Not a Women's Issue: How Cancer Nurses See the Impact of Post-*Dobbs* Legislation as a Threat to the Future of Good Healthcare for Us All

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With the ruling in *Dobbs v. Jackson Women's Health Organization* on June 24, 2022, the Supreme Court allowed the permanent injunction against a Mississippi abortion ban to be removed, paving the way for multiple states across the country to pass abortion-hostile legislation, some even banning abortion entirely (Harmon, 2023). In addition to eliminating the national right to an abortion, the concurring opinion by Justice Clarence Thomas created a legal environment with grave uncertainties for women's healthcare and public policy in general. In his opinion, he recommended that the Supreme Court reconsider other previous rulings; most notably, it recommended reconsidering the decision in *Griswold v. Connecticut* that established the legal precedent of a Right to Privacy (Stolber, 2023). Other legal pillars that are built on this right to privacy include the right to make decisions about intimate partners, how to raise children, whom we marry, and whether and when to use contraception (Harmon, 2023). Accordingly, experts are anticipating an influx of legal challenges and policy changes regarding reproductive health care and gender-related fundamental rights (Easter et al., 2024).

In the wake of substantial legal changes, like the Supreme Court decision in *Dobbs*, questions are raised about how individuals with different identities will experience the resulting public policy changes. Post-*Dobbs*, patients across different fields of medicine will be experiencing their various medical issues in a legal landscape where the type of care they are able to receive, especially reproductive care, varies across localities and even from hospital to hospital. Healthcare policy is already so complex in the United States between the regulation of insurance coverage, public financing, differing care models, and the disparities in research on women's health (Easter et al., 2024). The creation of additional hurdles to patient-centered care by national policy changes has the potential to impact essential healthcare services for women faced with serious medical decisions. As identified by Chabner and Bates (2022), the risk of serious harm to the rational practice of medicine lies in the fact that *Dobbs* establishes a social and legal acceptance for government intrusion into other areas of medical practice. One of the major fields establishing a standing in this legal debate is the field of oncology, as reproductive healthcare is closely tied to stem cell research, in vitro fertilization, genome-altering therapies, contraception, and other categories of research and medical practice relevant to cancer treatment (Chabner and Bates, 2022, p. 427). According to the American Society of Clinical Oncology, core principles for cancer care and pregnancy include practicing medicine that acknowledges pregnancy's effect on all aspects of cancer care "from screening and prevention to treatment and survivorship" (Spence et al., 2023, p. 2853). Their suggestions for the ethical practice of oncology include that all pregnant patients should be offered all effective cancer treatments. They state it is inappropriate to limit suggested treatment options due to pregnancy (Spence et al., 2023, p. 2853), as further reproductive legislation might demand in the post-

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Dobbs era. These early considerations around oncology and reproductive rights form the landscape for this study's investigation.

Literature Review

One of the primary areas of focus in the research on the impact of reproductive policy and legislation is the effects on healthcare providers in individual states. Studies in Tennessee, where providers face felony charges if found to have improperly performed or advised on abortion procedures, have noted that the impact is a return to hesitant and defensive medicine out of fears of medical malpractice liability (Lilly et al., 2024, p. 2). This finding has held in other states, like Georgia, where the ambiguous bill language in defining what qualifies as an "exception" or a "criminal abortion" has had the effect of limiting the amount of risk healthcare professionals are willing to take in care provision (Hartwig et al., 2023, p. 3). Even in a study conducted in California, where the current legislation is protective of abortion access, Preiksaitis et al. (2024) found that concerns about legal repercussions are still present amongst healthcare providers in multiple fields. This same study added, however, that the clarity of legal boundaries allows the decision-making regarding patient care to be more straightforward. Despite the complications of the unique legislative circumstances in each state, studies show that across state borders, abortion providers maintain an unshaken commitment to providing quality comprehensive care and remain dedicated to and satisfied by their work (Britton et al., 2017; Hartwig et al., 2023). Even in a state like North Carolina, where the mandatory waiting period puts physicians, doctors, and nurses in the direct position of carrying out the restrictive healthcare policy, studies show that these providers still describe the work as a "calling" and a "source of passion" (Britton et al., 2017, p. 227).

Additionally, more recent research on the perceived impact to abortion providers of changing legal landscapes commonly focuses on provider mental health. Abortion providers report attributing symptoms of anxiety and depression to a perceived loss of professional integrity (Sabbath et al., 2024, p. 7). When measuring the perceived impact of post-*Dobbs* abortion bans on obstetrician-gynecologists, almost all providers interviewed by Sabbath et al. (2024) reported moral distress from being legally obligated to regress clinical standards and used words like "muzzled", "handcuffed", and "straitjacketed" (p. 5). This is a parallel finding in other broader studies on healthcare workers' mental health when faced with frequent changes in everyday tasks and a perceived uncertainty of whether their employers will protect them from repercussions (Jerg-Bretzke et al., 2021, p. 10). More narrowly, as a direct response to the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization,* studies show that the greatest risk to increased stress, anxiety, and emotional distress in abortion providers is the possibility of being confronted with the inability to administer evidence-based or medically-indicated care to their patients due to outside legal forces (Buchbinder et al., 2024; Sabbath et al., 2024; Schultz et al., 2024). A supplementary finding added that differing levels of risk tolerance amongst clinicians as they collaborate on patient care is a critical contributor to moral distress (Buchbinder et al., 2024), which is beneficial to the research on the mental health of healthcare providers as they continue to be faced with increasingly complex medical situations.

Finally, as policies and legislation relating to reproduction and women's health

continue to change, studies are showing a changing attitude toward the viability of a career as an abortion provider. Studies show that challenges to the scope of practice available to abortion providers in the South have limited professional development opportunities and possible financial gains, creating unfavorable working conditions and affecting providers' motivations to work outside their current state of practice (Chowdhary et al., 2022, p. 1355). This same perception about the prospect of relocation is reflected in research on how medical students, regardless of intention to study obstetrics or gynecology, are deciding where to do their residency training as many are less interested in working and living in an abortion-hostile state (Hulsman et al., 2023; Preiksaitis et al., 2024). This adds to the body of research concerned with the potential for a future workforce shortage in abortion providers (Chowdhary et al., 2022; Hulsman et al., 2023) as turnover intention grows amongst current practicing OB-GYNs (Sabbath et al., 2024, p. 6) and educational deficits create gaps in necessary medical and legal training at the residency level (Preiksaitis et al., 2024, p. 448). In congruence with these findings, other studies suggest that the increased likelihood of losing physicians to other regions and the decreased likelihood of medical students' residency interest in women's health, has contributed to an accelerating rate of "workforce attrition" (Schultz et al., 2024, p. 7). As practitioners pursue careers in other locations with less restrictive policies or other fields of medicine less affected by these legal changes, there are no longer enough new practitioners to fill those voids in the workforce.

Current literature on studied impacts of abortion-restrictive legislation pre- and post-*Dobbs* mostly addresses current or potential effects of abortion bans to abortion providers and the decreasing quality of care they are able to provide. The state specific research highlights the variance in abortion provider experience as local governments define limits for the provision of abortion care. Broader research on the effect of these restrictive legislative environments shows a direct negative correlation between the mental health of abortion providers and the sustainability of the provider's career path. This focus on the impact of abortion bans on abortion providers, while understandably a result of the sociopolitical and legal landscape resulting from *Dobbs*, is incomplete. What's missing from existing research on this topic is the perspective of non-abortion-specific healthcare workers, who are specialized in other medical fields, on how they see reproductive policy changes impacting their lives and professional roles. The research done in this paper will fill that gap by asking how cancer nurses in New York City perceive the impact of post-*Dobbs* legislation on their roles as healthcare workers. By focusing on the experience of nurses in a cancer hospital, I plan to draw the focus of the inquiry away from abortion bans and produce a greater understanding of the pervasiveness of the *Dobbs* decision on a new demographic of healthcare providers.

Research Methods

To complete this research, I conducted in-depth, semi-structured interviews with three oncology nurses who live and work in New York City; Rose, age 26, Bonnie, age 23, and Poppy, age 28. These nurses all work at the same hospital in Manhattan and each of them has worked at this same hospital since graduating their respective nursing programs. Poppy has lived in the New York area for many years while Rose and Bonnie moved to the city for their work from out of state. Poppy and Rose went to nursing

programs in states that have continued to protect abortion rights (New York and California) while Bonnie went to school in a state with restrictive abortion laws (South Carolina). All participants in this study currently work as night-shift nurses and are in long-term relationships. I recruited these three research participants using my personal network through a connection I have with an employee who works at the same hospital.

These three individuals presented as good candidates for my research, as they are cancer nurses with varied identities and educational backgrounds, now working in the same hospital at the beginning of their careers in the years immediately following *Dobbs*. Nurses in particular are often pulled between personal feelings, strong relationships built with patients, hospital policies, and complying with government regulations. This positions them to be primed to comment on the effects of monumental changes to healthcare policy at the earliest stages. The fact that they work in a cancer center also provides an interesting area of study to analyze the impact of government restrictions on reproductive health care because cancer treatment is an ever-evolving and relatively new field of medicine. This makes it more susceptible to changes in healthcare policy and can be more long term than treatment for other illnesses, requiring many elements of a patient's life to be considered by the care team. Additionally, the fact that the participants are in their early to mid-twenties and in serious relationships adds to the personal considerations these nurses may be making in their own family planning in the next stages of their lives and increases the potential impact of post-*Dobbs* legislation relevant across many different aspects of their experiences.

The interviews I conducted centered on three main categories of questions. The first questions related to the education and early career decisions that led these individuals to become oncology nurses. I wanted to understand what pulled them into this specialty beyond why they wanted to be nurses to begin with. I also sought to understand what their day-to-day experiences were like in the hospital and how they interacted with patients, doctors, and other hospital personnel. In all my interviews, after understanding this background information, I asked specifically about their reactions to the *Dobbs* decision in 2022. I asked about their feelings surrounding the changing legislation both on a personal level and as healthcare professionals. While their responses varied from interview to interview, the remaining questions I asked focused on the potential crossovers in cancer care and reproductive healthcare and considered the further implications of the future of cancer treatment, research possibilities, and the realities of further potential healthcare bans and restrictions. Within the experiences of these nurses, I found three critical themes: the difficulty for these nurses of imagining life without choices, the challenges that widely restrictive healthcare policy presents to effective patient care, and the sense of resignation that they experience in the face of the insurmountable task of healing.

Analysis

Pro-choice

From my interviews with oncology nurses about their perception of post-*Dobbs* legal changes, a theme I found in their answers is the impact of imagining a life without choices. In their stories, these three nurses tended to emphasize how life as an oncology

nurse requires them to confront big questions alongside their patients. My interviewees shared how in dealing with patients who have just been given a life-altering diagnosis, the responsibility falls to them to guide their patients through the next phase of their lives. Cancer, like pregnancy, can be unforeseen, with one participant describing it as "people are just living their lives and then all of a sudden, they get this diagnosis." When faced with patients looking at their lives in the context of their new medical reality, each interviewee identified the ability for patients to make their own choices about what is happening to them as a major source of relief and comfort. In order to do their jobs effectively, these nurses explained they are not just thinking about cancer-related outcomes, but they are doing their best to treat the person in front of them and everything that comes along with that.

In imagining attempting to care for patients in this way under future contraception bans, Rose said…

> Or then with contraception, if contraception is illegal and a patient, if you're a woman and your husband has cancer and you just wanna have sex. You're in debt because of all the medical expenses, and then you get pregnant, and then your husband dies and like you don't have a say in being able to make those decisions with your partner…like I just can't. There's so many ways in which it would affect people's lives.

Also addressing the tension between making medical decisions and preserving quality of life, Bonnie suggested…

> I wouldn't be surprised if people just like turned down treatment altogether and just let it run its course, because like just ha! Not having these options. I mean, like for me, if I were in that position it'd be like, okay I'm just gonna live my life then.

It is clear that these nurses are concerned with what their lives and the lives of their patients may look like as options get taken away. For Rose, the decisions that she is making with her patients are never simple and they embody all of the complexities of life. Even just imagining the loss of one available option causes Rose to grapple with all of the pain, fear, and grief that her patient could experience - an everyday reality for these oncology nurses that is reflected across many answers in the transcripts. Considering these emotional burdens, Bonnie's answer speaks to how in her confrontation with making sense of the suffering she sees, being able to make choices is the antidote. She goes so far as to believe that people would rather turn down treatment than be forced to make certain decisions due to a lack of options. For most of them, the considerations they are making were expressed in the context of cancer care but it was also mentioned that the *Dobbs* decision has raised concerns for them in their personal lives too. Poppy shared…

> After the *Dobbs* decision my girlfriend and I did have to have a conversation about whether or not we should get married. Basically while we still have the right to do so, because after abortion, coming for marriage equality was basically the next step for the GOP. So we did have to have that conversation of, you know, should we just do it now, while we still, while it's still legal

> everywhere? Or you know, do we wait? Do we hope for the best? So that is a conversation that we had to have.

The same mental battle that all three nurses go through in their work as healthcare providers, attempting to predict the unpredictable, also applies to their lives outside of work. While for Poppy, the considerations they are taking on relate to relationship decisions, the other nurses also mention how the *Dobbs* decision impacts their own thoughts about family planning and where they would or would not be willing to work. The common thread through all of these examples is that my interviewees emphasized that life without choice gets a lot more complicated.

The Less Rules, The Better

A second theme I discovered in my interviews with oncology nurses is that they perceive healthcare providers as being largely more capable of providing help than they are often able to be in practice. Rather than focusing on the effect that abortion bans or related legislation would have on women specifically, the primary concern emphasized by my interviewees was the way that policy restrictions eliminate their ability to be proactive in patient care. In descriptions of their work at the hospital, all three nurses referenced times they can remember where certain hospital policies and practices prevented them from acting on anticipated problems and giving the level of care they believed their patients deserved. Throughout the transcripts, when talking about their roles as healthcare workers, these three nurses use words like "privilege", "responsibility", and "important", indicating that they see their ability to help their patients as fundamental to who they are as people and professionals. They expressed a shared ideal vision of what it means to be a healer and the frustration they feel when that vision is not realized. Bonnie expressed her frustrations with her hospital's policy when she said...

> Right now, our hospital, like, I truly think, for being a cancer center, like they need to really step up their game in the supportive care realm. It's a very reactive service right now. So they're consulted when something acutely changes in this patient that's causing them a lot of pain or discomfort. But if they were on board before the situation happened, like, there's a potential that that situation could have never happened if they had just managed the symptoms earlier. But right now it's so reactive. And they kind of like, wait for someone to like, start to actively die, or something bad happens, and they need more pain management all of a sudden. I wish it was just more proactive than reactive at this point, because what we're doing right now for them is not adequate.

While all of the interviewees had current examples of the ways that they see overcomplicated bureaucracy and policy in tension with good healthcare, it was also mentioned that the future of good healthcare hinges on the removal of these roadblocks. As Rose said...

> I definitely think, in general, for advancements in science, you need to be able to be creative. The less rules the better in order to experiment. So the more that the government gets involved in what you can and can't do medically, the less freedom people are gonna have to have creative ideas and try them out. And I

> think, both in reproductive health and in cancer, which are unknown, still pretty unknown fields, the more rules, the less we learn.

These nurses share the opinion that reactive or restrictive medical practices and policies have clear potential to interfere with their ability to provide good care, which they believe is the antithesis of what the healthcare system is supposed to do. Bonnie uses the phrases "not adequate" and "step up their game" in support of her expectations of what effective healthcare practice looks like, demonstrating that she believes policies that prevent her from helping her patients at an earlier stage are unacceptable. The second response is just one example of the additional concern these nurses share with the ability of the healthcare system to anticipate patient needs in the future. All three nurses reflected the need for creativity that Rose states above, mentioning ways they see cancer and cancer care evolving in the future that will require all kinds of medical professionals "to have creative ideas and try them out." One can see in both of these quotes that, to these three nurses, the provision of good medicine includes a healthcare system - from the research in the labs to the nurses at bedside - that is set up to allow care that can be given, to be given.

Just a Nurse

A final theme I found in my interviews with oncology nurses is a feeling of resignation in the face of juggling a work environment that demands so much of them. All three interviews included examples of times when these nurses have had to say "I don't know" to major patient concerns because of a lack of communication amongst the care team and the risk that this has to the patient-nurse relationship. This theme differs from the prior theme in that, while they are able to identify clear ways they believe hospital and legislative policy restricts their efficacy as healthcare providers, their legal consciousness in relation to these policies is one of compliance to the system. These interviewees tended to emphasize that in these moments, there is only so much they can do or so much they have the power to control, despite that they know it has an adverse effect on the patient's experience. The theme above demonstrates that these nurses imagine themselves as advocates whose job it is to make the process easier for the patient; however, across the transcripts, my interviewees also emphasized the difficulty of that challenge and the intensity of being the one in the room delivering somewhat incomplete patient care. For one of the nurses I interviewed, this tension presents itself often in her relationships with the doctors. For Rose, she shares…

> But there are often so many times I can see a patient suffering, and I have recommendations that would be very different from what the doctor is recommending, but it's not my place to voice them, or you know, I can make recommendations to a doctor, but if they say no, then that's where it ends. And when it feels really unethical, or I really see a lot of suffering, it can feel defeating, to not really have an avenue to change what's going on and to just have to find a way to do my best within the scope or the lane that I have. And there are ways that we can try to fight it. But at the end of the day, I'm just a nurse.

For Poppy, where they see themself on the ladder of influence in their workplace is

evident in how they make decisions…

> I've never made a decision without discussing it with a doctor. I'm too anxious to do that…I, just as a human being, like to go up the chain of command. I don't always check with the doctor about things, like sometimes I'll go to my charge nurse, and we kind of talk it out. But like if I'm not a hundred percent sure, I'm checking with somebody. I'm not gambling.

As clearly demonstrated in these responses, the nurses I interviewed see themselves as a very small part of a large system in which they do not feel they have the opportunity to effect change. Poppy's use of the phrases "go up the chain of command" and "I'm not gambling" demonstrates the challenge of being the one that patients look to for answers and the impossibility of taking that on alone. Similarly, it is clear from the first response that Rose feels there are times when she knows better what's right or wrong for the patient in front of her, but she is limited by the hierarchy of the workplace and the realities of what she is allowed to do. Rather than face this conflict everyday, and shoulder the responsibility of fixing a system in which there is still so much suffering, Rose instead reminded me, and maybe herself, that she is "just a nurse."

Conclusion

In this paper, I looked at how reproductive policy changes can have an impact in a variety of ways beyond the heavily studied effects of abortion bans on abortion providers. In order to widen the understanding of how another medical field may experience changes as a result of these policies, I focused on the perspectives of cancer nurses in New York City. From my in-depth and semi-structured interviews with these nurses, three main themes were apparent as important to consider in answering this research question. The impacts that these nurses see on their lives as healthcare workers include imagining life without choices, the challenges that restrictive policy presents to effective patient care, and the sense of resignation that they experience in the face of the insurmountable task of healing. Rather than presenting the issue as a women's health issue, the nurses I interviewed see the impact of the *Dobbs* decision as a clash between the realities of working in healthcare and being a caring human being. This study adds a new perspective to the literature because it demonstrates the potential effects post-*Dobbs* legislation can have on the entire healthcare system, not just on reproductive health.

Further research on this topic should consider a few key avenues of investigation. The first to consider is that research on this topic would be interesting to conduct at a cancer center in a state where abortion bans and other legal restrictions are currently pending or already in effect. While this study was effective at acknowledging many of the possible ways that this legislation could affect the work of these nurses, there are other nurses who may already be seeing the outcomes of these laws in action. Additionally, further research should consider how the changing legal landscape will affect medical training and education. Due to the recency of the *Dobbs* decision, the participants for this study had graduated prior to the ruling and therefore I was unable to measure the impact of the decision on nursing education.

Despite the different locations of these nurses' training and education, the

opinions of the nurses on the studied topics were similarly aligned, likely due to the fact that they are licensed to practice in an abortion-protective state and have chosen to lay down roots in their professional and personal lives in this type of political and social climate. However, the greatest measurable difference between the nurse trained in a state with abortion restrictions is more closely tied to the fact that her clinicals were run in person in 2021 despite the COVID pandemic, while the other two were restricted to socially-distant training. While not the main topic of this paper's investigation, this element of the study speaks to the impact of state-specific regulations on the training and practice of nursing. Lastly, this study would have benefitted from more time to review theories of psychology and sociology as it applies to the healthcare system, in order to dive deeper into the ways both patients and nurses are affected by relevant policy change. While this study attempted to be comprehensive in reporting on the experiences of the three nurses I interviewed, I think future scholars should more deeply consider how nurses perceive impact to themselves through impact to their patients. This is a finding from this paper that I did not have the opportunity to investigate more thoroughly.

The implication of this study's findings is that the *Dobbs* decision triggers concerns of a healthcare system in which providers know what to do, or could know what to do, but cannot do it. While the elements of this research question focused on a specific scope of legal changes, the ultimate findings are more concerned with the established precedent that it is acceptable, under any circumstance, to not offer certain healthcare when the science and the tools have been developed to offer it. The findings in this paper can be especially frightening when we look to a potential future where cancer treatment is happening within a limited and restrictive healthcare system. The impact that post-*Dobbs* legal changes could have on effective patient care, not just in the context of reproductive care, is greatly established by this study. Though nurses are just one piece of the puzzle in the complexity of healthcare, the experiences of the nurses I interviewed and the insights in this study expose the damage that limiting or roadblocking care options has on holistic and effective treatment. As the paper suggests, the complexities of cancer care demands flexibility and an informed, proactive, and engaged healthcare system; banning abortion (and possibly IVF, and sperm banking, and stem cell research) is a direct threat to that flexibility.

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