his testimony before Congress about the Dobbs decision—which overturned Roe vs. Wade—AMA President, Jack Resneck Jr., MD, discusses the AMA’s efforts to protect physicians and patients, as well as what America faces as abortion restrictions take effect. AMA Chief Experience Officer Todd Unger hosts.

Speaker

- Jack Resneck Jr., MD, president, AMA

Transcript

Unger: Hello, this is the American Medical Association’s Moving Medicine video and podcast. Today we’re talking about the AMA’s efforts to protect physicians and patients in the wake of the Dobbs decision, which overturned Roe v. Wade, overturning nearly a half century of precedent protecting patients rights to critical reproductive health care. I'm joined today by Dr. Jack Resneck Jr., a practicing dermatologist and health care policy expert in San Francisco who recently testified before Congress about this issue and what America faces as abortion restrictions take effect.

I'm Todd Unger, AMA's chief experience officer in Chicago. Welcome back, Dr. Resneck.

Dr. Resneck: Thanks for having me, Todd.
Unger: You recently testified before Congress this week on the potential implications of the Supreme Court Dobbs decision. Before we get into details of your testimony, let's just get the basics about why this hearing is being held in the first place.

Dr. Resneck: Thanks, Todd. It's a good question. We already are seeing a great deal of chaos and confusion in those states that have put bans or major restrictions in place regarding comprehensive reproductive health care. So this was the subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce. It's quite a mouthful but they decided to have this hearing because they really wanted to explore the impact of the Supreme Court's Dobbs ruling, as we're all seeing these several states that are already implementing restrictive laws.

Unger: Well, let's get specific in terms of the AMA's position on the issue of abortion.

Dr. Resneck: Yeah, our position has been long held at the AMA, and that is that the termination of a pregnancy is really a medical matter between patients and their physicians that should be subject only to the physician's clinical judgment, as well as, of course, the patient's informed consent. We recognize that physicians and our AMA members really come to a topic like this with a variety of individual views that are based on and driven by their own values and their beliefs but our policy really recognizes the immense danger when politicians insert themselves into that decision making process between patients and doctors.

We opposed the criminalization of medical care and our policy supports patients’ access to the full spectrum of comprehensive reproductive health care options, including abortion. And I just want to make sure our listeners also are aware of where that policy comes from. The way we make policy in the AMA is a very democratic process in which physicians representing really every specialty, every state medical association. Doctors coming from urban and rural communities from across the political spectrum come together in our House of Delegates a couple of times a year to debate and vote on policy, and so it comes through that democratic process.

Unger: Well, let's first I want to talk about the AMA's immediate response, and then I want to probe a little bit more about some of these issues around the fallout and the confusion you talked about. How did am immediately respond to the Dobbs decision?

Dr. Resneck: We were deeply disturbed by the Supreme Court's decision. We made it clear right away that it was overturning nearly a half century of precedent that really was ending our patients’ rights to comprehensive reproductive health care. And really allowing government intrusion at the state level into the medical exam room and the criminalization of medical care.

So we immediately spoke out. We immediately said that states that were implementing bans in the wake of Dobbs were risking devastating consequences, including patients’ lives.
Unger: So in your testimony, you addressed the quote, "deep political rift" that this opens between states over access to reproductive health services. How does this place sound medical practice and the health of the patients at risk?

Dr. Resneck: What I’m hearing from colleagues across the country in those states is that physicians are being placed in really impossible situations. They're trying on the one hand to meet their ethical duties to place patient health and well-being first. That's really what drew us all to medicine in the first place. While at the same time, they're attempting to comply with what are really vague and restrictive complex, and in many cases, even conflicting state laws that are interfering in the practice of medicine and jeopardizing the health of our patients.

Practicing medicine is pretty complex and difficult to begin with, which is again, what drew many of us to it because that's what makes it interesting. But it is so much harder when you layer on top of that the knowledge that a state attorney general or a prosecutor or a politician is really sitting on your shoulder joining you and your patient in the exam room and basically threatening to second guess you.

Unger: I guess that makes the exam room pretty full and very uncomfortable with that kind of intrusion. You said it makes for some very, very difficult situations between patients and physicians. Puts physicians in an untenable position. Article this morning in the New York Times about the impact on patients who often face tough decisions between treatments like chemotherapy that they might be undergoing when pregnant.

So I guess there are many unanticipated implications. Not the least of which you point out is that patient-physician relationship. Talk a little bit more about how that gets undermined in a situation like this.

Dr. Resneck: That relationship between a physician and a patient really relies upon and sits upon a foundation of honest, open communication and it has to involve a great deal of trust. And it's undermined when we have lawmakers substituting their views and their judgment for a physician's expert medical judgment. Really is spoken to in our code of ethics as physicians, which paints a picture of our ethical responsibility being all about helping patients choose the optimal course of treatment through shared decision making, and that shared decision making is fully informed by evidence-based medical science and it's certainly shaped by patient autonomy.

And we at the AMA feel that anything less puts patients at risk and undermines, both the practice of medicine and, ultimately, our nation's health.

Unger: And speaking of untenable positions, you also brought up in your testimony that the am is receiving a lot of questions from physicians right now, particularly around the potential for prosecution of both themselves and their patients. I have to imagine that answering questions like this has got to
be pretty challenging.

**Dr. Resneck:** It is, and it's made more challenging by just the degree of confusion that's happening out there right now in the weeks after the decision. When I talk, again, to physician colleagues around the country, I'm hearing words like chaos be used. And part of that is because the laws are not only unclear and they also are written in ways that just don't recognize the realities and complexities of medical care but in many cases, they actually conflict with each other.

So on one level, you have state laws and federal laws that sometimes are bumping into each other. There's a law called Impala, that's a federal law that really governs our responsibility as physicians particularly in emergency departments to take care of a patient who's in front of us, regardless of the situation, regardless of their insurance, and says that if they're very ill, that we have a responsibility to protect their life and to stabilize that patient that is in front of us. And so we sought clarification from the federal government and from the administration and really applauded the administration's statement when they came out a few days ago and said that Impala does preempt state law when you have a sick or dying patient in front of you. And that protects our ability as physicians to take care of that patient.

But that's going to be litigated, and in fact, Texas just brought a legal challenge against the U.S. government's assertion of Impala preemption. So that's one piece of these conflicting laws that we bump into or one example but we also sometimes have multiple laws even within a state that are very confusing for physicians and for the places that we work. Sometimes, even in some of these states have laws on the books that date back to the 1800s and medical practice was a little bit different than today in the 1800s, fortunately, and so that's another thing we're running into is just a tremendous lack of clarity.

**Unger:** So one can imagine the confusion that you just described really leading to serious, potentially life threatening consequences. Will you take us through some of those scenarios?

**Dr. Resneck:** Yeah, and I want to be really clear about this that these are not very rare examples, because these are the kind of things that actually we are running into every day and emergency departments and physician practices around the country, but I'm going to give you some of the more frightening things that we have been seeing. Patients show up sometimes with what's called an ectopic pregnancy that happens outside of the uterus and is not a pregnancy that can survive, and that's not a rare thing. It turns out about 1% to 2% of pregnancies end up being ectopic.

And those have to be treated. They can be very dangerous left untreated. They can actually rupture a patient’s fallopian tubes, cause a multitude of problems for pregnant patients. We see similar things with miscarriages. Sometimes they get complicated by an infection or by retain tissue, where sometimes a procedure or medication needs to be used following a miscarriage and what we are hearing is that physicians who are treating pregnant patients in these situations are actually having to
call their hospital attorneys to say, "What can I do and what will put me or my patient at risk of prosecution?"

Again, they're making these very important life or death decisions often with substantial importance of time and how fast they act, and the hospital attorney and the physician are having to think about questions like, "Well, what risk of death for the patient is high enough to meet the state law requirement to be able to intervene? Is kidney failure bad enough to be a risk to the health of the pregnant patient? Is 20% chance of death high enough or do you need to wait till it gets up to 50."

Obviously, that's not the way we practice medicine normally, so physicians are sometimes being told by those attorneys, "Well, you got to wait until the patient with that infection is septic and has a bloodstream infection or you have to wait until that ectopic pregnancy is closer to rupturing or the patient is more unstable." This is incredibly dangerous for our patients. As I said, there are times when minutes matter and delays put lives at risk. Ectopic pregnancies are already actually the leading cause of maternal mortality in the first trimester of pregnancies.

There are also situations sometimes, where a patient with a desired pregnancy gets, for example, a new life threatening cancer and this is a difficult choice that patients sometimes have to face. Do I terminate this pregnancy in order to be able to start my chemotherapy or my immunotherapy to save my own life, in some instances. And we're seeing patients actually have to travel to another state actually to get that care to be able to treat their own cancer.

Unger: These are very harrowing and real world examples. In the testimony, you also surfaced issues regarding access to certain medications that may now be in jeopardy. Take us through some of those concerns.

Dr. Resneck: Well, I'll give you a couple. I'm going to start with a drug called mifepristone. And mifepristone is part of a very safe, very effective regimen for medication abortion. It's also used for the management of miscarriages. It's approved by the Food and Drug Administration, the FDA but we are seeing some states try to limit its use even for miscarriage management and put additional barriers in the way to using that, and again, that just decreases safety for our patients.

Interestingly, it's not just drugs that are directly used for abortion or miscarriage management where we're seeing this. So patients who think this may not affect them in any way or even bumping into challenges. There's a drug called methotrexate and methotrexate is used for a lot of medical conditions. It's used for lupus, it's used for rheumatoid arthritis. It's used for some inflammatory bowel diseases. I happen to be a dermatologist, we use it for psoriasis. Some types of skin cancers, actually, that we use it for as well. But it happens to also be used as a treatment for ectopic pregnancies as a way to avoid having to do surgery in some cases.
And we are actually hearing in these restrictive states about some pharmacists who are refusing to stock or refusing to dispense methotrexate in fear of prosecution, even when a patient is coming in for their rheumatoid arthritis treatment to refill their methotrexate. So we're beginning to see delayed care and refused care as a result. There's a long list of additional drugs, where again, we're beginning to hear stories about this.

Basically, any drug that not only affects a pregnancy itself but might be a cause of birth defects and end up affecting a choice around continuing a pregnancy later where pharmacists are sometimes not fulfilling their prescriptions for these drugs.

**Unger:** And so like so many areas of medicine where we see health disparities, talk a little bit about how—what you see as equity concerns that come with the decision and how certain populations might be disproportionately impacted by the decision.

**Dr. Resneck:** I'm glad you brought this up. Health equity is a big priority of mine and of the AMA in general. And as you know, there are a lot of existing inequities that we still need to fix out there in health care and maternal mortality is one existing inequities that already exists. And I am extraordinarily worried that the Dobbs decision is going to exacerbate some of those inequities.

Patients who have sufficient resources are probably in many circumstances going to be able to travel and access the reproductive health care that they need but the heaviest burdens are likely to fall on patients from Black, and Latino, and Indigenous, low income, rural and other historically disadvantaged communities. Among those patients who are turned away from access to comprehensive reproductive health care, different things may happen. Some may resort to self managed abortions without medical supervision.

Some who are able to get abortions might get them much later in their pregnancies after they travel to another state, arrange time off of work for that travel, maybe wait in a longer queue in that other state. And we know from very solid evidence that some patients who end up carrying unwanted pregnancies to term are going to experience actually worsening physical and mental health. Some are going to have more exposure to intimate partner violence as a result and face a lot more economic distress.

So this issue of health equity and its intersection with the Supreme Court decision is a substantial one.

**Unger:** Well, last question. Reflecting back on this whole conversation with emotions running very high on the issue with the chaos. You said many physicians are facing right now uncertainties and laws. Real impacts on patients.

When you think about all of these concerns, how is the AMA going to move forward to protect physicians and patients in the coming months?
Dr. Resneck: It's only been a few weeks, and so I think we've only begun to assess the full impact of the Dobbs decision on our physicians and their patients. We have a lot of folks within the AMA who are thinking a lot about this. We haven't even talked today about the impacts on medical education but we have people thinking about that and medical students and residents are going to be training in states where they potentially won't even have access to being taught about miscarriage management.

We haven't talked today about the privacy of medical data and what will happen when people's apps and the data from those apps and health care data potentially can fall into the wrong hands in the midst of all this controversy around reproductive health. Protecting people who want to travel across state lines, the physical safety of patients and of physicians. So I just think there's no way I can sugarcoat how dangerous this situation is right now in some of these states but we at the AMA are always going to have doctors backs.

We are always going to have patients backs. This fight is very far from over and we're going to continue to challenge the criminalization of medical care.

Unger: Dr. Resneck, thank you so much for being here today and giving us your perspective and talking about how the AMA will have the backs of both patients and physicians. We'll look forward to talking with you again as we learn more about the situation. We'll be back with another Moving Medicine video and podcast soon. In the meantime, you can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today and please take care.

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