

ABORTION, POWER, AND THE FUTURE OF HEALTHCARE

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In their latest book, *After Dobbs: How the Supreme Court Ended Roe But Not Abortion*¹ (“*After Dobbs*”), Professors David S. Cohen and Carole Joffe tell a set of important stories about abortion provision in the United States in the period surrounding the consequential *Dobbs v. Jackson Women’s Health Organization*² decision, in which the U.S. Supreme Court dismantled federal constitutional protection for abortion after almost fifty years.³ The authors’ deep relationships with abortion providers, developed over decades of thoughtful research and scholarship on the law, politics, and practical realities of abortion care, meant they were able to collect real-time information about how providers across the country prepared for and then responded to the Court’s decision.⁴ By conducting a series of interviews—before the Court released its opinion, immediately after the decision, and six months later—Cohen and Joffe captured a nuanced account of the relationship between law and abortion care and gave readers a unique view of the shifting landscape of abortion access in the United States.

Together, the interviews reveal a narrative of creativity, adaptability, and courage, detailing how abortion continued despite the risks of legal uncertainty and the additional barriers imposed by some states. However, the resulting volume is more than a collection of vignettes about navigating changes in the law. *After Dobbs* tells a story about collective efforts to care for vulnerable people in the face of many challenges. We learn about Tammi Kromenaker’s painstaking efforts to move her clinic secretly from North Dakota across the river to Moorhead, Minnesota, where she can serve the same patient population with far fewer restrictions.⁵ We also encounter Julie Burkhart’s unlikely decision to open a new abortion clinic in Casper, Wyoming.⁶ At the time, abortion access in the state was extremely limited:

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1. DAVID S. COHEN & CAROLE JOFFE, *AFTER DOBBS: HOW THE SUPREME COURT ENDED ROE BUT NOT ABORTION* (2025).

2. 597 U.S. 215 (2022).

3. *Id.* at 215.

4. *See, e.g.*, DAVID S. COHEN & CAROLE JOFFE, *OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA* (2020); DAVID S. COHEN & KRYSTEN CONNON, *LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM* (2015); CAROLE JOFFE, *DISPATCHES FROM THE ABORTION WARS: THE COSTS OF FANATICISM TO DOCTORS, PATIENTS, AND THE REST OF US* (2009); CAROLE JOFFE, *DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE* (1995).

5. *See* COHEN & JOFFE, *supra* note 1, at 72–78.

6. *See* COHEN & JOFFE, *supra* note 1, at 79–86.

only two doctors were performing abortions, both located at the opposite end of Wyoming and both providing medication abortion only.⁷ Burkhart was willing to proceed with her new clinic in part because of the existence of a state constitutional amendment guaranteeing Wyoming citizens the right to make their own healthcare decisions.⁸ This amendment had, ironically, been passed in opposition to the Affordable Care Act years prior.⁹ And we learn of the painstaking efforts clinic owner Curtis Boyd took to help his patients fly from Texas to New Mexico in order to avoid Texas's restrictive abortion laws.¹⁰ Boyd went so far as to organize clergy accompaniment for his patients to ease the burden and stress of travel.¹¹ For readers who support abortion access, this inspiring narrative of providers who have found ways to continue providing needed care offers hope and reassurance against the backdrop of upheaval and tumultuous change.

At the same time, *After Dobbs* is an infuriating read. The abortion providers Cohen and Joffe interviewed are forced to be resilient and visionary because so many states have imposed oppressive legal restrictions on abortion. These restrictions make providers' jobs much harder, creating unnecessary stress, risk, and expenditure of resources that could be put to better use.¹² More broadly, the book reflects the brokenness of our healthcare system and how that brokenness impacts access to reproductive healthcare services. For example, Dr. Leah Torres, whose experiences as an abortion provider in Alabama are detailed in chapter two, is just one of many doctors across the country who have been denied hospital privileges because they provide abortion care or who have been unable to garner support from hospital-based colleagues on medically complicated cases.¹³ Other forms of marginalization limit the participation of advanced practice clinicians, and midwives in particular, in a healthcare system that often favors economic protectionism instead of meeting the needs of patients, particularly related to reproductive healthcare.¹⁴ Several of Cohen and Joffe's interviewees discuss

7. *Id.* at 80.

8. *Id.* 81–82.

9. *Id.* at 81.

10. *Id.* at 86–91.

11. *Id.* at 86.

12. See Allison McCann & Amy Schoenfeld Walker, *Tracking Abortion Laws Across the Country*, N.Y. TIMES (Jan. 6, 2026, at 16:54 ET), <https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html> (on file with the *Fordham Law Review*). No amount of vision or resilience was enough to save those clinics forced to close entirely in the wake of *Dobbs*, reflecting a tragic loss to countless communities across abortion-restrictive states. See COHEN & JOFFE, *supra* note 1, at 49–56 (discussing Andrea Ferrigno's experience with the now-closed Whole Woman's Health network of clinics in Texas).

13. COHEN & JOFFE, *supra* note 1, at 58–60.

14. See generally Ruth Kleinpell, Carole R. Myers, Wendy Likes & Mavis N. Schorn, *Breaking Down Institutional Barriers to Advanced Practice Registered Nurse Practice*, 46 NURSING ADMIN. Q. 137 (2022) (discussing barriers to advanced practice registered nursing practice); Am. Coll. of Obstetricians & Gynecologists, *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision* (2023), <https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/advanced-practice-clinicians-and-abortion-care->

the centrality of private fundraising to support medical and travel costs for women forced to leave their home states to receive care.¹⁵ Fragmentation in the healthcare system, and within the health insurance market in particular, means some people have their abortions paid for by insurance without issue and others are left scrambling to fundraise for their care or depend on the kindness of strangers.¹⁶

Cohen and Joffe's findings about how abortion providers have scrambled to care for their patients highlight harsh realities about the system's failure to meet people's healthcare needs more generally. Indeed, the scholarly literature contains extensive analysis of the healthcare system's flaws and failings. Care deserts leave people without access to healthcare providers, hospitals, and clinics, especially in rural areas.¹⁷ Physicians face increasing administrative burdens and low reimbursement rates that limit the time they can spend with patients.¹⁸ Private equity and profit-seeking behavior more generally have corporatized healthcare and undermined facilities that people have long relied on for care.¹⁹ Bias and discrimination run rampant, harming patients and deterring them from seeking care when they need it.²⁰ Finally, the skyrocketing costs of healthcare put essential care out of reach and lead to high rates of medical debt and bankruptcy.²¹ The burdens of a broken healthcare system tend to fall hardest on the most vulnerable: low-income

provision.pdf?rev=ed4c1757442c4b3f8947154ae5627f6c&hash=15EC3922D4D0609D9162C1A4F1D6831D [https://perma.cc/9RYL-3RG6] (arguing that advanced practice clinicians' (APCs) integration can expand access to abortion care); Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243 (2021) (highlighting that midwife integration promotes better infant and maternal health outcomes and arguing that restrictions impede progress).

15. COHEN & JOFFE, *supra* note 1, at 122, 169–92.

16. See Erin R. Johnson & Monica R. McLemore, *Place Matters: Geographic Distribution of Abortion Fund Services*, 9 HEALTH EQUITY 397, 399–400 (2025), <https://journals.sagepub.com/doi/full/10.1177/24731242251369612>

[https://doi.org/10.1177/24731242251369612] (discussing fundraising through local organizations for costs associated with abortion care).

17. See Andrea Sonenberg & Diana J. Mason, *Maternity Care Deserts in the US*, [J]AMA HEALTH F., Jan. 12, 2023, at 1–2; Jacqueline Ross, *The Impact of Health Care Deserts on Patient Safety*, 39 J. PERIANESTH. NURS. 686, 686 (2024).

18. See generally Shari M. Erickson, Brooke Rockwern, Michelle Koltov & Robert M. McLean, *Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians*, 166 ANN. INTERNAL MED. 659 (2017) (providing a framework for analyzing administrative tasks required to be performed by clinicians and their staff).

19. See Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527, 527–28 (2024); Robert I. Field, Barry Furrow, David R. Hoffman, Kevin Lownds & Hilary Pearsall, *Private Equity in Health Care: Barbarians at the Gate?*, 15 DREXEL L. REV. 821, 821–22 (2023).

20. See John F. Dovidio & Susan T. Fiske, *Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Can Contribute to Health Care Disparities*, 102 AM. J. PUB. HEALTH 945, 945 (2012). For more discussion of medical racism, see VANESSA GRUBBS, *NEGLIGENT BY DESIGN: ANTI-BLACKNESS IN AMERICAN MEDICINE AND HOW TO ADDRESS IT* (2025).

21. See Irene Papanicolas, Liana R. Woskie & Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 [J]AMA 1024, 1024 (2018); Daniel A. Austin, *Medical Debt as a Cause of Consumer Bankruptcy*, 67 ME. L. REV. 1, 14–15 (2014).

and uninsured patients, racially minoritized patients, LGBTQ patients, rural patients, immigrant patients, and patients with disabilities.

Among many scholars and advocates interested in restoring constitutional protections for abortion, there is a desire to build a stronger, more enduring foundation upon which to ground a right to abortion than the legal framework of *Roe v. Wade*²² and *Planned Parenthood v. Casey*.²³ The invitation to think more expansively and creatively about legal arguments in favor of abortion rights should extend to how care is provided as well. This necessarily means reimagining the delivery and financing of healthcare services more generally because, despite the ability of some pregnant people to end their pregnancies using medication abortion without the involvement of medical personnel, abortion continues to be an essential form of healthcare for which many people will need or want assistance within the formal healthcare system.²⁴

When it comes to reconceiving the healthcare system, Professor Matthew B. Lawrence provides a thought-provoking invitation in an essay exploring an analogy between criminal law and health law.²⁵ Drawing inspiration from the prison abolition movement and its goal of shifting “focus from the dimension of substance to the dimension of power,” he proposes a hospital abolition hypothesis. He suggests that a similar set of moves in healthcare reform—shifting from a focus on the substantive dimensions of cost, access, quality, and equity to the dimension of power—would yield more progress in addressing the brokenness of the healthcare system.²⁶ Hospitals thrive when people are seriously ill, not when preventive care and effective management of chronic conditions keep people out of the hospital.²⁷ This necessarily raises concerns about the perverse incentives hospitals have as institutions when it comes to healthcare reform.²⁸ Perhaps, he argues, we should strive to “take hospital power out of the picture, shifting hospitals’ influence to other existing players” or creating new centers of power that will better serve the substantive goals of expanding access to care, ensuring quality, minimizing costs, and achieving equity.²⁹

Extending the argument of prison abolitionists that they seek “[n]ot so much the abolition of prisons but the abolition of a society that could have

22. 410 U.S. 113 (1973), *overruled by*, *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2242 (2022).

23. 505 U.S. 833 (1992), *overruled by*, *Dobbs*, 142 S. Ct. at 2242; *see* Rachel Rebouché & Mary Ziegler, *Fracture: Abortion Law and Politics After Dobbs*, 76 SMU L. REV. 27, 71–72 (2023); David S. Cohen, Greer Donley & Rachel Rebouché, *Rethinking Strategy After Dobbs*, 75 STAN. L. REV. ONLINE 1, 1–8 (2022).

24. Nor will efforts by abortion opponents to reframe abortion as something other than healthcare disentangle abortion care from the structures, institutions, and regulatory frameworks that shape the U.S. healthcare system.

25. Matthew B. Lawrence, *Operationalizing Power in Health Law: The Hospital Abolition Hypothesis*, 52 J.L., MED. & ETHICS 364 (2024).

26. *Id.* at 364–65; *see also id.* at 367 (“Abolitionists evaluate substantive policies based not only on their immediate impact but on their dynamic interaction with the power arrangements that determine which substantive policies get enacted and which don’t.”).

27. *Id.*

28. *Id.* at 370.

29. *Id.* at 365.

prisons,” Professor Lawrence suggests we could engage in a similar reimagining of aspects of healthcare currently understood as core hospital functions.³⁰ He asks what it would mean for maternal and infant health if neonatal care and childbirth were located in “childcare-centered institutions” that existed “to support [the] care of infants generally, not just at birth.”³¹ Under such a model, money invested in “labor and delivery would empower institutions committed to healthier child rearing” more generally.³² Similarly, “[i]f care for serious children’s health harms were located in schools, then the money [dedicated to treating] childhood cancers and broken arms would empower institutions with broader, less-conflicted interests.”³³ He extends this reframing to other aspects of care that are currently located within hospital systems but do not necessarily need to be, including cardiac care as elder care, cancer care as population health, and emergency mental health services as the purview of community health centers.³⁴

Professor Lawrence’s hospital abolition hypothesis encourages us to see that conceptualizing many forms of healthcare as hospital-based care is a choice and we collectively could make different choices about how to organize the provision of healthcare within our communities.³⁵ The abortion providers whose stories Cohen and Joffe tell in *After Dobbs* have been forced to make different choices about how to survive; their vision and adaptability could inspire other forms of reimagining. For example, it makes a lot of conceptual, political, and practical sense for clinics to expand services to provide prenatal care and other reproductive health services, including HIV care and gender-affirming care for transgender patients. This is what Dr. Leah Torres did as medical director of the West Alabama Women’s Center. Of course, the people who go to an abortion clinic for pregnancy termination also need care during other pregnancies, as well as pap smears, birth control, and other forms of reproductive healthcare.³⁶ Long before *Dobbs*, there were rare examples where a freestanding birth center provided both community birth and abortion care, enabling continuity of care across the reproductive life course. These models have been difficult to maintain, however, given both political interference with abortion care and the low reimbursement rate for midwives, for birth centers, and for Medicaid-covered births.³⁷ We could make different policy choices that enable such facilities to be common in

30. *Id.* at 372 (quoting STEFANO HARNEY & FRED MOTEN, *THE UNDERCOMMONS: FUGITIVE PLANNING & BLACK STUDY* 42 (2013)).

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *See id.* Indeed, people are already being forced to make different choices in rural areas where hospitals have closed or eliminated essential services.

36. COHEN & JOFFE, *supra* note 1, at 57, 61.

37. *See* Heather Wood Rudolph, *Meet the Doctor Who Opened a Natural Birth Center in Her Abortion Clinic*, COSMOPOLITAN (Mar. 11, 2014, at 10:52 ET), <https://www.cosmopolitan.com/lifestyle/news/a5915/katharine-morrison-birthing-center-abortion/> [<https://perma.cc/S4Q2-RDXL>]; Elizabeth Kukura, *Rethinking the Infrastructure of Childbirth*, 91 UMKC L. REV. 497, 534–42 (2023) (discussing regulatory and financial barriers to maintaining freestanding birth centers).

communities across the United States rather than allowing political and economic preferences that favor hospitals and other powerful stakeholders to dictate how and where people manage their pregnancies.

Professor Allison Hoffman has written about how the corporatization of healthcare has led doctors to cede much of their longstanding power, with corporate owners asserting control over physician autonomy in exchange for lucrative payments and the promise of freedom from administrative burden and certain forms of risk.³⁸ Given the historical success of the medical profession at asserting power over virtually all aspects of our healthcare system, including medical education, this shift is striking.³⁹ Professor Hoffman's account not only describes this trend in a clear and compelling way, despite its complexity, but it also makes a powerful argument about how power flows in the healthcare system, sounding a warning bell about what that means for patients and healthcare outcomes.

The focus on power in both Professor Lawrence and Professor Hoffman's essays facilitates a useful shift in mindset as we imagine a less contested future for reproductive healthcare within a healthcare system that meets the needs of all people. The abortion providers Cohen and Joffe studied exercise different forms of power, sometimes in unexpected ways, and remind us of important underutilized, often overlooked sources of power. For example, *After Dobbs* tells stories about doctors and administrators with extensive knowledge of the law. This savvy enables them to anticipate and plan meticulously for operational needs as state abortion laws change—sometimes repeatedly—in the face of legislative activity, court challenges, appeals, and ballot initiatives.⁴⁰ Their familiarity with law and regulation ensures less disruption for patients and more confidence among clinic staff in navigating periods of legal whiplash. Such experiences might raise questions about where medical and nursing training should introduce relevant legal education to develop legal competence for healthcare professionals.⁴¹ Expanding such education beyond malpractice and bioethics would more appropriately prepare physicians to navigate the legal and regulatory systems that shape medical practice, facilitating better patient care. Viewed this way, law is a form of specialized knowledge that shapes the exercise of power. If this knowledge is shared more widely by physicians

38. See Allison K. Hoffman, *How Power Undermined the Medical Profession*, in *RETHINKING THE LAWYERS' MONOPOLY: ACCESS TO JUSTICE AND THE FUTURE OF LEGAL SERVICES* 203, 212–16 (David Freeman Engstrom & Nora Freeman Engstrom eds., 2025).

39. *Id.* at 203 (“Over the course of the twentieth century, the medical profession in the United States aggrandized power and profit and is now watching it begin to slip away.”).

40. See COHEN & JOFFE, *supra* note 1, at 97–103 (discussing Kwajelyn Jackson's experience navigating multiple changes in Georgia law to ensure her Atlanta-based clinic remained operational).

41. See, e.g., Nirav D. Shah, *The Teaching of Law in Medical Education*, 10 *AMA J. ETHICS* 332, 334 (2008) (proposing a legal medicine curriculum that would “give medical students concrete tools with which to enter medical practice”). Dr. Shah notes a “reluctance within medicine to discuss practical legal and business realities,” particularly in medical education, despite survey findings that over 80 percent of medical students wished for training in “legal pitfalls in practice.” *Id.* at 333.

invested in patient care, there is more opportunity to exercise such power in beneficial ways.

Another source of power for the abortion providers included in *After Dobbs* is a high degree of community centeredness that guides decision-making about how to operate their practices and how to communicate with patients. Placing a high value on the needs of the community shapes the successful work of clinic owners like Julie Burkhart, whose bold decision to open a new clinic in Wyoming was responsive to local advocacy efforts. It also shapes the work of providers like Erin King in abortion-friendly states such as Illinois that saw dramatic increases in patient loads and relied on a regional logistics center and patient navigators to meet the needs of patients traveling from out of state.⁴² Specifically, in an effort to reduce the burden on abortion patients and streamline the process of securing an appointment, providers in Illinois created the Complex Abortion Regional Line for Access (CARLA) program. CARLA refers patients with medically complicated needs to an intake worker who takes a medical history and then arranges an appointment at a participating Chicago hospital.⁴³ This collaboration between hospitals and other providers has smoothed the path for patients seeking abortion care under challenging circumstances, in contrast to the competition for patient business seen in many other places throughout the healthcare system. Importantly, it reflects an awareness of the patients' experiences navigating the healthcare system and the marshaling of resources to reduce the burden on patients. Providers understand what their patients and communities need and expect from their healthcare providers. Such an understanding both builds trust in providers and makes clinics resilient in challenging regulatory and financial environments. Relatedly, Cohen and Joffe's interview subjects also derive power from deep relationship building in multiple areas related to operating their medical practices. They have cultivated relationships of trust with and among staff, with patients, and with allies in local government and law enforcement that have helped to make them successful under challenging circumstances.⁴⁴

The stories in *After Dobbs* reflect a variety of types of power, sources of power, and methods of exercising power that could help us envision a world in which communities exercise more control in shaping where and how people access healthcare. Such a reimagining could include where clinics are located, what kind of services should be provided under the same roof, and what barriers to accessing care providers might be able to ease if it were considered part of their professional responsibility (and something for which they are compensated). Or perhaps more radically transformative when it comes to patient experiences, we could imagine what it would mean to give communities power in shaping the education and training of our doctors. At the very least, more community centeredness in the training of healthcare

42. COHEN & JOFFE, *supra* note 1, at 80, 129.

43. *Id.* at 131.

44. *Id.* at 77–78, 103, 125.

professionals could generate greater understanding of their patients' lives and lead to better communication, more trust, and improved outcomes.

Ultimately, the experiences recounted in *After Dobbs* may rightfully inspire fury about the many inadequacies of the healthcare system and the unnecessary harm inflicted on patients ill-served by existing healthcare infrastructure. However, the book should also cultivate hope among readers, not just because abortion providers have continued to find ways to help their patients exercise reproductive self-determination in the face of unwanted pregnancies, but also because their resourceful strategies when confronting legal and political challenges, their fierce determination, and their deep compassion for their patients illuminate qualities that are necessary for shifting power and transforming healthcare for the benefit of all.