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Ohio Abortion Regulations and Ethical Dilemmas for Obstetrician–Gynecologists

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Short Title: Abortion Regulations Create Ethical Dilemmas

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Precis

Ohio abortion regulations limit obstetrician–gynecologists' ability to provide comprehensive reproductive health care, creating ethical dilemmas for these physicians and increasing risks to their patients’ lives and health.

Abstract

Objective: To analyze obstetrician–gynecologists' experiences with, and perspectives on, how Ohio's abortion-restrictive regulatory landscape affects their health care practices.

Methods: Between 2019 and 2020, we conducted qualitative interviews and focus groups with obstetrician–gynecologists (n=35) who had practiced in Ohio for at least six months between 2010 and 2020. Discussions were recorded, transcribed, coded, and analyzed thematically using ATLAS.ti software.

Results: Participants perceived Ohio abortion regulations affecting their practice in three key ways: abortion regulations framed abortion and physicians who provide abortion as separate and distinct from other medical practices and physicians; many institutional interpretations of abortion regulations undermined physician expertise and professional autonomy; and the constellation of abortion regulations, institutional interpretations, physicians' trepidation, and their perceived inability to exercise clinical judgement worked together to limit abortion access and increase risks to patients' lives and health. The combined factors left participants feeling distraught that they were unable to practice medicine in an ethical and compassionate manner.

Conclusions: Ohio abortion regulations limit obstetrician–gynecologists' ability to provide comprehensive reproductive healthcare, creating ethical dilemmas for these physicians as they attempt to care for their patients. As Ohio's abortion laws increase in number

and restrictiveness, they further undermine obstetric and gynecologic ethical practice guidelines. However, medical institutions play a key role in determining abortion provision in Ohio: through their interpretation of the law, institutions can demonstrate support or further limit obstetrician–gynecologists' abilities to exercise clinical judgment and provide ethical, compassionate care to their patients. Considerable work remains to bring Ohio's abortion regulations, institutional interpretations, and physician practices into alignment with professional clinical practice and ethics guidelines.

Introduction

Ohio enacted sixteen abortion care-related regulations between 2010 and 2019.[1,2] Passage of these laws, many of which are imprecise and do not correspond to clinical frameworks, coincided with seven procedural abortion clinic closures in the state since 2010.[2] While many regulations have targeted free-standing abortion clinics, some limit when public hospitals can provide abortion (Table 1). Moreover, roughly one third of Ohio's private hospitals are affiliated with the Catholic Church, whose religious directives constrain the abortion care those hospitals provide.[3,4]

Abortion regulations cause major disruptions to access.[5,6,7,8] Physicians who perform abortion accommodate these regulations by altering their clinical and counseling practices.[9] However, little is known about the impact of the recent proliferation of abortion regulations on reproductive healthcare physicians who work outside of free-standing abortion facilities. To understand the effects of Ohio's abortion regulations beyond abortion clinics, we assessed how other physicians interface with them.

Our study documents the experiences and perspectives of obstetrician–gynecologists (ob-gyns) within Ohio's abortion regulatory landscape. Our study asks how Ohio abortion regulations affect the reproductive healthcare practices of clinic-adjacent ob-gyns. The objectives of this paper are to: examine ob-gyns' perceptions of how regulations characterize abortion and physicians who perform abortions; describe how ob-gyns perceive healthcare institutions' interpretations of abortion regulations; and discuss dilemmas that arise for ob-gyns when abortion laws and institutional policies are at odds with ethical practice guidelines.

Methods

We employed qualitative research methods, conducting in-person semi-structured focus groups and in-depth interviews. Using snowball sampling, we recruited participants (n=35) from hospitals, medical specialty professional societies, and professional society advocacy events. Obstetrician–gynecologists met eligibility criteria if they had practiced obstetrics and gynecology in Ohio for at least six months between 2010 and 2020. Obstetrician–gynecologists who worked in free-standing abortion clinics at the time of the study were ineligible to participate. Most of our participants were White and female.

Between April 2019 and March 2020, we held four focus groups, ranging from two to nineteen participants, and conducted five individual interviews (Table 2). Before each meeting, participants received an information sheet that outlined study procedures and their rights as participants. Participants also received an abortion legislation timeline that included state laws that were enacted, enjoined (blocked by the courts), or proposed in Ohio between 2011 and 2019.[10] After securing verbal consent from each participant to participate in the study, we asked them to review the timeline and discuss which, if any, pieces of legislation impacted their work.

Interviews and focus groups lasted 45- to 90-minutes. We determined sampling saturation based on exhausting recruitment efforts of ob-gyns who worked in the major population centers in the state. We audio-recorded each research interaction, transcribed the recordings, and de-identified transcripts by assigning pseudonyms to participants. Two members of the research team used ATLAS.ti to code all transcripts

separately before meeting to discuss thematic findings.[11] The coders discussed discrepancies to reach consensus on emerging themes. Discussions in weekly research meetings confirmed thematic saturation. The University of Cincinnati Institutional Review Board approved this study protocol (Study #2019-0095).

Results

The 35 ob-gyns who participated in the study reported working in a broad range of healthcare institutions including public, not-for-profit, and community hospitals, academic medical centers, and private practice. A small number practiced privately. Participants included attending physicians, fellows, and residents. Most participants worked in Ohio's most populous regions – Northwest, Northeast, Central, and Southwest. Although no participants worked in free-standing abortion clinics at the time of the study, a few mentioned they had worked in abortion clinics earlier in their training or career and had current or previous experience providing abortion care outside of abortion clinic settings.

We identified three key themes that describe how Ohio ob-gyns perceived the effects of abortion regulations on reproductive healthcare provision (Table 3). First, ob-gyns reported that Ohio abortion regulations characterize abortion and physicians who perform abortion as separate and distinct from other types of health care and physicians. Second, ob-gyns perceived hospitals as powerful interpreters of abortion regulations; interpretations varied widely among institutions. Third, ob-gyns encountered ethical dilemmas at the intersection of abortion regulations, institutional interpretations of these laws, and patient care. Throughout this section, using descriptive names, we

reference the specific Ohio regulations that ob-gyns reported having impacted their practice and professional autonomy (Table 1).

The American College of Obstetricians and Gynecologists (ACOG) states that "safe, legal abortion is a necessary component of women's healthcare"[12] – a stance our participants echoed. However, participants felt that Ohio's regulations exemplify abortion exceptionalism[12] by regulating it more strictly than other areas of healthcare, attempting to distinguish physicians who perform abortion from other physicians, and targeting them with criminal penalties.

Participants discussed the influence of regulations such as Ohio's 21 weeks 6 days (21.6) abortion limit on documentation – sometimes explicitly required by law and other times required by institutions to document compliance. Participants commented on the contradiction between such requirements and the lack of documentation requirements for other major reproductive health procedures. Laws that include expanded documentation requirements for abortion signal to physicians that abortion is distinct from standard healthcare.

Referring to Ohio's abortion regulations, one participant said, "In this situation now…it's kind of become something that more providers are anxious about…making sure we have all the right documentation." Other participants said they believed many abortion regulations were designed to catch physician wrongdoing, revoke their licenses, and criminalize them rather than protect patients' well-being. Participants articulated that this fear pushed them to spend additional time on documentation rather than with patients – even in clinically straightforward cases. Documentation

requirements, combined with ob-gyns' fears, created more work for them and added to the framing of abortion as exceptional.

Participants argued that laws, in addition to treating abortion differently than other procedures, were written as though physicians who perform abortion differ from other physicians. One participant said that abortion regulations are indicative of how legislators "have been able to basically try to separate [abortion] out from normal healthcare; [those who support the regulations believe] it's abortion and regular healthcare, ob-gyns and abortionists." Participants felt that this type of separation stigmatized abortion and demonized physicians who perform abortion. Most of the participants who perceived this differentiation saw legislation distinguishing those who primarily perform abortion from other physicians, but some saw abortion regulations as implicating OBGYN as a profession. One participant said, "I see these laws as restricting and attacking the total package of care that we as healthcare providers for women are able to provide…." Many participants agreed that by differentiating abortion from other healthcare, legislation made it more challenging for ob-gyns to provide comprehensive reproductive healthcare, especially in cases where therapeutic abortion was indicated.

Participants expressed confusion and frustration with their institutions' interpretations of Ohio abortion regulations and resulting internal policies. Participants discussed how institutional interpretations of specific regulations varied across the state, and participants experienced uneven levels of communication about abortion regulations from institutional administrators. One participant said, "Different hospitals are giving different legal counsel and practice patterns, and some of the gray areas vary

from hospital to hospital." For example, interpretations of the 21.6 limit varied regarding which medical cases meet the criteria for a medically-indicated exception for a termination beyond that limit. Some participants said their institutions supported physician determination of what qualified as "life-threatening" to the patient and therefore necessitated abortion beyond 21.6 gestation, while other participants said that their institutions never allowed abortion beyond this limit, although abortions that met the criteria would be legal.

Ohio requires "viability testing" (generally measured via fetal weight or other fetal measurements "after the beginning of the twentieth week of gestation"; attending physicians must sign a state form after each abortion, certifying that the legal requirements were met. Institutions varied regarding their communication about the regulation and its documentation requirements. Participants worried that physicians at institutions that did not inform clinicians about the viability ban requirements could be at legal risk for criminal or other penalties if they were out of compliance with the regulation.

Although participants commonly remarked that their hospital legal counsel held the power to determine when abortion is medically necessary, one institution empowered physicians to make that determination. In this departure from the norm, several participants reported that the institutional leadership trusted physicians so long as they documented their justification extensively. The case of preterm prelabor rupture of membranes (PROM) (see Appendix 1, available online at http://links.lww.com/xxx) illustrates how some institutional policies restricted physicians from performing therapeutic abortions until situations became emergent. Institutions also varied as to

whether they categorized pregnancy terminations as “therapeutic” (participants did not agree on a definition for this term) in cases of fetal anomaly that would create increased pregnancy risks to the mother and, ultimately, result in fetal demise. Regardless of how empowered physicians felt to exercise professional judgment, the added documentation requirements from regulations and institutional policy additionally burdened physicians.

How and when physicians came to understand institutional policies varied greatly. Few institutions provided ongoing information to ob-gyns about abortion regulations and institution-specific interpretation. Some institutions’ legal counsel only informed physicians about laws if they asked questions about specific regulations or medical cases. For example, in the absence of institutional guidance, one participant erroneously believed that the Down syndrome ban, a bill that bans abortions sought for reasons related to a fetal Down syndrome diagnosis, was in effect. In reality, a federal judge had blocked it temporarily due to a legal challenge as to its constitutionality. Lacking information from the institution, some participants stated that they relied upon their professional judgment regarding the medical necessity for abortions rather than involving legal counsel. Some participants at institutions without explicit internal guidance about regulations were unsure whom to ask (inside or outside their organizations) if they wanted accurate and digestible information about Ohio abortion regulations. The institutional variation in guidance regarding regulations and internal policies contributes to perceived legal risk for physicians and their employing institutions, and can confound abortion access for patients.

Participants discussed how Ohio abortion regulations' imprecise terminology and non-evidence-based claims and procedures present a conflict of obligation. Pointing out that Ohio law bans abortion 'once viability has been confirmed,' one participant said, "It's like a very vague term that is hard to interpret." Participants articulated the moral burden of being required to communicate medically unsupported or murky claims to their patients: Another participant said, "There's just so much about these targeted restrictions that is…not medically sound and not ethically sound…it's almost too much sometimes to think about." In some cases, participants directly addressed the ethical dilemmas that Ohio abortion regulations present. Discussing abortion regulations broadly, A third participant said, "if you conscientiously decide that you don't want to say the script or you don't want to do this because you don't think it's good clinical care, then…professionals [are] choosing between professional obligations and their legal obligations, which also is an uncomfortable position to be in." Obstetrician–gynecologists struggled with how to comply with vague laws while also upholding their professional obligations to promote patients' rights to compassionate and ethical care.

Several participants believed that in a quest to eliminate elective abortion, legislators neglected to account for medically indicated abortions for maternal or fetal indications. In cases such as previable preterm PROM, abortions are performed to protect maternal health or life. However, cases of fetal anomaly present a different type of dilemma. Obstetrician–gynecologists reported patients struggling to decide whether to continue pregnancies that could result in neonatal suffering and death.

Several participants echoed the sentiment that the Ohio legislature's ignorance of clinical realities contributes to the creation of regulations that increase risks to patients

in emergent situations. This generates an ethical dilemma because physicians feel constrained in their duties to care for their patients with beneficence and nonmaleficence. The following exchange about restrictive regulations illustrates that point:

> *Participant13: The D&E ban is also going to require us to perform procedures that have no medical benefit for the woman and potentially have risk.*
>
> *Participant14: And medical problems that may make carrying that baby to viability dangerous.*
>
> *Participant15: [Legislators] don't think about that. They don't think about the mom dying…*

Participants felt the effects of Ohio abortion regulations acutely with longtime patients, especially when they were unable to provide abortion care during some of the patients' most challenging moments.

One participant said, "I think that some [legislators] are trying to come from… a good place…. But there's so many nuances that occur for many different patients and individual clinical scenarios that some of these laws make things a lot more dangerous for patients. …that creates a lot of challenges when, as a physician, you want to be able to do the right thing and keep your patients safe, and alive, and healthy, and you wish that you had the opportunity to provide the care that these patients need and deserve…." The scenarios that these participants reference illustrate the myriad ways that abortion regulations create a conflict of obligation for physicians to both adhere to the law and provide ethical care to patients.

Discussing the inability to provide abortions in non-emergent situations, one participant said, “So it’s hard to kind of counsel those patients that are already going through a really difficult time. They’ve found out this news about their pregnancy, a very much desired pregnancy that has anomalies and complications. And we’re not able to meet those needs.” Many participants were visibly distraught as they recalled cases that presented ethical dilemmas for them because they believed pregnancy termination would have been best aligned with the patient’s values and needs, but their understanding of Ohio abortion regulations prevented them from providing the care. Another participant said of legislators, “I think the hard part is none of those people have sat in a room with a woman, and held their hand, and counseled them in these situations. And those of us that do, our hands are tied, and it’s so incredibly frustrating to not feel like you can do the right thing for your patient.” In these cases, regulations kept physicians from providing a beneficial service and created additional burdens for patients.

In another focus group, a participant described the perceived legal threats that often impact clinical decision-making: “you have these scenarios where you know what the right thing is to do, but you also know in your back of your mind that you don't wanna lose your license or you don't want to have any legal consequences for doing the right thing.” She continued by explaining that the ethical dilemma weighs heavy on physicians’ minds and remains with them after work.

Participants described the emotional burden they felt due to Ohio abortion regulations and institutional policies, expressing anger that they cannot perform abortions in many situations they viewed as medically warranted, and frustration that

they have little say in laws that restrict their practice. Instead, participants perceived lawmakers as people with no medical training creating laws which have major impacts on obstetric and gynecological practice, and lawyers without knowledge of medicine translating those laws to the healthcare setting. One participant summarized the frustration with a sentiment common among participants: “I think, in general, policymakers should stay out of my exam room…unless you get to medical school, you don’t get to have a say of what happens between me and my patient.” Several participants agreed that legislators should leave the policy-making to professional organizations and public health institutions that create evidence-based policy with the best interests of patients in mind rather than creating “random restrictions.”

Participants expressed fear and frustration for patients’ safety and their own careers. They felt frustration when forced to refer patients to physicians who perform abortions in less restrictive states like Michigan, New York, and Pennsylvania because Ohio law prevents them from serving their patients. Even when a patient is able to access care in Ohio, the path can be long and convoluted. One participant summarized the emotional burden of Ohio’s abortion regulations by saying, “I’m in a constant state of despair, anger, frustration, and just waiting for how much worse it’s going to get, because it’s going to get worse. And patients are going to get hurt and harmed, and I think that’s terrifying.”

Obstetrician–gynecologists are trained to provide comprehensive reproductive healthcare throughout the life course. However, our participants perceived the combination of Ohio’s vague abortion regulations and institutional interpretations as preventing them from providing comprehensive care, by undermining their medical

expertise and increasing risks to patients' health and lives. This generates ethical dilemmas for physicians, who must navigate the conflict of obligation between following institutional interpretations of the law and promoting the well-being of their patients, and who are unable to practice principles of beneficence and nonmaleficence. Throughout our focus groups and interviews, physicians described feelings of anger, worry, and frustration they experience on a daily basis as they attempt to prioritize their patients while avoiding breaking the law.

Discussion

Our participants reported that Ohio abortion regulations affected their practice of comprehensive reproductive healthcare in three key ways. First, participants viewed abortion regulations as framing abortion and physicians who perform abortion as separate and distinct from other medical practices and physicians. Perhaps counterintuitively, this narrow regulatory framing resulted in broad consequences for physicians who sought to provide comprehensive reproductive healthcare. Second, participants asserted that many institutional interpretations of abortion regulations undermined physician expertise and professional autonomy. Institutional interpretation was highly variable across Ohio, so participants experienced these interpretations differently, although overwhelmingly negatively, within their respective institutions. Third, the constellation of abortion regulations, institutional interpretations, physicians' trepidation, and their perceived inability to exercise clinical judgement *worked together* to limit abortion access and increase risks to patients' lives and health. The combined

factors left participants distraught because they felt unable to practice medicine in the most ethical and compassionate manner.

State abortion regulations have been well documented to create considerable challenges for patients seeking abortion services.[2,5,6,7,8] Our study affirms and extends the literature by examining how abortion regulations impact physicians who do not work in abortion clinics, and their efforts to work around or within those regulations. For example, researchers argue that despite abortion being legal, stigma persists such that both abortion and physicians who perform abortion are frequently viewed as *exceptional*: illegitimate, dangerous, and in need of legal wrangling to ensure public safety.[4,13,14] Likewise, our participants described myriad ways, including excessive legislation, reporting and documentation requirements, and threat of legal penalties against physicians who perform abortion, that the law has framed them as distinct from the broader medical field.

Consistent with Grossman et al.'s survey which reported that each year 19.0% of ob-gyns in the United States do not provide abortion care due to "practice setting restrictions" (with some institutional restrictions potentially originating in responses to state laws), our participants suggest internal policies at ob-gyns' employing institutions play an important role in restricting the provision of abortion services.[16] Grossman et al.'s survey results mirror previous qualitative research wherein ob-gyns indicated they were unable to deliver abortion care for reasons including feeling ill-equipped to understand and comply with state abortion laws, fear of legal and professional consequences, and the "formal and informal policies" of abortion provision at their places of employment.[4,17,18]

A key finding of our study is that Ohio ob-gyns perceive their institutions as overreaching in their interpretations of abortion regulations, prioritizing protecting the institution from legal liability at the expense of both physicians and patients. Study participants felt that institutional support was inadequate in terms of training regarding abortion regulations and related internal policies, and in terms of defending physicians' clinical judgments surrounding therapeutic abortion. Importantly, uneven processes for communicating changes in state abortion regulations, and subsequent institutional policy changes, led to confusion about what procedures were permissible, and frustration when participants could not provide abortion care when needed.

ACOG recognizes access to safe, legal abortion as a fundamental part of healthcare and opposes legal measures to restrict it that pose safety risks, interfere with the patient–physician relationship, and are medically unnecessary.[12,20-22] Additionally, ACOG's Committee Opinion 819 emphasizes the importance of informed consent and shared decision-making in the ethical practice of obstetrics and gynecology .[23] Participants described two types of ethical dilemmas they face when trying to provide comprehensive reproductive healthcare in the context of Ohio abortion regulations that conflict with ACOG statements, committee opinions, and ethical guidelines.

First, participants felt caught in a conflict of obligation – the ethical tension that results when one is forced to prioritize one of multiple primary interests, often of equal importance.[14] Obstetrician–gynecologists in Ohio must navigate the conflict of complying with vague and non-evidence-based laws while attempting to respect institutional policies and uphold ethical practice guidelines that prioritize patient care. Although ACOG expects its members to treat all patients with compassion and dignity,

and study participants expressed profound desire to do so, they experienced Ohio's abortion laws and their institution's interpretations of these laws as major barriers to providing compassionate care that meets professional standards for ethical conduct.

Second, physicians felt that their duty to uphold the highest ethical principles of beneficence (maximizing benefit to the patient) and nonmaleficence (not harming the patient) was at odds with both state abortion regulations and institutional interpretations of them. Participants described the emotional and psychological burden they suffered due to these dilemmas. Our participants felt distraught and ethically conflicted when they could not provide abortions in circumstances when they felt it was appropriate for their patient, but state laws and institutional interpretations prevented it. Such experiences, which caused feelings of despair, frustration, and anger for participants, reflect what Harris calls a "crisis of conscience" because physicians feel abortion provision respects the safety, well-being, and autonomy of pregnant persons.[19] Our findings underscore ob-gyns' perceptions that abortion work is a moral and requisite component of comprehensive obstetrics and gynecology practice.

Importantly, participants believed that the combination of these ethical dilemmas undermined their expertise, limited patient access to abortion care, and risked patient health and lives. Many participants found themselves asking how they might improve such a problematic context for practice. ACOG implores physicians to advocate for safe and just laws that prioritize patients. ACOG asks members to use their positions to engage in "consultation with and advice to community leaders, government officials, and members of the judiciary; expert witness testimony; and education of the public."[23] In Ohio, where participants find many abortion regulations to be problematic, individual ob-

gyns often feel powerless in relation to legislators and healthcare administrators. Although several study participants engaged in advocacy efforts for evidence-based policy, a sense of powerlessness exacerbated despair for many participants. Thus, while ACOG and researchers have promoted individualized physician responses to abortion restrictions, there remains a need for novel strategies from professional societies that address systemic barriers to abortion provision.[9,15-17, 20-23]

Our study provides important new evidence about the impact of abortion regulation on clinic-adjacent ob-gyns. We note that although many participants cared for rural patients who traveled to urban centers, our sample includes few physicians who perform abortion who were rurally situated, and our findings may insufficiently describe the consequences of Ohio's abortion regulations for rural ob-gyns. Also, it is possible that our sample includes only those ob-gyns who care about the impact of state regulations on abortion service due to the potential for self-selection bias to exist.

While participants regularly commented on *their perceptions* of how Ohio's abortion regulations impact their patients, scholarship that documents patients' firsthand experience is also important to deepen our understanding of the impact of these regulations on Ohioans. Additionally, research with professionals in other medical subspecialties would illuminate the extent to which Ohio's abortion regulations impact other physicians.

Our study finds that as Ohio's abortion laws increase in number and restrictiveness, they further undermine obstetric and gynecologic ethical practice guidelines. Furthermore, medical institutions play a key role in determining abortion provision in Ohio: through their interpretation of the law, they can either support or

further limit physicians' abilities to provide ethical, compassionate care. Thus, the juxtaposition of abortion regulations, institutional interpretation, physicians' trepidation, and their perceived inability to exercise their clinical judgement *combine* to further limit ethical provision of reproductive healthcare and abortion access, and increase risks to patients' lives and health. Considerable work remains to bring Ohio's abortion regulations, institutional interpretations, and physician practices into alignment with ACOG's clinical and ethical guidelines.

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PEER REVIEW HISTORY

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552 **Table 1:** Effective Ohio abortion regulations described by obstetrician– gynecologists
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Regulation	Description	Year Proposed
§ 2919.17	**Viability Ban:** Bans abortion once viability confirmed; requires viability testing at 20th week of pregnancy post-fertilization; medical emergency exceptions but not for mental health. **Enacted.**	2011
§ 9.04 § 5101.57	**Public Facilities Ban:** Bans public facilities from providing non-therapeutic abortions. Extends ban on state funding of insurance plans that cover abortion; prevents local funding of those insurance plans. **Enacted.**	2011
§ 2317.56	**Mandated Counseling:** Prohibits abortion without testing for fetal heartbeat (medical emergency exception); if detected, doctor must recite state-mandated abortion counseling. **Enacted.** **Rape Crisis Counseling**: Restricts rape crisis funding so that only programs that don't counsel/refer survivors to abortion services are funded. **Enacted.**	2013
§ 2919.10	**Down Syndrome Ban:** Prohibits abortion if reason sought is prenatal Down Syndrome diagnosis. **Enacted.**	2017
§ 2919.20	**21.6 Limit:** Bans abortion after 22 weeks since a pregnant person's LMP (also referred to as the 20-week ban, counting 20 weeks post-fertilization); includes exceptions for conditions that threaten the patient's life or create a serious risk to the patient's physical health. **Enacted.**	2017
§ 2919.15	**D&E Ban:** Bans dilation and evacuation procedures, the most common second-trimester abortion procedure. **Partially enjoined; only enforceable on procedures done at 18 weeks gestation LMP or greater, and makes some exceptions.**	2018

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Table 2: Data Collection Events

Focus Group/Interview	Region	Number of Participants
Focus Group	Columbus	19
Focus Group	Cleveland	2
Focus Group	Cincinnati	2
Interview	Cincinnati	1
Interview	Cincinnati	1
Interview	Cincinnati	1
Interview	Toledo	1
Interview	Columbus	1
Focus Group	Columbus	7

*This focus group was held in conjunction with a professional society state lobbying day, so participants came from all over the state.

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563 **Table 3:** Findings and Illustrative Participant Quotes

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Finding	Illustrative Quotes
1) Abortion as distinct from other health care	"I don't have to report when I do [a] hysterectomy…. Or if I do a tubal ligation. I mean, ultimately, all those things result in somebody not being able to have a child. So why is it that this particular group of procedures, legislatively, must get reported?"
	"it might be obvious what needs to be done clinically. But, it also is layers of protection to have that kind of documentation…I'd rather make two phone calls than have to be in a legal context defending myself from murder…there's this added pressure.
	"It's more than just criminalizing the procedure, the people doing it, or the people getting it. It's demonizing it, you know. I mean, they want to make OBGYNs out to be murderers with this."
2) Varied institutional interpretations of Ohio abortion regulations	"'We're going to treat you as professionals, we're going to support you as professionals. Just put the documentation in.' I did not get any sense of, 'no, you can't do this.'"
3) Ethical dilemmas for OBGYNs	"It's such a complex issue. And unless you're sitting there face-to-face with a woman with that decision…, I just don't think you're equipped to make rules about it."
	"How tied am I to the law that I came in to care for a patient, and does that make me a bad doctor to not care for the patient appropriately because there's a law [sic] consequence, and it's just a hard decision to make."
	"My biggest frustration is that a lot of times the patient gets shuttled around between multiple institutions, multiple OBGYNs, subspecialists. She might see easily three to five different physicians before she gets the procedure…It is just very difficult to be one of the last people coming into that situation and you need to provide her the care and knowing that she may feel marginalized by that process."

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