



TCL

THE CANCER LETTER

Inside information on cancer
research and drug development

Vol.

48

No.

26

JULY 1, 2022

www.cancerletter.com

“THIS IS NOT ABOUT PROTECTING LIFE”: SUPREME COURT OVERTURN OF ROE V. WADE THREATENS LIVES OF CANCER PATIENTS, DOCTORS

When Jill Hawkins realized that she was six weeks pregnant this March, her oncologist gave her two options.

→ PAGE 3

HARVARD LAW'S I. GLENN COHEN: TO PROVIDE GOOD CARE, DOCTORS WILL RUN AFOUL OF CRIMINAL LAW IN SOME STATES AS ROE V. WADE ENDS

→ PAGE 16

CANCER PATIENTS AND THEIR FAMILIES WILL FEEL THE IMPACT OF SCOTUS ABORTION RULING

→ PAGE 22

CANCER CARE MUST REMAIN IN THE HANDS OF DOCTORS AND THEIR PATIENTS

→ PAGE 26

VIRGINIA GYNECOLOGIC ONCOLOGISTS: “PRO-LIFE” IS NOT PRO-LIFE AT ALL

→ PAGE 28

Editor & Publisher

Paul Goldberg

Associate Editor

Matthew Bin Han Ong

Reporter

Alexandria Carolan

Reporter

Alice Tracey

Director of Operations,

Illustrator

Katie Goldberg

Marketing &

Account Manager

Mona Mirmortazavi

Designer

Jacqueline Ong

IT Manager

David Koh

Editorial, Subscriptions and Customer Service

PO Box 9905 -
Washington, DC 20016

T 202-362-1809

F 202-379-1787

W www.cancerletter.com

Individual subscriptions \$555 per year worldwide. Group subscriptions required for institutional distribution. To subscribe, [click here](#).

ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc. Other than "fair use" as specified by U.S. copyright law, none of the content of this publication may be reproduced, stored in a retrieval system, or transmitted in any form (electronic, photocopying, or facsimile) without prior written permission of the publisher. Violators risk criminal penalties and damages. Founded Dec. 21, 1973, by Jerry D. Boyd.

© Copyright 2022.
The Cancer Letter Inc.
All rights reserved.

® The Cancer Letter is a
registered trademark.

In this issue

COVER STORY

3 "This is not about protecting life": Supreme Court overturn of *Roe v. Wade* threatens lives of cancer patients, doctors

CONVERSATION WITH THE CANCER LETTER

16 Harvard Law's I. Glenn Cohen: To provide good care, doctors will run afoul of criminal law in some states as *Roe v. Wade* ends

GUEST EDITORIAL

22 Cancer patients and their families will feel the impact of SCOTUS abortion ruling

26 Cancer care must remain in the hands of doctors and their patients

28 Virginia gynecologic oncologists: "Pro-life" is not pro-life at all

32 Oncology and healthcare groups respond to the end of *Roe v. Wade*

IN BRIEF

51 Selwyn M. Vickers named MSK president and CEO

51 Alicia M. Terando named San Gabriel Valley regional medical director for surgical oncology at Cedars-Sinai

51 Colleen Lewis named vice president of nursing and research at Florida

Cancer Specialists and Research Institute

52 Justin F. Klamerus named EVP, chief medical officer at McLaren Health Care

52 Jeffrey M. Rosen to receive 2022 William L. McGuire Memorial Lecture Award

53 ASTRO announces 2022 Fellows

53 ACCC supports CMS Enhancing Oncology Model but says it may disadvantage small practices

THE CLINICAL CANCER LETTER

CLINICAL ROUNDUP

55 OSUCCC – James study identifies molecular factors driving melanoma development

55 SWOG-nCartes pilot collaboration shows significant expected time savings for study data entry

DRUGS & TARGETS

56 FDA approves Breyanzi in relapsed or refractory large B-cell lymphoma after one prior therapy

56 EMA CHMP adopts positive opinion for Lynparza in germline BRCA-mutated, HER2-negative high-risk early breast cancer

57 Community Health Network, GRAIL to offer Galleri MCD test in Central Indiana

57 FDA issues draft guidance on patient-focused drug development

**“This is not about protecting life”:
Supreme Court overturn of
Roe v. Wade threatens lives
of cancer patients, doctors**

By Alex Carolan and Alice Tracey



When Jill Hawkins realized that she was six weeks pregnant this March, her oncologist gave her two options.

One was to continue with the pregnancy and switch to interferon, a treatment that would be safer for the fetus, but more toxic to her. Alternatively, she could get an abortion.

Hawkins was diagnosed with chronic myeloid leukemia in August 2021 and was taking the drug Bosulif (bosutinib), a tyrosine kinase inhibitor not recommended for use during any part of pregnancy.

“At the end of the day, for me, I can handle the risk to me, or the birth defect. I don’t think I can handle both. I don’t think I can handle the uncertainty and the fear around all of it. I need to feel good about one thing. In this situation, I didn’t feel good about any of it,” Hawkins, a clinical social worker and therapist based in New York City, said to *The Cancer Letter*. “It’s not a good idea for my health. Do I want to let go of this pregnancy and be sad and grieve, or do I want to keep it and feel anxious and fearful of losing my life?”

As she was making the decision, Hawkins took one week off the tyrosine kinase inhibitor, and after speaking with her fertility doctor and her oncologist about the risks involved, chose to terminate the pregnancy.

“It could have been a very difficult pregnancy. I could have lost my life. I could have had to make a really hard decision at 24 weeks,” Hawkins said, referring to potential birth defects caused by Bosulif that would become apparent by that point. “There were so many potential negatives attached to both choices. I just had to make the preferable of the two shitty choices I had.”

Hawkins said the direct, non-judgmental approach of her New York doctors

made all the difference as she weighed her options.

“Having had an abortion seven years ago in Houston, I had a very different, very horrific, judgmental experience. This felt just like night and day. I felt so supported,” Hawkins said.

Hawkins, 37, was given a choice that pregnant cancer patients have lost in states where abortion has become illegal following the Supreme Court’s June 24 ruling on *Dobbs v. Jackson Women’s Health*.

Decisions like the one made by Hawkins belong in the doctor-patient relationship, said Eric Winer, director of Yale Cancer Center, physician-in-chief of Smilow Cancer Network, and Alfred Gilman Professor of Medicine and Pharmacology at Yale. Winer, who is also president of the American Society of Clinical Oncology, was not speaking on behalf of the professional society.

“Limiting the option of terminating a pregnancy severely curtails the ability of clinicians when caring for a pregnant patient with cancer to be able to provide the kind of guidance that we typically provide,” Winer said to *The Cancer Letter*. “A decision that’s made in the examining room has been made in the courts.”

The Supreme Court’s ruling has activated “trigger bans” on abortion in 13 states, with more states expected to impose bans or severe restrictions. At least three states have temporarily blocked trigger bans.

Abortion restrictions will have immediate implications for cancer patients. Approximately one in 1,000 patients—about 6,400 American women—are diagnosed with cancer during pregnancy

each year. For perspective, here are the overall cancer incidence rates among women: 55 in 100,000 women ages 20-29 and 161 in 100,000 women ages 30-39 are diagnosed with cancer each year.

“Reversing the protections offered by *Roe v. Wade* will have far-reaching second- and third-order effects in women’s health, including cancer care delivery and cancer-specific mortality,” wrote Devin T. Miller, Leslie M. Randall, and Stephanie A. Sullivan, all practicing gynecologic oncologists in Richmond, VA, in a guest editorial for *The Cancer Letter*. “Our education and experience has informed our strong stance that the ‘pro-life’ position is not pro-life at all.”

The guest editorial appears on [page 28](#).

There is little data on the safety of next-generation targeted agents during pregnancy. Therefore, drugs like Bosulif come with concerns about risk to the fetus—and, now, legal liability.

“I do think there are going to be physicians in some states who are going to be called upon to give patients good care, where that good care now will run afoul of the criminal law as it might be interpreted by some of those states,” I. Glenn Cohen, deputy dean and and James A. Attwood and Leslie Williams Professor of Law at Harvard Law School, said to *The Cancer Letter*.

A conversation with Cohen appears on [page 16](#).

Patients must be able to trust their doctors, Julie R. Gralow, chief medical officer and executive vice president of the American Society of Clinical Oncology, said in a guest editorial published in this issue of *The Cancer Letter*.

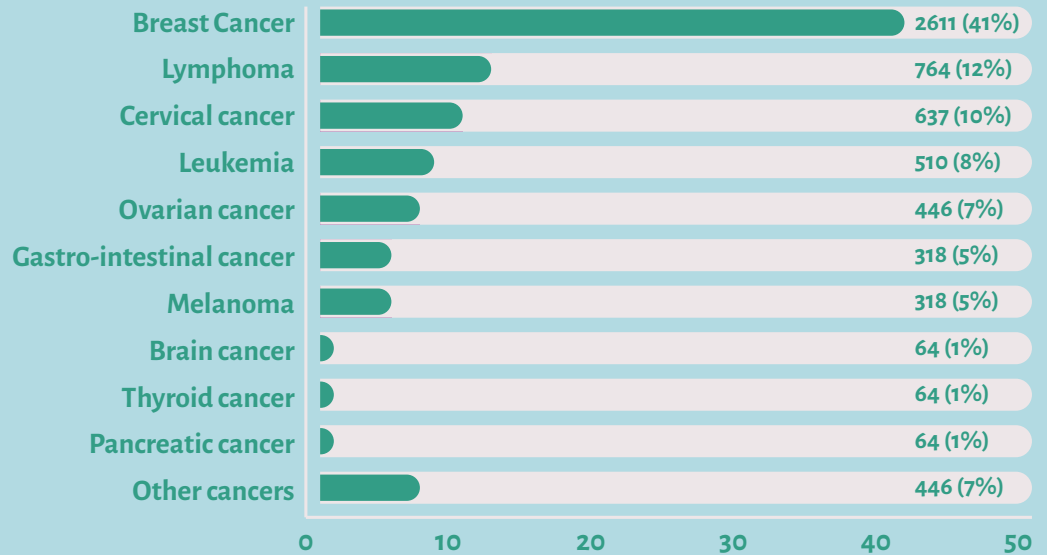
We are therefore concerned about the potential impact of the decision that inserts the government and even lay-people into the most



CANCER DURING PREGNANCY

1/1000
patients who are pregnant
are diagnosed with cancer¹,
an estimated 6,369 cases per year²

THOSE PATIENTS ARE DIAGNOSED WITH³

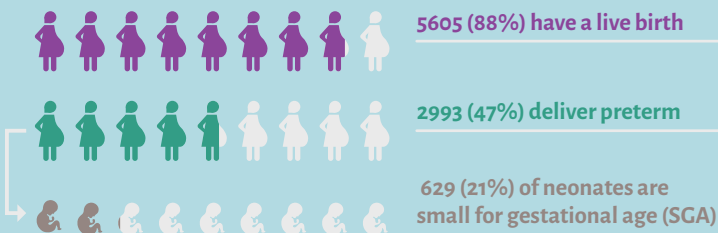


1. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6396773/>

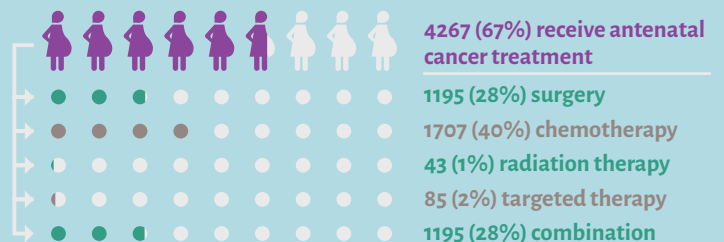
2. <https://www.cdc.gov/nchs/products/databriefs/db136.htm>

3. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7002463/>

OUTCOMES³



TREATMENT³



private and personal decisions patients face.

The *Dobbs* ruling creates uncertainty and confusion that can undermine the sacred doctor-patient relationship.

Already, the prevailing confusion and fear has caused many physicians, including those where access to abortion is protected, to question whether delivering standard evidence-based cancer care could result in harassment, prosecution, prison sentence, or revocation of their medical license.

These concerns are a threat to high quality, equitable cancer care.

Gralow's guest editorial appears on [page 26](#).

In an analysis of the impact of the *Dobbs* decision, Karen E. Knudsen, CEO of American Cancer Society and the American Cancer Society Cancer Action Network, touches on a clinical scenario analogous to Hawkins's.

Writes Knudsen:

After a thoughtful conversation of risk, benefits, and alternatives between an oncologist and a pregnant patient with chronic myeloid leukemia, they may together choose to move forward with imatinib as a proven treatment to prolong disease-free survival.

As imatinib can be associated with spontaneous abortion, we worry that the threat of state law-based criminal or civil penalties may preclude this shared decision-making conversation, thus reducing patient autonomy in managing their own cancer and putting the oncologist at risk.

Immunotherapy, which has yielded significant promise in a subset of cancer types occurring in pregnant women, has yet to be assessed for the impact on the fetus and maintenance of a successful pregnancy.

Some immunomodulatory agents are known to cross the placenta and have the potential to cause direct toxicity to the fetus. Given these concerns, a subset of immunotherapies is not currently recommended during pregnancy.

Knudsen's guest editorial appears on [page 22](#).

In addition to harming cancer patients, the bans fundamentally endanger their doctors. Physicians face higher rates of infertility and other pregnancy complications, including miscarriage.

"Let's say I come out of residency. I come to practice in a state that has these strict laws. I get pregnant, I'm having a miscarriage. I'm sitting in the exam room, and my doctor says, 'Well, I can't do anything until that heart stops—even though I know that as you're bleeding out or as you're becoming septic, your life will be in danger, but it's not a danger enough yet for me to do that procedure,'" Theresa Rohr-Kirchgraber, president of the American Medical Women's Association, said to *The Cancer Letter*. "I don't want to be in a position where that could ever happen. So, therefore, I'm not going to even consider a job in a state like that."

A study showed that [24.1% of American female physicians are diagnosed with infertility](#), and [42% of female surgeons](#) included in a survey had experienced pregnancy loss; meanwhile, [11% of women](#) of reproductive age in the US have experienced fertility problems, and it is estimated that up to [26% of all pregnancies](#) end in miscarriage.

Retaining a workforce—and recruiting into institutions in states with restrictive abortion laws, has just become more difficult—oncologists say.

Lives at stake

"The goal in any case is, ideally, to preserve both the mother's health and viability of the embryo/fetus. But in some cases, this just isn't possible," Katherine Van Loon, a gastrointestinal oncologist at UCSF, said to *The Cancer Letter*. "Taking away a woman's bodily autonomy to pursue a termination of the pregnancy and prioritize her own health will create a scenario in which oncologists can't provide necessary care. We will lose these lives unnecessarily—at a profound cost to the women and their families."

With the *Roe v. Wade* protections stripped away, fear has infected America's patient examining rooms.

"What I don't want to see is us compromise the care of the pregnant patient with cancer based solely on the overturning of *Roe v. Wade*. There are people whose lives are at stake, and we have the responsibility to treat that person with cancer as our first and foremost objective," Don Dizon, professor of medicine and surgery at Brown University, and director of Community Outreach and Engagement at Legoretta Cancer center at Brown University, said to *The Cancer Letter*.

The *Roe v. Wade* reversal may cost patients their lives, said Maitri Kalra, a hematologist/oncologist and clinical assistant professor of medicine at Indiana University Health Ball Memorial Cancer Center.

In Indiana, where Kalra practices, abortion is still legal, but Republican lawmakers are expected to push for further restrictions or an outright ban.

PHYSICIAN PREGNANCY COMPLICATIONS



WOMEN PHYSICIANS



24.1% diagnosed with infertility¹



42% experienced a pregnancy loss²

GENERAL POPULATION



11% diagnosed with infertility³



26% pregnancies end in miscarriage⁴

1. <https://pubmed.ncbi.nlm.nih.gov/27347614/>

2. <https://pubmed.ncbi.nlm.nih.gov/34319353/>

3. <https://www.nichd.nih.gov/health/topics/infertility/conditioninfo/common>

4. <https://www.ncbi.nlm.nih.gov/books/NBK532992/>

“The conversation is very difficult, but the choice is that we either treat [our patients] suboptimally for their cancer, meaning we give them chemotherapy which may not be effective for their cancer, and they can retain their pregnancy,” Kalra said to *The Cancer Letter*. “Or they can medically terminate the pregnancy and get the optimal treatment, which would be best from the cancer standpoint.”

Most pregnant patients Kalra treats in the first trimester opt for medical termination of their pregnancy—“They need to survive first.”

Poor outcomes are a major concern. Unsafe abortions are another.

“My other concern is that they might resort to some other means of abortion, which would be highly unsafe, because—this is putting them in a very desperate situation,” Kalra said. “They might desperately try to do things to get rid of their pregnancy by some home remedies, which can get really unsafe for the patient’s life.”

At a time when the oncology profession is focused on health disparities, the Supreme Court’s decision has likely worsened outcomes for the underserved, Van Loon said.

“In circumstances in which a woman has to travel to another state to terminate a pregnancy in order to prioritize her own health, it’s going to result in additional delays to cancer care, and it’s going to galvanize inequities between those who have the resources to be able to travel versus those who do not,” said Van Loon, associate professor of clinical medicine at UCSF and director of the Global Cancer Program at UCSF Helen Diller Family Comprehensive Cancer Center.

Overturing *Roe v. Wade* limits access not only to voluntary abortions, but also to treatment for miscarriages—and, possibly, contraceptives and reproduc-

tive technologies. This could place doctors, who are more likely to experience pregnancy complications, miscarriages, and infertility, at higher risk.

“A lot of my colleagues that I know of are undergoing infertility treatment, because they’re unable to get pregnant by the time they finish their training,” Kalra said. “It puts that into question, and it puts that into an area of concern. You never know when that right would be taken away from you.”

Abortion bans are likely to affect patients and physicians across the country, even in states that protect abortion rights, said Ariela L. Marshall, director of the Women’s Thrombosis and Hemostasis Program at Penn Medicine.

“If abortion is now outlawed in at least half of the states, and you have to travel to another state, that’s going to double or triple the waiting list in all those states,” Marshall said to *The Cancer Letter*. “We know that the further you get along in a pregnancy, the more complex it can become to have an abortion. So, if it’s waitlist, that’s pretty much a guarantee that people are going to be having later-term abortion in places where it’s still legal.”

Cancer centers and medical societies have a responsibility to take action, said Shikha Jain, assistant professor of medicine in the Division of Hematology and Oncology, director of communication strategies in medicine at the University of Illinois Chicago, and associate director of oncology communication and digital innovation at the University of Illinois Cancer Center.

“I’m terrified for our next generation of people coming up and what this means. I’m scared for my children. I’m scared for my patients. I’m mad and disappointed and frustrated,” said Jain, also the CEO and co-founder of IMPACT, president, CEO, and founder of Women in Medicine NFP, and founder and chair of the

Women in Medicine Summit. “This is a ruling that is not supported by the majority of the country, and its impacts are going to be devastating for years to come, and we need to do something now to change it.”

One in a thousand

A 2019 study published in the *World Journal of Oncology* found that one in 1,000 pregnancies annually are affected by a concurrent cancer diagnosis—and this risk estimate doesn’t include patients like Hawkins, who became pregnant after cancer diagnosis.

As the nationwide trend to postpone childbirth to a later age continues, the incidence of cancer during pregnancy is expected to increase.

“When cancer is diagnosed during pregnancy, a huge multidisciplinary effort is typically required to try to figure out how to manage it. On one hand, we need to take care of the mother, and there’s also an embryo or fetus at stake,” Van Loon said. “In many of those cases, the fetus can remain viable without compromising the mother’s care, but in a portion of cases, preservation of the pregnancy to viability could compromise the mom’s prognosis and potential outcomes.”

The most common cancers associated with pregnancy are, in order of decreasing frequency, melanoma and breast cancer, cervical cancer, and lymphomas and leukemias.

The number of cancer diagnoses during pregnancy is further expected to increase as the use of cell-free DNA screening in early pregnancy expands, Van Loon said. This technology can sometimes detect cancer.

“We’re going to see an increase in early-term diagnosis of cancer in pregnancy,” Van Loon said. “I just took care of

a recent case where it was picked up through somewhat routine blood work for a woman. She ended up with a diagnosis of metastatic rectal cancer. Those are really complex situations—we could be seeing this more and more, and earlier in pregnancy.”

Consider a scenario where a pregnant person is diagnosed with cervical cancer.

“If it’s very early, in the first 12 weeks of a pregnancy, and we know it’s a cervical lesion—this is something we discuss at multidisciplinary tumor conferences,” said Dizon, also director of the Pelvic Malignancies Program, founder of The Oncology Sexual Health First Responders Clinic, director of the Hematology-Oncology Outpatient Clinics at Lifespan Cancer Institute, and director of medical oncology at Rhode Island Hospital.

The gold standard for treating locally advanced cervical cancer is chemotherapy plus radiation. But radiation causes pregnancy loss, and chemotherapy early on in a pregnancy is dangerous to the fetus.

“If this pregnancy is something you truly, truly want—then the two options would be to just observe until you get into the second trimester, in which case we can give primary chemotherapy until the point of delivery, knowing that there is no comparative data in a pregnant patient that says cure rates are as good as chemo-radiation,” Dizon said. “And in fact, in non-pregnant patients, the data suggests chemotherapy is not as good as chemo-radiation.”

Waiting to treat a patient until the second trimester is risky, he said.

“That whole thing of surveillance—it’s a scary time. Can we guarantee there will be no progression while we wait? No, we cannot,” he said. The worst case is to see someone progress from locally

advanced or just a cervical lesion to all of a sudden being a very bulky tumor that is no longer amenable to definitive treatments.”

Early in his career, Dizon treated a patient with cervical cancer who was in the second trimester of pregnancy. The cancer was growing exponentially, and without treatment she was not expected to survive through the pregnancy.



How are we going to protect these patients who are going for—life-saving, in some cases—care, and then they’re going to be prosecuted when they come home?



—*Shikha Jain*

The best treatment in this case was hysterectomy, which includes an abortion. That was what the patient chose.

“To do a hysterectomy in the second trimester—no one escaped without trauma. The nurses, the OR team, the surgeon who had to perform it, the woman who really wanted this baby,” Dizon said. “This is not a neutral decision for anybody.”

The Supreme Court’s June 24 decision to reverse *Roe v. Wade* doesn’t take cases like this into account, Dizon said.

“It just boggles the mind that that kind of nuance is just not taken into consideration for this theoretical argument of life beginning at conception,” he said.

“To just minimize that this experience can be very traumatic within the context of cancer—that it is traumatic.”

What happens to patients who require that same treatment as Dizon’s patient, in states where abortion is illegal?

Dizon has seen this play out before, back when he was an attending physician at a Catholic hospital.

“The ultimate conclusion was if you don’t offer the services at this Catholic hospital, we need to transfer this patient, and that’s what happened,” he said. “If you are in a red state, and a colleague, and a cancer center provider, we always have to think of the person in front of us who is dealing with that cancer, and we need to get her the best care possible.”

Pregnant patients with Hodgkin lymphoma in states where abortion is illegal will receive suboptimal treatment, IU’s Kalra said.

“This is a very fast-growing tumor, and at the same time very curable. It has more than a 90% cure rate with the current chemotherapy treatment,” Kalra said. “However, if they cannot get that treatment in a timely manner, this can be life-threatening.”

How should a doctor in Kalra’s situation respond if the patient is unable to obtain an abortion?

“I would have to treat them with a chemotherapy that is probably less effective from their lymphoma standpoint,” she said. “It would be compromising care, essentially. We would be able to give them some treatment that would be a compromise of care, which none of us would want.”

“If you give a man a chance for a cure, versus a suboptimal treatment, if you have a choice, which one would you choose? That’s a no-brainer.”

Now, pregnant patients will be offered a different menu of therapeutic options.

“Right now, these patients will not be getting that choice very soon,” Kalra said.

Patients who receive chemotherapy and become pregnant are at higher risk for bad outcomes, Jain said.

Banu Symington, a hematologist/oncologist and medical director based in rural Wyoming, said conversations she used to have with pregnant patients—whether to continue with the pregnancy and delay care, or terminate the pregnancy—are now off the table.

“I’m going to tell them that their ability to make a choice about abortion is taken out of their hands,” she said to *The Cancer Letter*. “I could, I suppose, make a case that waiting is an extreme hazard to their lives, but most of the time waiting means that their treatment will not be as successful.”

Even before this ruling, an abortion in Wyoming was never easy to obtain. The only clinic was based in Jackson, near the Idaho border, and that clinic would only offer medical abortions up to 10 weeks.

In May, someone set fire to a newly built abortion clinic in Casper, WY. It was initially supposed to open in mid-June and is now not expected to open at all.

To Symington’s knowledge, the hospital affiliated with her center has not performed an abortion in 40 years. In the past, the hospital informed patients about abortion clinics in Utah.

“Once Utah makes abortion illegal in that state, a patient who would normally only have to drive two-and-a-half hours to get a medical abortion is going to have to drive across the state to Colorado to get an abortion,” she said.

Taking away the ability to choose is the entire problem, Hawkins said.

“It’s horrifying to me that we would value the future potential life of a tiny little ball of cells that we already know is at super high risk of not being a successful pregnancy, of not being a healthy baby,” Hawkins said.



This is not about protecting life. This is about power, and controlling people’s bodies, and making sex into something that’s only supposed to happen for procreation, and otherwise you’re punished.



— Jill Hawkins

The effects of abortion bans reach deep into family planning of people with cancer and their family members.

“It goes beyond the woman who’s pregnant with cancer, and includes the woman who may be taking care of her husband, who is dying of cancer, and who finds out that she’s pregnant,” Yale’s Winer said. “I think it’s both the patient with cancer, but also the family with cancer.

“I just feel very strongly that this is a setting where a woman needs to be able to make her own decision,” Winer said.

Because of the toxicity of chemotherapy, Symington advises her male chemo patients to avoid causing pregnancies.

“The other woman may have no knowledge that she’s been exposed to sperm that may be damaged,” Symington said. “She won’t know that she’s carrying a potentially mutated fetus, and her health will not be endangered by that mutation. So, she’ll carry it to term. There will be no excuse for her to get an abortion.”

Not a decision for the courts

In a state with an abortion ban, pregnant patients with cancer may need to convince the courts that cancer presents a medical emergency.

Even if the courts ultimately concur, the Kafkaesque proceedings would take time, leading to treatment delays.

“Let’s say it’s unclear as to whether it’s considered an emergency situation or not,” Jain said to *The Cancer Letter*. “While we are waiting for the courts to decide during that entire time—time does not stop. Cancer will progress. A pregnancy will continue. And by the time a decision comes down from the courts, it may be too late to safely terminate the pregnancy.”

It’s preposterous to suggest that the courts have a role to play in limiting access to care in this clinical setting, Winer said.

“This is really a very fundamental decision that should be made between the people taking care of a woman who has cancer and is pregnant, and the woman,” Winer said. “The fact that treatment would be delayed because a judge is making a ruling or reviewing a situation just horrifies me.”

Patients with financial means will travel to states where abortion is legal.

“Patients with all sorts of different problems and challenges are going to be flooding these states, if they have the resources,” the University of Illinois’s Jain said. “And those who don’t have the resources are going to end up bleeding out in their homes or in their home states.”

In states that preserve abortion rights, patients who need immediate care may run into long wait lists.

“There are going to be challenges of timing, because, again, the further you go along in the pregnancy, the more complicated it can be to actually do a safe abortion,” Jain said. “In some situations, the abortion may be a medical emergency, and the patient may not be able to get to a site in time.”

All of this will widen disparities in care and, likely, an increase in the maternal death rate.

“We’re going to see an increase in our already bad maternal mortality numbers, especially in populations like the African American population,” Jain said.

The peril of criminal prosecution

The risk of criminal charges for providing abortion care now looms as a new reality for physicians.

Many find themselves reflecting on past clinical scenarios that, should they recur in post-*Roe* America, would spell out peril.

UPenn’s Marshall tells the story of a young woman with immune thrombocytopenia whose platelet counts were dangerously low—a condition exacerbated by pregnancy.

“She managed to survive through [two prior] pregnancies, but became pregnant a third time,” Marshall said. “She wanted to have an abortion, and she was told, ‘Your platelets are not at a safe enough level for this procedure.’”

The patient came to Marshall for a treatment that would allow her to have a safe abortion.

“I’m just thinking, for her sake, and for my sake as a physician, if I was in a state where to aid and abet an abortion is illegal, is my treating her blood condition so she can have an abortion illegal? Is treating my patient in a way that she needs to be treated now illegal, even if I’m not the one physically doing the abortion?”

After *Roe* was overturned, a physician Jain knows was treating a patient who was in the middle of a miscarriage.

“The physician did not know if they could legally take care of this patient, or would they be prosecuted for helping a patient who was miscarrying, because the treatment would’ve been to do a D&C, or dilation and curettage, or dilation and evacuation,” she said. “But is that considered illegal? Because it’s the same procedure as what’s done for an abortion. Miscarriages are also abortions. They’re just abortions that happen naturally.

“We really are at a point where physicians are going to be practicing medicine, scared that they’re going to be arrested for homicide or manslaughter, because they’ve done something to save their patient’s life,” she said.

Symington’s patients who are able to become pregnant receive a pregnancy test before each cycle of chemo.

“With laws being enacted in many states that anyone who aids or abets a termination of a pregnancy could be held liable, we are concerned about our

records being subpoenaed to show that a patient was pregnant at one visit and isn’t pregnant at the next visit,” Symington said.

Doctors who do try to make the case to terminate a pregnancy because of cancer may face consequences more severe than legal battles. Some also fear for their lives and their families.

“If we think that we’re going to be personally attacked, we may be a little more reticent about sticking our necks out to help our patients get medical abortions,” Symington said.

Patients who seek to terminate pregnancy in another state may run afoul of the law.

“Women who do leave the state to get this done may come back and face legal battles, because they have technically violated the law of their state,” Jain said. “How are we going to protect these patients who are going for—life-saving, in some cases—care, and then they’re going to be prosecuted when they come home?”

Harvard Law’s Cohen said this scenario is plausible.

“If your state prohibits abortion, can they also prohibit you to travel out of the state? No state, as far as I know, has passed a law to that effect yet, but that doesn’t mean that they won’t,” said Cohen, faculty director of the Petrie-Flom Center for Health Law Policy, Biotechnology & Bioethics.

“One of the biggest issues for people in the medical community—beyond what the rules actually are—will be the uncertainty around the rules,” Cohen said. “How do you practice and how do you make decisions about whether to relocate your clinic or to offer something, if you just don’t know what’s going to happen?”

When physicians become patients

“When physicians become pregnant, they are the patient,” UPenn’s Marshall said. “Knowing that female physicians often start to build families at an older age, and that as we age, the risks of complications both to mom and baby are a lot higher—so, for mom, things like preeclampsia and preterm birth, and for baby, things like severe chromosomal abnormalities—[pregnancy] could even be lethal, or have a very high risk of being nonviable.”

“If we knew one of those conditions was present, a lot of us would choose, I think, to have an abortion,” Marshall said. “But [the *Dobbs v. Jackson Women’s Health* decision] means that this whole population of female physicians is going to not be able to have access to that care, even when it may be right for them and their families.”

Doctors tend to start building families later due to the length of their training. The median age at first childbirth was 32 years in physicians and 27 years in nonphysicians, according to another 2021 [study](#). This can lead to pregnancy complications.

“There’s also the stress of the job—the shift work, the overnight and unpredictable schedules, and emotional stress,” Marshall said. “These, not incidentally, are all risk factors for bad pregnancy outcomes.”

Bans on abortion could limit access to treatment for miscarriages and ectopic pregnancies, which often require the same procedure as an abortion. A 2021 [survey](#) found that, out of 692 female surgeons, 29 (42.0%) had experienced a pregnancy loss, more than twice the rate of the general population.

“Providers would be scared of this, and even when they’re actually provid-

ing the normal, warranted care, could somebody who is very anti-abortion or anti-choice, and looking for a way to scare or punish doctors, say, ‘How do you know that wasn’t an abortion that you’re treating,’ when it was actually a miscarriage?” Marshall said.

A 2016 [study](#) found that, out of 600 female physicians who graduated medical school between 1995 and 2000, 24.1% of respondents who had attempted to become pregnant were diagnosed with infertility. The average age at diagnosis was 33.7 years.

The *Roe v. Wade* decision may complicate the use of assisted reproductive technologies, Marshall said.

“A lot of us out there have frozen embryos,” said Marshall, who helped found an infertility task force with the American Medical Women’s Association. “If they’re created and stored in a state where, technically, it might be illegal to stop paying those hundreds of dollars per year for storage fees—would that count as abortion? We have seven frozen embryos; would we be guilty of killing seven?”

Limits or outright bans on abortion threaten the empathy and trust upon which the physician-patient relationship rests, Marshall said.

“We’re always saying that the physician-patient relationship is sacred. If physicians can’t get the care we need and patients can’t get the care they need, it’s impacting us, it’s impacting our patients, and it’s impacting what’s supposed to be a sacred relationship,” Marshall said. “If we can’t have the power to deliver appropriate care and the support to remain empathetic while doing it, then I think the whole idea of being a physician is just shattered.”

The *Dobbs* decision will have an outsized impact on doctors, in turn compromis-

ing the quality of care for patients, Marshall said.

“If you’re suffering yourself, if you are burnt out, if you are not able to provide empathetic care because of the mental anguish of not being able to access abortion care, that’s taking out of commission a whole group of physicians who now won’t be able to provide care for their own patients,” Marshall said. “I also think we don’t talk enough about implications for male physicians.

“Data show that many male physicians, if they’re married, are married to another physician. So, it may not impact them physically, but what if it’s their wife or partner that’s going through a pregnancy that they don’t want? They are also forced to be a bystander in this process,” Marshall said.

Some doctors will be factoring abortion rights into their choice of jobs and training programs.

Kalra has a colleague who is—right now—weighing her options.

“She’s thinking of putting this as a decision maker in terms of where she would be choosing a fellowship program, because we are physicians, but we are also women in reproductive age,” Kalra said. “With this rule being passed, and being in such a state, my concern is not just having an unwanted pregnancy, but also, what if I’m pregnant with a chromosomal abnormality? I now won’t have rights, in some states, to decide whether I want to have a child with a chromosomal abnormality, or not.

“With the long course of training, a lot of physicians, by the time they have their first pregnancy, they are more than 35. It’s not uncommon. Which puts them at high risk of chromosomal abnormalities.”

Implications for recruitment and re-

tention are obvious at this early stage, doctors say.

“They may not leave the state—they may leave medicine altogether because they’re just tired of being told what to do from non-medical individuals who are negatively impacting patient care,” Jain said. “For all of the advances in and research that we’ve been able to advance medical care in this nation over the last several decades, it is being put so far backwards.”

On a larger scale, Symington is concerned about doctors losing the skills needed to perform abortions.

“A lot of people who are trained and leave residency with the ability to perform abortions, if they join a practice where the senior partner doesn’t want to do abortions, they’re not going to be doing abortions,” she said. “That’s going to be a skill set that they lose. How can you train residents in how to do an abortion if you are in a state where abortions are illegal?”

Medical students may choose to avoid states where they will not be trained to perform abortions and treat miscarriages, said AMWA’s Rohr-Kirchgraber, who is based in Georgia, where abortion rights are under fire.

“We know that where you do your residency, you’re most likely to stay there to see patients and establish care,” Rohr-Kirchgraber said. “So, if we put all these students through our medical school system, and then we make them leave to go elsewhere to get the training that they require, they’re not coming back.”

“We’re talking about real people”

Cross-state coalitions—formal or informal—may help mitigate the harm caused by abortion bans.

To help patients receive proper treatment, health systems in states where abortion is illegal may end up partnering with counterparts in states where abortion is legal, Dizon said.

“Alliances, probably, is what this might look like, where there’s going to be alliances between two health systems across state lines that say, this is a hospital you go to,” he said. “Not only will it take more time, but it’s going to take that person out of their center of support. I mean, it’s not an easy thing to uproot for cancer care.”

Cancer centers in states that ban or limit abortion rights still have a responsibility to provide life-saving care, said Leonidas C. Platanius, director of the Robert H. Lurie Comprehensive Cancer Center of Northwestern University and the Jesse, Sara, Andrew, Abigail, Benjamin and Elizabeth Lurie Professor of Oncology in the Departments of Medicine and Biochemistry and Molecular Genetics.

“There may be variations [of laws] from state to state,” Platanius said to *The Cancer Letter*. “There should be some advocacy on behalf of the cancer centers in these states to make sure high-risk situations for the patients are prevented.”

Winer, who lives and works in a state that protects abortion rights, said Yale Cancer Center’s doors are open.

“We would be happy to take care of people from anywhere who are in need of our services,” he said. “I think that’s a very practical thing that we can do in places like Connecticut. On the other hand, I think probably, the more important thing that we can do is to raise awareness about this whole issue.”

Symington hopes oncology leaders speak loud and clear against this ruling.

“I’m hoping for leadership to come out strongly against interference of government in the physician-patient relation-

ship,” she said. “I hope they come out strongly against these proposed laws about crossing state lines to prosecute people in other states for helping people get an abortion.

“I really am in favor of—if abortions are legal in federal lands, let’s have an abortion clinic in every post office. It might help business,” Symington said. “I’m being facetious, but we need to preserve the ability of patients in every state to get abortions if they need them, because people can’t always travel.”

Jain said medical societies have power on a national level to fight against the Supreme Court decision.

“They need to be using that power to advocate for this to be reversed,” she said. “We need all medical societies to not just be putting out statements. They need to be doing more.”

Medical societies should not hold conferences in states where abortion is banned, Jain said.

“The concern is, as medical experts, as physicians, as healthcare workers, I don’t think we should be supporting having large conferences in these locations, because it’s not safe, medically, for women to attend these conferences and those locations,” she said.

“I would be concerned attending a conference in any of these states, because if, God forbid, something were to happen to me or to one of the attendees, I would be concerned as to what type of medical care they would be able to get if they needed emergency care or otherwise.”

Dizon said oncologists should help people understand that abortion is a nuanced issue, and that not every pregnancy is viable.

“We’re talking about real people and various situations, all of which are dif-

ferent, all of which are complicated, and all of which require a doctor and a patient to have a very meaningful conversation,” Dizon said. “At the end of the day, there’s a decision. In the oncology world, it’s never a decision that people approach lightly. It’s always a decision that has consequences.

“People experience pregnancy loss, and it can happen naturally—but to subject women to risk to their lives for something that is not viable goes against everything that we stand for in this country,” Dizon said. “It’s essentially committing half of our population to, essentially, indentured servitude, because we are not giving them the choice of whether or not to carry. We’re just saying you need to carry your pregnancy.”

Hawkins said the view of motherhood as the be-all, end-all for women seemed to influence the way her doctors framed her options.

“I think it’s telling that even these very pro-choice providers, their first thought was, how do we help this woman keep this baby?” Hawkins said. “Part of me is just still really surprised that my high-risk pregnancy doctor, two different oncologists, and my IVF specialist—everyone just really, really wanted to do everything they could to help me figure out how to have this baby, if that’s what I wanted. And while I respect and understand and appreciate that, I also feel like we’re all conditioned to think that way, that the end goal for any woman in her thirties is to have kids.”

In August, Hawkins plans to work with a fertility specialist to freeze embryos so she and her partner could have the option of having a child at a time that works for them.

No one should be denied the right to choose, Hawkins said.

“I was hesitant to share my story, because you don’t need to have cancer, or be raped, or be a victim of incest to make a decision to not want to have a baby. I feel very strongly about that,” Hawkins said. “This is not about protecting life. This is about power, and controlling people’s bodies, and making sex into something that’s only supposed to happen for procreation, and otherwise you’re punished.”

.....
Matthew Bin Han Ong contributed to this story.



We’re always saying that the physician-patient relationship is sacred. If physicians can’t get the care we need and patients can’t get the care they need, it’s impacting us, it’s impacting our patients, and it’s impacting what’s supposed to be a sacred relationship.



—Ariela L. Marshall

INSTITUTIONAL PLANS

Allow everyone in your organization to read The Cancer Letter and The Clinical Cancer Letter.

Find subscription plans

HERE

or visit:
<http://cancerletter.com/subscribe/>

Q

&

Cohen spoke with
Matthew Ong, associate editor of
The Cancer Letter.

A



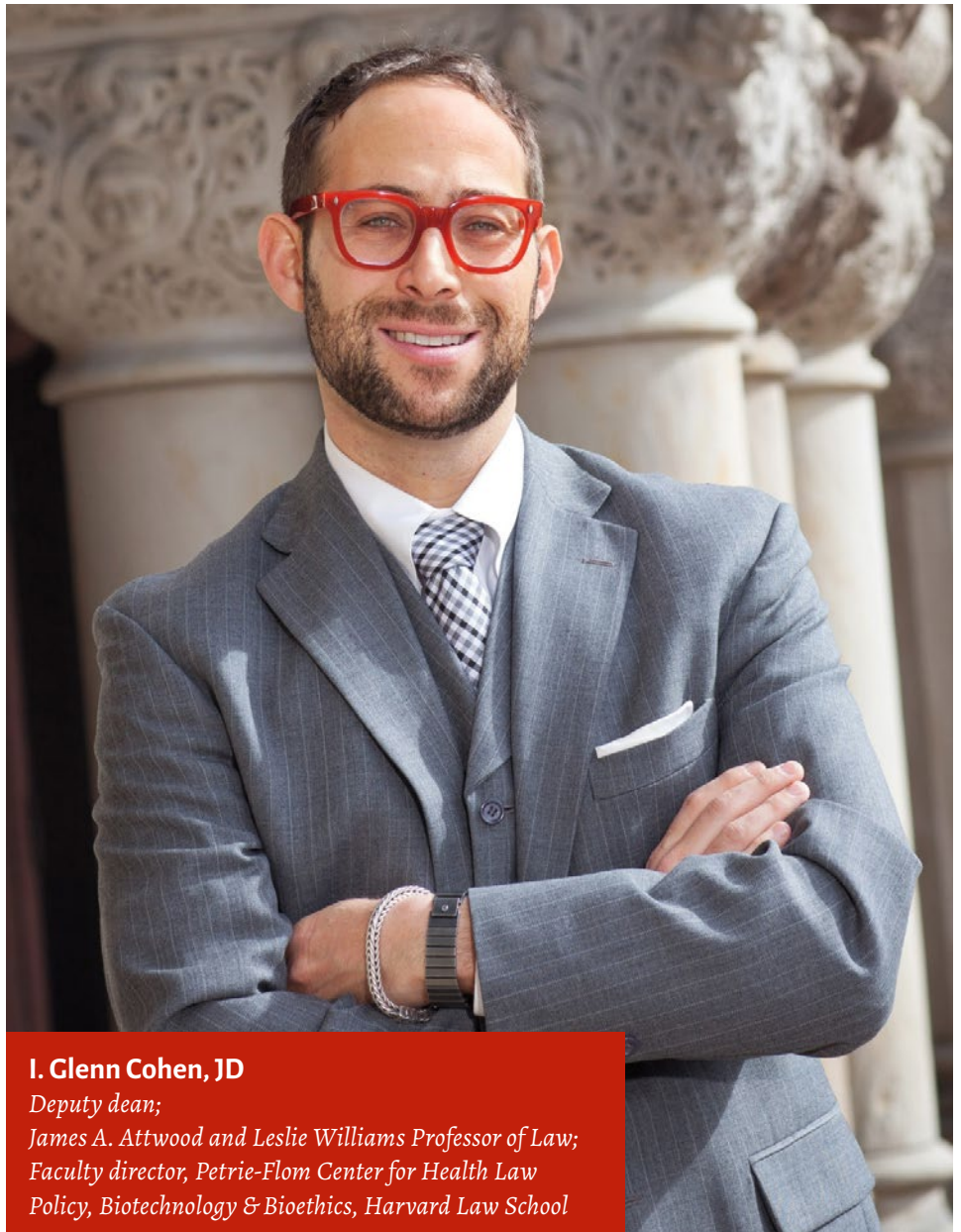
CONVERSATION WITH
THE CANCER LETTER

Harvard Law's I. Glenn Cohen: To provide good care, doctors will run afoul of criminal law in some states as *Roe v. Wade* ends

“

How do you practice and how do you make decisions about whether to relocate your clinic or to offer something, if you just don't know what's going to happen?

”



I. Glenn Cohen, JD

Deputy dean;

James A. Attwood and Leslie Williams Professor of Law;

Faculty director, Petrie-Flom Center for Health Law

Policy, Biotechnology & Bioethics, Harvard Law School

Now that the constitutional right to abortion has been eliminated, U.S. healthcare providers have to choose one of three options: give up abortion services, relocate, or wrangle with enforcement and unfriendly state legislatures.

I. Glenn Cohen, deputy dean and James A. Attwood and Leslie Williams Professor of Law at Harvard Law School, has these words of guidance for the perplexed:

“Hire a good lawyer. I think one of the biggest issues for people in the medical community—beyond what the rules actually are—will be the uncertainty around the rules.”

Physicians and pregnant women alike have no choice but to navigate the labyrinthine complexities generated by the *Dobbs v. Jackson* decision—including the risk of being accused of committing a crime.

“It’s bad to know that the answer is you can’t do it, but it’s also bad to be *deeply uncertain* about whether what you’re doing will expose you to criminal or civil liability,” Cohen, who is also faculty director of the Petrie-Flom Center for Health Law Policy, Biotechnology & Bioethics at Harvard Law School, said to *The Cancer Letter*. “Part of the question will be whether it be some of the statutes that speak to abortion, for example, there’s also the question about how they treat miscarriage. There’s the question about how they treat certain contraceptives.”

The end of *Roe v. Wade* has legal ramifications for fetal tissue research, in vitro fertilization, stem cell derivation, selective reduction of embryos, medical abortion, and interstate travel for abortion, Cohen said.

“I think we’re going to see really difficult questions faced by individuals, and by hospital systems, and by governments,” Cohen said. “So, the idea that this decision somehow resolves a lot, and now,

it’s all clear, I think is facetious. Instead, it’s really going to be just more questions that we have.”

Cohen, who is the author and editor of more than 18 books on health law, bioethics, and reproductive technologies, said the *Dobbs* ruling may indicate that constitutional protections for contraception, same-sex intimacy, and same-sex marriage are also on the SCOTUS chopping block.

“Even though they disclaim that they’re not deciding anything other than abortion, nonetheless, the opinion’s exact same logic would seem to create problems for many other things,” Cohen said. “Justice [Clarence] Thomas wrote separately, and he basically said the quiet part out loud, if you will.

“He says they should be reexamined. We’re just not doing that today. So, it’s a little bit jarring to see him join Justice [Samuel] Alito’s opinion, who says, ‘Oh, no, no, this is just about abortion,’ but then say, ‘Oh, actually, you know what? It isn’t just about abortion. It’s about these other things.’”

As roughly half the country enacts anti-abortion laws—including 13 states with “trigger bans”—physicians in some states practicing routine “good care” may find themselves at odds with criminal law interpretations of the *Dobbs* decision, Cohen said.

“One of the most challenging parts is, it may not be the right resolution to say, ‘There’s some legal risk here, so don’t do anything,’” Cohen said. “I think that that runs straight ahead into the fact that as medical providers who want to help their patients, they also have duties, ethical duties to try to do what they can. And that might, in some instances, require pushing the envelope legally a little bit.

“It’s time to refocus attention on state elections, state lobbying, and state leg-

islative processes, and state law interpretation. Because I think that much of the action will now be state-by-state, which is a little unfortunate, because if you operate in multiple states—some providers do—you may be under different regimes in different places.”

Cohen spoke with Matthew Ong, associate editor of *The Cancer Letter*.

Matthew Ong: Ideologies aside, how far does the Supreme Court decision on *Roe v. Wade* set us back—from a scientific, medical, public health, and human rights perspective?

Glenn Cohen: For people who believe that abortion should be available in the United States, at least under some circumstances, we’re set back quite a lot in that, essentially now, states are free to ban abortion from literally the first day, post-fertilization. And some states will.

So, this is a huge setback for women’s rights and for human rights, I think, in that respect.

On the other hand, for people who believe that abortion is murder, who believe fetuses are persons and that their termination is equivalent to murder and can’t be justified by women’s rights to control of their bodies—from their view, it’s a huge human rights victory, and that we’ve protected the lives of large numbers of people.

I really do think that you can’t put politics to a side on this one in evaluating it—or perhaps more accurately, moral views about the fetus.

Beyond abortion, I think the decision itself has implications for in vitro fertilization, contraception, same-sex marriage, those kinds of issues. But these are a little less certain, in part because

they were not squarely the holding of the case.

What are some takeaways that you think our audience should pay attention to?

GC: I think one is that we see a split between even the conservative justices.

Six justices voted for the results in the case—that the Mississippi 15-week ban should be upheld. But among those justices, Chief Justice [John] Roberts didn't join the majority opinion.

He concurred in the judgment only, and basically said, "We should just leave it at that. And in the future, we can decide what happens before 15 weeks."

The five justices that formed Justice Alito's majority said, "No, *Roe v. Wade* is over." And essentially, their rationale essentially connects it to what the state of the law was and the traditions of the nation at the time of the framing of the 14th Amendment—so, in the 1860s.

That's a very conservative kind of perspective on how to understand due process and what the 14th Amendment means.

And, even though they disclaim that they're not deciding anything other than abortion, nonetheless, the opinion's exact same logic would seem to create problems for many other things, including rights for same-sex marriage or same-sex intimacy.

Justice Thomas wrote separately, and he basically said the quiet part out loud, if you will. In that, he essentially said that he believes the entire edifice of substantive due process—in which the rights of contraception, same-sex intimacy, same-sex marriage lie—are all problematic and are clearly erroneous, the way *Roe* was erroneous.

He says they should be reexamined. We're just not doing that today.

So, it's a little bit jarring to see [Thomas] join Justice Alito's opinion, who says, "Oh, no, no, this is just about abortion," but then say, "Oh, actually, you know what? It isn't just about abortion. It's about these other things."

And that's what the dissent says as well, that even if you believe Justice Alito sincerely thinks he's just limiting this to abortion, in fact, the reality is that the logic of his opinion leans much further, and whatever he thinks about the matter, future judges and future courts can extend it in this way. I'll just highlight one.

And then, lastly, I'll just say Justice Kavanaugh wrote separately—even though he joined the five justices of Alito's majority—to flag a couple of issues where he thinks he wanted to state the position that he thinks the law is clear.

One is about a right to interstate travel for abortion, that he thinks the Constitution clearly supports that. He's just speaking for himself. He thinks it's an easy case.

I'm not so sure it's that easy.

The other was on retroactive criminalization of abortions before this point, where he thinks again, the Constitution clearly says you can't retroactively criminalize or punish someone for an abortion they already had.

And maybe I'll just say, one of the things that I think is particularly relevant to the science audiences—and I'm going to try and read this exactly verbatim, because I want to make sure I get this right.

It's the passage where Justice Alito says that what makes this case different from *Griswold* and these other earlier cases is ... he says, "Finally, the defense suggests that our decision calls into question *Griswold*, *Eisenstadt*, *Lawrence*,

Obergefell." Those are cases about contraception, sterilization, and same-sex intimacy, and same-sex marriage.

"But we have stated equivocally that '[n]othing in the opinion should be understood to cast doubt on precedents that do not concern abortion.' We have also explained why that is so: rights regarding contraception and same-sex relationships are inherently different from the right to abortion because the latter (as we have stressed) uniquely involves what *Roe* and *Casey* termed 'potential life.'"

So, what I just want to emphasize here is, even if you take him as his word, that's his dividing line. That dividing line does implicate embryo destruction, which would be relevant both to in vitro fertilization as commonly it's practiced in the United States (with a fair number of additional embryos created that are not ultimately implanted), but also stem cell derivation and many forms of research done by many scientific communities.

Speaking of research, what does this mean for fetal tissue research and translational discoveries that rely on fetal tissue? For instance, I see that the Pennsylvania Republicans are now pushing to end it in their state.

GC: This research has been a political football over the course of the last 30 years, with different administrations of the federal government taking different positions on it.

But essentially, what Justice Alito's opinion is saying, or what I understand him to say, is that if the state were to want to ban this research entirely, to say, "Any research involving the destruction of an embryo is banned in X state," there's nothing in the Constitution that prohibits that.

That's how I read his opinion, which is to say, because it involves the destruction

of potential life, and there's no right to destroy potential life. There's a way, by the way, in which that result is even easier for him to reach than the abortion result, because notice there, there's no woman who's gestating a fetus whose rights we're interfering with.

Instead, it's merely this question of what scientists can do. And that's important, but, certainly, you would think in terms of bodily autonomy versus scientific rights, actually, bodily autonomy would be the harder one to overrule or trump. And yet in this decision, a decision on abortion, he's telling women, "You know what? We're trumping that."

Now, it's a political question whether individual states adopt prohibitions on embryo destruction or not. There's a lot of reasons and a lot of lobbying involved in the scientific community that will likely prevent that in many states.

But there's probably some states where the balance between conservatives opposed to embryo destruction are strong enough. And I should emphasize that there's actually a big gap, for example, between pro-life as to abortion versus being opposed to IVF with embryo destruction.

So, we know that, actually, people have very different attitudes towards this, even within these pro-life communities.

But that said, what Alito has suggested is that after this decision, it seems to me, a legislature that did pass this, if they tried to say, "Oh, it's unconstitutional," that'd be a very hard argument to make.

What recourse do women and their physicians have if they need to make a case for medically necessary abortions? What are their options and legal rights?

GC: It's going to depend a lot on the state. The things to keep an eye on will

be this question about interstate travel for abortion.

If your state prohibits abortion, can they also prohibit you to travel out of the state?

No state, as far as I know, has passed a law to that effect yet, but that doesn't mean that they won't.

A second matter, I think, to keep an eye on, will be medical abortion. In particular, the two-drug regimen of mifepristone and misoprostol, and here, they are FDA-approved. Mifepristone has an REMS, a set of restrictions around it. And there's going to be a fight.

There's already a lawsuit, but there's likely going to be further fights about the question about whether the state wants to ban medical abortion.

So, the use of these pills by pregnant women, not an abortion provider now, but merely the prescribing of these pills; can a state restrict that?

Or does the FDA's approval plus its REMS around it preempt contrary state laws? That's an issue to be faced by the courts.

There may be some questions about interpreting individual states' laws there, if they have exceptions for the health of the mother or what that means, and what counts as that?

When we look across the world, we see actually great variations to what extent mental distress is considered and suicidality risk is considered as part of a health-of-the-mother kind of analysis.

So, I imagine we'll see some fights about that.

There may be some fights in individual states, but even though the federal Constitution doesn't guarantee a right to abortion after *Dobbs*, whether their state Constitution does so.

And then, we're likely to see some legislation at the federal level. Though, what exactly it'll look like, it's hard to say.

The president doesn't have a very strong majority in the House and Senate, and as a result he doesn't necessarily have the votes for something very widespread. And if he does try something very widespread, there's also a question about whether the Supreme Court will find the federal government has or lacks the power to do this.

I think the White House is trying to figure out what it is they can do and how much they want to take a chance and do something and have it struck down versus only doing things that they really believe will be sustained by the Supreme Court.

And along the same lines, up to one in 1,000 women have cancer during pregnancy, and treatments can cause miscarriage and abortion. Will they be exempt from prosecution? I think this goes back to what you just said about states that ban abortion.

GC: Exactly.

And again, part of the question will be whether it be some of the statutes that speak to abortion, for example, there's also the question about how they treat miscarriage.

There's the question about how they treat certain contraceptives.

And here, I think one of the biggest issues for people in the medical community—beyond what the rules actually are—will be the uncertainty around the rules.

How do you practice and how do you make decisions about whether to relocate your clinic or to offer some-

thing, if you just don't know what's going to happen?

And we have seen some letters from district attorneys, so, largely left-leaning district attorneys thus far, declaring that they won't enforce these rules and stuff like that.

But if you have a conservative governor and a conservative state legislature, that's possible that they can take the power to enforce this sort of stuff.

I just think there's a lot of uncertainty.

It's bad to know that the answer is you *can't* do it, but it's also bad to be *deeply uncertain* about whether what you're doing will expose you to criminal or civil liability.

What are some other scenarios that you're aware of in which life-saving medical interventions also involve a high risk of spontaneous or therapeutic abortion?

GC: I'm not a clinician, I think that I probably would defer to others who are on this.

But I think one of the questions will be with IVF, for example, there's a question about selective reduction. If you've had multiple embryos implanted that are developing, sometimes inadvertently, can you terminate one or more for the sake of a good outcome for the health of the others?

That's going to be an issue that will raise the question about whether selective reduction is abortion. And I think probably it is, under most of these state statutes.

But it's a real change in the way people who do reproductive technologies will practice, and what they can do and how

they have to warn their patients, and what it means to be a patient.

There also will be interesting questions about whether there will be hubs that develop that people travel to.

For example, if you are a person who's thinking about using one of these technologies, or you are a person with a particular set of medical needs, where as part of the course of your treatment, an abortion may be required on an emergency basis, and your home state is one that's fairly restrictive on this, whether you decide to relocate your entire treatment to a state that's more friendly.

And that's going to be available to some people, but not to others—not for people with disabilities, for people who don't have a lot of money, for people who are immunocompromised in a state where actually traveling somewhere is just not a great option for them.

I think we're going to see really difficult questions faced by individuals, and by hospital systems, and by governments.

So, the idea that this decision somehow resolves a lot, and now, it's all clear, I think is facetious.

Instead, it's really going to be just more questions that we have.

Since so much is in flux right now, what would you say to hospitals and healthcare institutions that serve patients across state lines and across different abortion access laws?

GC: I think that it's very difficult. I think there's a lot of particularities.

Hire a good lawyer. But also, I think, one of the most challenging parts is, it may not be the right resolution to say,

"There's some legal risk here, so don't do anything."

I think that that runs straight ahead into the fact that as medical providers who want to help their patients, they also have duties, ethical duties, to try to do what they can.

And that might, in some instances, require pushing the envelope legally a little bit.

I think it's a conversation that's a little bit between ethical duties of beneficence, on the one hand, and assessments of legal risk.

But making those assessments of legal risk is quite hard, because we're entering a period of uncertainty.

Maybe the one thing I will say, and this is more to non-lawyers, is to understand that while the decision in *Dobbs* has opened the floodgates to individual states to make decisions about all these sorts of things, that's a decision for each state to make.

It's time to refocus attention on state elections, state lobbying, and state legislative processes, and state law interpretation.

Because I think that much of the action will now be state-by-state, which is a little unfortunate, because if you operate in multiple states—some providers do—you may be under different regimes in different places.

And where bioethics is concerned, is there a bright line to be drawn anywhere on this issue, with regards to what a physician has a duty to do and what is deemed to be the practice of medicine?

GC: I think it's a really interesting question. I think emergencies are a particular

area where my sense is that bioethics tends to think that perhaps you ought to go a little bit further.

But that said, if you ask me, “Is a physician ethically obligated to subject themselves to criminal liability to basically risk being put in jail for a patient?” I think it would be a very strong stance to take that this is ethically required of physicians.

Now, maybe there’s instances of very low risk where people might feel differently.

I think physicians are heroes in many ways, but I don’t think we should think that we demand they be heroes in the sense of risking going to prison. I think it’s just a very difficult situation for a physician to face. But it’s one that they may soon be facing in some instances, and I think it is time for them to get a realistic sense of what the risks are.

I do think there are going to be physicians in some states who are going to be called upon to give patients good care, where that good care now will run afoul of the criminal law as it might be interpreted by some of those states.

Is there a precedent for the Supreme Court to change its mind twice? Meaning, the justices overturned a decision and then went back on it?

GC: Gosh, I’d have to think about a double change.

There have definitely been reversals, and Justice Alito kind of helpfully gives us a large number of them. But double reversals in a short period of time might be rare.

All that said, while *stare decisis*—which is the idea that we should follow precedent—is a general principle, it’s not always followed.

Justice Alito’s completely correct that it’s not always followed.

And sometimes, it’s not always followed in ways that progressives are happy about.

Lawrence v. Texas, which struck down the criminalization of same-sex sodomy in Texas, overruled an earlier case called *Bowers v. Hardwick*, which essentially had adopted the opposite perspective.

So, this is to say, things can change.

What I think is jarring for most people is when you have a precedent that’s 50 years-old that gives people a constitutional right, and you’re withdrawing it, the *stare decisis* analysis that was offered as to why overrule this case and why it’s okay in this instance to do it, I think that’s what didn’t sit so well with many people who are progressives, or even just people who believe in a continuity in legal decision-making.

The Supreme Court ultimately is only one institution in our democracy, but it’s an institution that has a lot of power. And in some ways, when you ask, what is the constitutional law on a particular subject?

Some would say the answer is it’s whatever these five people on the Court say it is at a particular moment in time.

So, if some or all of those five people change, it is possible the holding of *Dobbs* will be changed too.

We know pretty much where most academic institutions and public health leaders stand on this. What about the constitutional law community? Is there a consensus on this ruling?

GC: I think it’s tough, in that they’re a very heterogeneous group.

I would say, most American law professors tend to be left-leaning, and even self-identified as progressives.

For that reason, I would say the majority of individuals in constitutional law circles are dismayed by the results in *Dobbs*.

But there are certainly conservatives or pro-life individuals who are very happy about the result.

And there’s a group of people who are just skeptical about the process of constitutional lawmaking by the Supreme Court in general, and treat this as just an example of that problem.

While the court portrays itself as being jurists acting in a judicial function, these people would say this just shows that this is legislation by another name and by unelected individuals.

So, I think you’d find all three: largely people who are very upset, but believe in the project of constitutional law; a smaller subset of people who are actually happy and think this is the right result, in particular people who return to certain currents of views of originalism as a theory of constitutional interpretation; and then, the third group that just thinks that this just exposes how skeptical we should be about the Supreme Court and constitutional decision-making in general.

Thanks for taking the time to speak with me.

GC: Thank you.



GUEST EDITORIAL

Cancer patients and their families will feel the impact of SCOTUS abortion ruling



Karen E. Knudsen, PhD, MBA

*Chief executive officer,
American Cancer Society,
American Cancer Society Cancer Action Network*

The American Cancer Society's key stakeholders are people with cancer and their families.

As described in our [public statement](#), and as a non-partisan organization, we hold a steadfast commitment to health equity. We believe that everyone should have a fair and just opportunity to prevent, find, treat, and survive cancer, and not be disadvantaged because of how much money they make, the color of their skin, their age; their sex, sexual orientation, or gender identity; their physical or mental ability; or where they live.

In overturning the 50-year-old landmark 1973 *Roe v. Wade* decision on June

24, the Supreme Court determined that the U.S. Constitution does not confer a right to abortion and therefore granted the authority to determine abortion rights to individual states.

The result is the potential for immediate and profound impact for certain cancer patients and their families because of where they live.

Cancer during pregnancy is a reality on the rise

Annually, up to one in 1,000 pregnant women in the U.S. receive a cancer diagnosis.¹⁻³ This number is expected to

increase as a function of the increase in maternal childbearing age in the United States.⁴

Moreover, it is notable that cancer is the second most common cause of death for women during childbearing age,⁵ and further, that cancer diagnoses during pregnancy are often delayed due to overlapping symptoms such as fatigue, anemia, and nausea.⁶

Given the strong link between early detection and treatment with increased cancer survivorship, we are concerned about the implications for the ruling to impede timely, life-saving care for cancer patients.

Challenges to cancer care during pregnancy

The proposal in some states to define personhood at fertilization (e.g., as exemplified in under Arkansas law, which immediately went into effect after the Supreme Court ruling and defines in statute an “unborn child mean(ing) an individual organism of the species *Homo sapiens* from fertilization until live birth”) creates a likely barrier for a subset of pregnant women to receive immediate, effective cancer care.

Notably, while surgical procedures are generally considered safe during pregnancy, other common cancer interventions which ensure a better outcome for the mother are not recommended if the goal is continuation of pregnancy^{6,7} due to the impact of treatment on a fetus.

For example, any type of radiation therapy is avoided during pregnancy, regardless of the location of the cancer. Further, most cytotoxic chemotherapies must also be avoided during the first trimester if the clinical goal is to prevent harm to the fetus, thus in some cases placing the health of the mother at risk by delaying treatment.

This is particularly important in fast-growing, aggressive cancers where delays in treatment measured in days or weeks can be lethal to the mother.

Such decisions regarding how to move forward using a patient-centered approach require thoughtful discussion between the pregnant patient and the oncology team, which historically have not been interfered with by government.

It is also notable that many uncertainties remain with regard to use of chemotherapy and targeted therapies during pregnancy, since pregnant women are excluded from almost all clinical trials. There is therefore a concern that

sufficient lack of understanding of therapeutic intervention on a developing embryo or fetus will lead to hesitancy to treat the patient.

In the modern era of oncology, additional cancer therapies with the potential to save or extend life of the mother are not recommended during any stage of pregnancy.^{6,7} Amongst these are hormonal therapies for breast cancer (e.g., tamoxifen, anastrozole), which is the most common cancer diagnosed in pregnant women.

As for newer generation targeted agents, limited understanding of drug safety during pregnancy creates clinical challenges for oncologists and their worry about potential legal or criminal implications of their decisions.

For example, after a thoughtful conversation of risk, benefits, and alternatives between an oncologist and a pregnant patient with chronic myeloid leukemia, they may together choose to move forward with imatinib as a proven treatment to prolong disease-free survival.

As imatinib can be associated with spontaneous abortion, we worry that the threat of state law-based criminal or civil penalties may preclude this shared decision-making conversation, thus reducing patient autonomy in managing their own cancer and putting the oncologist at risk.

Immunotherapy, which has yielded significant promise in a subset of cancer types occurring in pregnant women, has yet to be assessed for the impact on the fetus and maintenance of a successful pregnancy.

Some immunomodulatory agents are known to cross the placenta and have the potential to cause direct toxicity to the fetus. Given these concerns, a subset of immunotherapies is not currently recommended during pregnancy.

Given the more narrow range of options for some pregnant patients to receive cancer care without the potential danger of fetal harm, questions arise regarding the implications of new or proposed state legislation for timely access to cancer care.

As such, the American Cancer Society's Cancer Action Network is actively monitoring the implications of the *Dobbs vs. Jackson* ruling, and will continue to advocate for evidence-based, unimpeded access to cancer care.

Learning by precedent: potential impact of abortion restrictions on cancer care

Given the challenges described above, the importance of addressing the issue of barriers to cancer care for pregnant patients is critical. In the aftermath of the *Dobbs vs. Jackson* ruling, families in some states will face an unprecedented and potentially life-threatening dilemma for the pregnant patient, especially in states where the exceptions are statutorily defined as the life of the mother and medical emergencies rather than the health of the mother.

Put simply, in such scenarios there is a significant concern that timely cancer care to the pregnant patient would be impeded due to potential harm to the developing fetus, and physician hesitancy to treat due to fear of unintended pregnancy termination and legal prosecution.

While to some it may seem inconceivable that such critical barriers to care may manifest itself within the United States, precedent in other countries serves as a cautionary tale.

For example, in Nicaragua where there is a total ban on abortion, it has been reported that pregnant women have been

unable to receive potentially life-saving cancer care due to the potential of harm to the fetus or inducing a spontaneous abortion.

Indeed, women and girls who terminate pregnancy in Nicaragua face two years in prison, and medical professionals can be sentenced to up to six years for providing care that even unintentionally leads to an abortion.⁸



Such decisions regarding how to move forward using a patient-centered approach require thoughtful discussion between the pregnant patient and the oncology team, which historically have not been interfered with by government.



Similar themes have been observed in the Dominican Republic, including a horrifying and highly publicized story of a 16-year-old girl who was nine weeks pregnant and diagnosed with leukemia. This young woman was initially denied chemotherapy due to concern that the treatment which could have saved her life may inadvertently terminate the pregnancy.

She ultimately died of her cancer at 13 weeks pregnancy due to delayed treatment.

This case is notable given the similarity to some proposed legislation within a subset of U.S. states, wherein according to the Dominican Republic constitution, the right to life is inviolable from the moment of conception until death.⁹

Even more recent and alarming reports have emerged from Poland, in which the ban on abortion has had consequence on cancer care. As reported by *The New York Times*, pregnant women diagnosed with aggressive cancer have even resorted to leaving the country to receive care.¹⁰

Importantly, all these cases violate the well-accepted ethical principal in medicine of “dual effect”, where after thoughtful discussions between patients and their clinicians, sometimes it is permissible to experience a negative outcome if the primary intention is for a good outcome (e.g., saving the mother’s life) and risks of the negative outcome are minimized to the extent possible.

This principle, widely applied across medicine during times of patient extremus and complex clinical situations, prioritizes the intentionality of the patient and their clinical team (e.g., saving the mother’s life).

Further concerns arise as related to the potential for a disproportionate impact on persons of color. Research has shown that Black men and women have the highest death rate and shortest survival of any racial or ethnic group in the nation for most cancers.

Strikingly, Black women have a 41% higher death rate from breast cancer as compared to whites, which is the most frequent cancer type diagnosed in the pregnant population. Inflammatory breast cancer, which is an aggressive subtype for which rapid treatment is imperative, is more common in Black women.

In parallel to the increased cancer burden for Black women, Black women in the United States have reduced access to highly effective contraception as compared to whites, and as such a higher rate of unintended pregnancies.¹¹

Given these data, there is reason to predict that barriers of cancer care to pregnant individuals have the potential to impact communities of color even more deeply.

Implications for fertility preservation

Finally, proposed new legislation has the potential to impact all cancer patients who seek fertility preservation. Current guidelines recommend that all cancer patients of childbearing age should receive the option for fertility preservation. Studies demonstrate that lack of such preservation is a common regret, which affects downstream quality of life during cancer survivorship.¹²

More than 80,000 young adults aged 20-39 are diagnosed with cancer each year in the U.S., many of whom opt to preserve for fertility preservation to start or grow their families after their cancer therapy is complete. Further, approximately 5%-6% of the population in childbearing age are cancer survivors.¹³

The most recommended approach to fertility preservation for cancer patients is through the creation and freezing of fertilized embryos for post-treatment implantation. Oftentimes, to ensure success of this process, multiple such embryos are created.

It remains unclear after the recent *Dobbs* ruling how embryos that are not considered viable (due to non-life sustaining malformations) or that are beyond the family’s needs will be treated by varying state laws.

This creates significant uncertainty for patients, their families, and oncology teams related to potential new financial, civil, and criminal penalties that have not for five decades interfered in this critical patient/clinician discussion.

In sum, the *Dobbs vs. Jackson* ruling has significant implications for the cancer patients and families we represent.

This is not a partisan issue. Through the American Cancer Society Cancer Action Network, we are committed to working with states to provide needed information about the consequences of reproductive legislation on access to care for pregnant cancer patients, access to fertility preservation for all cancer patients of childbearing age, and any other implication with the potential to influence cancer survivorship.

As aligned to our mission to improve the lives of cancer patients and their families, we will continue to advocate for policies that maximize all person's ability to survive and thrive after a cancer diagnosis.

Citation:

1. Donegan WL. Cancer and pregnancy. *CA Cancer J Clin*. 1983;33(4): 194–214.
2. Nieminen U, Remes N: Malignancy during pregnancy. *Acta Obstet Gynecol Scand* 49:315-319, 1970
3. Smith LH, Danielsen B, Allen ME, et al: Cancer associated with obstetric delivery: Results of linkage with the California cancer registry. *Am J Obstet Gynecol* 189:1128-1135, 2003
4. [US Census report.](#)
5. Siegel RL, Miller KD, Jemal A: Cancer statistics, 2019. *CA Cancer J Clin* 69:7-34, 2019
6. Silverstein J, Post AL, Chien AJ, Olin R, Tsai KK, Ngo Z, Van Loon K. *Multidisciplinary Management of Cancer During Pregnancy*. *JCO Oncol Pract*. 2020 Sep;16(9):545-557. doi: 10.1200/OP.20.00077. PMID: 32910882.
7. Hepner A, Negrini D, Hase EA, Exman P, Testa L, Trinconi AF, Filassi JR, Francisco RPV, Zugaib M, O'Connor TL, Martin MG. *Cancer During Pregnancy: The Oncologist Overview*. *World J Oncol*. 2019 Feb;10(1):28-34. doi: 10.14740/wjon1177. Epub 2019 Feb 26. PMID: 30834049; PMCID: PMC6396773.
8. Hutchison C. *Nicaragua's anti-abortion policy endangers women, criminalizes doctors, experts say*. ABC News. 2010 Feb 10. [Nicaragua's Anti-Abortion Policy Endangers Women, Criminalizes Doctors, Experts Say - ABC News \(go.com\)](#)
9. Romo R. *Dominican Republic abortion ban stops treatment for pregnant teen with cancer*. CNN. 2012 July 25. [Dominican Republic abortion ban stops treatment for pregnant teen with cancer | CNN](#)
10. Bennhold K, Pronczuk M. *Poland Shows the Risks for Women When Abortion Is Banned*. *The New York Times*. 2022 June 26. <https://www.nytimes.com/2022/06/12/world/europe/poland-abortion-ban.html>
11. American Cancer Society. *Cancer Facts & Figures for African American/Black People 2022-2024*.
12. Benedict C, Thom B, Kelvin JF. *Young Adult Female Cancer Survivors' Decision Regret About Fertility Preservation*. *J Adolesc Young Adult Oncol*. 2015 Dec;4(4):213-8.
13. Pinelli S, Basile S. *Fertility Preservation: Current and Future Perspectives for Oncologic Patients at Risk for Iatrogenic Premature Ovarian Insufficiency*. *BioMed research international*, 2018, 6465903.



Put simply, in such scenarios there is a significant concern that timely cancer care to the pregnant patient would be impeded due to potential harm to the developing fetus, and physician hesitancy to treat due to fear of unintended pregnancy termination and legal prosecution.





GUEST EDITORIAL

Cancer care must remain in the hands of doctors and their patients



Julie R. Gralow, MD

*Chief medical officer,
Executive vice president, American Society of Clinical Oncology*

Last week's Supreme Court decision to overrule *Roe v. Wade* returned the power to regulate reproductive health to individual states.

In the midst of what will surely become a wave of legal challenges and a confusing landscape of inconsistent policy, one thing remains constant:

ASCO's singular focus on assuring every individual with cancer—regardless of who they are or where they live—is able to receive high quality, equitable, evidence-based cancer care.

For people who are diagnosed with cancer during pregnancy, already a devastating life circumstance, decisions about what treatments to pursue—and when—are urgent and best made with an informed physician who can consider all evidence-based, scientific options, including termination.

Many cancer treatments can impact the pregnancy, result in miscarriage, or harm the fetus. In those circumstances, pregnancy termination is an important component of high-quality cancer care and it must remain an option for patients.

Patients must be able to trust their doctors and we are therefore concerned

about the potential impact of the decision that inserts the government and even lay-people into the most private and personal decisions patients face.

The *Dobbs* ruling creates uncertainty and confusion that can undermine the sacred doctor-patient relationship.

Already, the prevailing confusion and fear has caused many physicians, including those where access to abortion is protected, to question whether delivering standard evidence-based cancer care could result in harassment, prosecution, prison sentence, or revocation of their medical license. These concerns are a threat to high-quality, equitable cancer care.

Per ASCO's (and others') evidence-based guidelines, for people of child-bearing age, high-quality, evidence-based cancer care should include careful consideration and discussion of fertility preservation.

ASCO's 2018 [clinical practice guideline on fertility preservation](#) specifically recommends that providers discuss fertility preservation options with all patients of child-bearing age as early as possible to allow for the widest array of options for fertility preservation.

ASCO is committed to the availability of these options even as they are potentially threatened by the *Dobbs* ruling.

The *Dobbs* decision pushes regulation and control to the individual states. For now, ASCO is closely monitoring related activity in state legislatures and especially the 13 that have so-called "trigger laws" that would serve almost immediately to impose bans or strict limitations on reproductive health services, mainly abortion. Other states have signaled intentions to impose similar limitations while some states are making plans to assure continued access to abortion.

As this situation is rapidly evolving, with each state making individual decisions, we are closely reviewing and analyzing state laws to understand the implications for patients with cancer and their physicians so we can provide support to our colleagues.

We will continue to advocate for patients' access to appropriate fertility preservation care, and will work with ASCO State Affiliates and others in the cancer community to educate lawmakers on the impact of relevant policy developments on cancer care.

No court decision, regulation, or legislation should deprive our patients of high quality, potentially life-saving, life-extending, or palliative treatment.

Further, no oncologist should fear for their safety or profession as they provide evidence-based, high-quality care to their patients.

ASCO's North Star is high-quality, equitable, evidence-based cancer care—and we intend to do everything within our means to ensure patients have access to this level of care.



Already, the prevailing confusion and fear has caused many physicians, including those where access to abortion is protected, to question whether delivering standard evidence-based cancer care could result in a harassment, prosecution, prison sentence, or revocation of their medical license.



REACH PEOPLE WHO MATTER IN ONCOLOGY

Advertise your meetings and recruitments in The Cancer Letter and The Clinical Cancer Letter

Find more information

HERE

or visit:
<https://cancerletter.com/media-kit/>



GUEST EDITORIAL

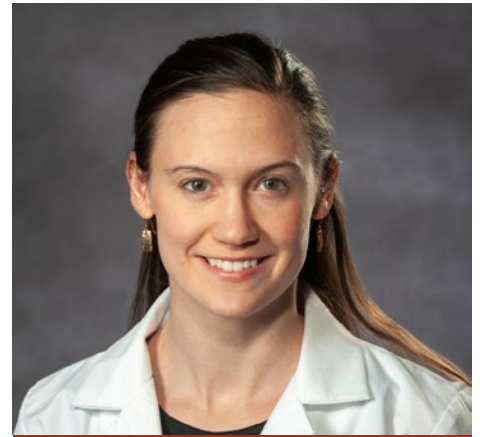
Virginia gynecologic oncologists: “Pro-life” is not pro-life at all



Leslie M. Randall MD, MAS



Devin T. Miller MD



Stephanie A. Sullivan MD

Roe v. Wade is about more than just abortion.

In this past week following the Supreme Court’s overturning of *Roe v. Wade* on June 24, we apprehensively discussed the coming ripple effects we anticipate as gynecologic oncologists, as obstetrician-gynecologists, and as women.

We can relate to the desire to protect innocent human life on a deep and personal level. However, our education and experience has informed our strong stance that the “pro-life” position is not pro-life at all.

Reversing the protections offered by *Roe v. Wade* will have farreaching second- and third-order effects in women’s health, including cancer care delivery and cancer-specific mortality.

Aligned with this concern, several of our professional societies issued statements this past week reaffirming that abortion is medical care, plain and simple.

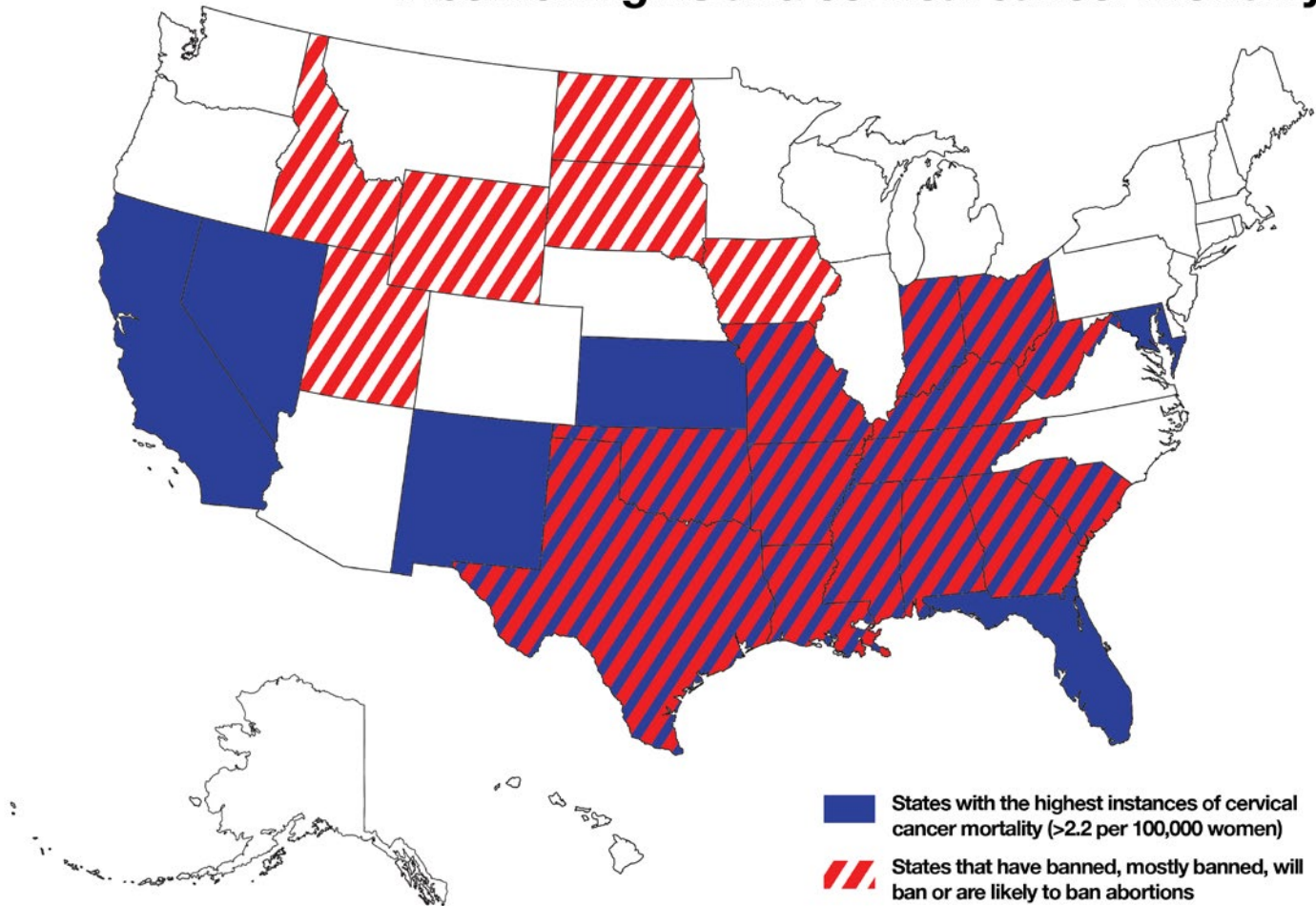
Editor’s note: A compilation of statements from professional societies, advocacy groups, and cancer centers appears on [page 32](#).

The difficult decision to terminate a pregnancy is nuanced and best made by that individual, and those they choose to include, in consultation with a trained physician.

Removal of this autonomy is—ironically—an injustice, and a violation of medical ethics.

Specifically for gynecologic cancer, the criminalization of pregnancy termination limits options and choices relative to fertility preservation, cancer diagnosed during pregnancy, and the management of gestational trophoblasticity—the malignant transformation of a conception.

Abortion rights and cervical cancer mortality



Sources: Centers for Disease Control and Prevention, The Washington Post

Likely more far-reaching, however, is that the loss of the right to choose creates a social construct where women are devalued or even stigmatized, dissatisfied with their reproductive medical care, and less likely to participate in cancer screening and prevention programs or present at symptom onset for early cancer diagnosis.

If you think this is catastrophizing—keep reading.

First, let's address onco-fertility. Many patients are diagnosed with cancer during their reproductive years and treatment of their cancer can impact fertility. Women have two options, ei-

ther to freeze their eggs or to freeze embryos, a fertilized egg.

Freezing embryos has some advantages over freezing eggs alone, such as improved survival rate and a better understanding of which eggs were healthy which can lead to less procedures.

With recent anti-abortion legislation, the role of embryos in the personhood debate becomes complicated. For cancer patients who have embryos saved, many will plan for a couple of children but they can have tens of embryos.

Many choose to donate unused embryos and others chose to discard them.

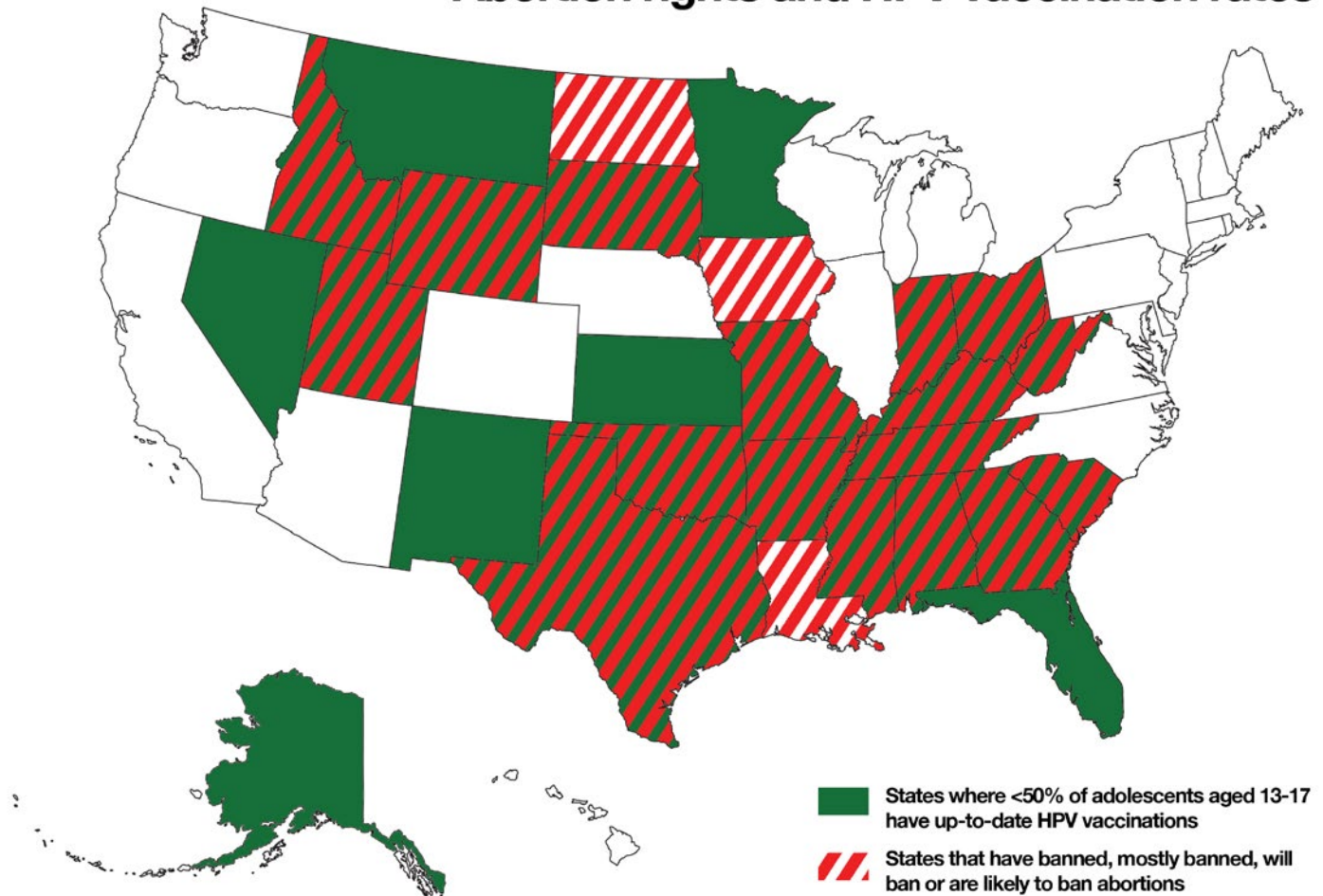
Some states use language such as 'developing humans' or 'conception' in legislation that may restrict how cancer patients want to safely use their embryos to complete their families.

This leaves women with hard decisions about whether to pursue fertility preservation at all and far fewer options during an unthinkable challenging time of their life.

Additionally, many families with genetic predisposition to cancer, such as the BRCA gene mutation, will utilize IVF and pre-implantation genetic diagnosis to select embryos without the mutation.

Those embryos that carry the gene mutation might be discarded, while those

Abortion rights and HPV vaccination rates



Sources: President's Cancer Panel, The Washington Post

that don't would be implanted. Many couples would explicitly not want to be forced to implant embryos with a genetic predisposition to cancer and may lose the option to provide a life without a dramatically increased risk of cancer to their children.

Next is when cancer is diagnosed during pregnancy. This is thankfully not common, and we have developed many ways for pregnancy and cancer care to co-exist. These treatment modifications, however, can increase a mother's risk for poor cancer outcomes. Some patients, however, do not have these options.

Therefore, not only must termination remain an option for these patients,

but it also needs to be free of distress and stigmatization. You will be hard-pressed to find another situation in medicine so distressing as this.

An angle that didn't immediately occur to us was in the management of gestational trophoblastic neoplasia, or GTN. GTN is also not a common event, but it occurs at the time of an abnormal chromosomal sorting at conception.

The result is a spectrum of malignancies, many of which are curable if appropriately diagnosed and managed, and nearly all of which are initially diagnosed as pregnancy.

In the context of criminalization of pregnancy termination, we are hopeful that malignant and abnormal pregnancy would be a clear indication for a medically necessary termination, but a hostile legal environment raises concerns.

Finally, our greatest concern is the social construct that lack of choice and autonomy creates for women at a very basic level.

The anti-abortion movement disregards CDC and DOJ statistics—as cited by ACOG—that more than one in three women in the U.S. have experienced rape, physical violence, or stalking by an intimate partner in their lifetime,

and 4.8 million incidents of physical or sexual assault are reported annually.

These estimates do not count the incidents that went unreported due to fear or cultural acceptance as norm, and they don't reflect the disproportionate effect on women of color, in the LGBTQIA+ community, and the economically disadvantaged.

66

The loss of the right to choose creates a social construct where women are devalued or even stigmatized, dissatisfied with their reproductive medical care, and less likely to participate in cancer screening and prevention programs or present at symptom onset for early cancer diagnosis.

99

The evidence that these populations carry a disproportionate burden of gynecologic cancer is indisputable, and there is no better concrete example than cervical cancer.

Cervical cancer incidence in the United States has significantly declined over the past several decades due to the availability of screening, the treatment of preinvasive disease, and the early detection of curable cancer.

With the advent of a preventative vaccine that was first FDA-approved in 2006 and universally endorsed by ACIP in 2011, cervical cancer is now nearly 100% preventable.

Despite this, the U.S. still sees a consistent incidence of approximately 14,000 new cases per year, with a disproportionate number in the exact same cultural groups that are adversely impacted by intimate partner violence.

In fact, these are not only the women that develop cervical cancer, but also the women that die from it, (Figure 1. Cervical Cancer Mortality in the U.S.). This is no coincidence.

In 2012, a paper was published by investigators in Africa who associated the incidence and mortality of cervical cancer in women living in poor conditions and with low social status (Singh GK, Azuine RE, Siahpush M. Global Inequalities in Cervical Cancer Incidence and Mortality are Linked to Deprivation, Low Socio-economic Status, and Human Development. *Int J MCH AIDS*. 2012;1(1):17-30.).

We read this with initial relief that we lived in a country that was not like this—however, we were forced to face the sobering reality that these conditions are a reality for many women in this country.

Since access to and acceptance of cervical cancer screening and prevention behaviors are so strongly linked to decreased incidence of cervical cancer, and women who lack access to just reproductive care will be more prone to avoid this care, we expect an exacerbation of cervical cancer incidence and mortality in the coming years.

Hauntingly, if you superimpose the geographic distribution of immediate, upcoming and likely abortion bans in the U.S. on the maps of cervical cancer mortality and delayed HPV vaccination uptake—also driven by misguided political forces—you can see significant

correlations between attitudes toward abortion and cervical cancer burden (Figures 1 and 2).

We are curious if the gun violence pattern discussed by Robert A. Winn in the May 27 issue of TCL is similar (*The Cancer Letter*, [May 27, 2022](#)).

Avoidance of care will affect more than cervical cancer. The next tier involves women who have symptoms of gynecologic cancer.

They will be less likely to seek care early, and that can lead to delays in diagnosis, a more advanced stage of disease at diagnosis and less curable cancers at diagnosis.

We see this in our current practice. It is not well-documented, but it is there. Now it will be there more.

Repercussions from *Roe v. Wade* will trickle down also to a patient's willingness to receive treatments and enroll in clinical trials. We already have male-female disparities in almost every aspect of care, including clinical trials.

The cancer war is far from over, and clinical trials are the only way to improve survival from cancer. Exacerbating the apprehension of women to seek health care and enroll in clinical trials will undoubtedly widen the gap.

While this overturning is seemingly based on religious, ethical, or legal arguments, we cannot ignore the fact that it precludes discussions between patients and their physicians, women and their health care providers.

The recent Supreme Court decision is distressing on a personal level, and it is about much more than abortion.

.....

Randall, Miller, and Sullivan are all practicing gynecologic oncologists in Richmond, VA.

Oncology and healthcare groups respond to the end of *Roe v. Wade*

In the wake of the Supreme Court decision on *Dobbs v. Jackson Women's Health Organization*, *The Cancer Letter* has compiled comments from U.S. cancer centers, advocacy groups, professional societies, and medical journals.

If you would like your institution's or group's statement included, please [contact us](#). This list will continue to be updated.

TABLE OF CONTENTS

- Professional groups
- Advocacy groups
- Medical journals
- U.S. cancer centers, health systems, and academic hospitals, *by state*
 - ▶ Alabama
 - ▶ Alaska
 - ▶ Arizona
 - ▶ Arkansas
 - ▶ California
 - ▶ Colorado
 - ▶ Connecticut
 - ▶ Delaware
 - ▶ District of Columbia
 - ▶ Florida

- ▶ Georgia
- ▶ Hawaii
- ▶ Idaho
- ▶ Illinois
- ▶ Indiana
- ▶ Iowa
- ▶ Kansas
- ▶ Kentucky
- ▶ Louisiana
- ▶ Maine
- ▶ Maryland
- ▶ Massachusetts
- ▶ Michigan
- ▶ Minnesota
- ▶ Mississippi
- ▶ Missouri
- ▶ Montana
- ▶ Nebraska
- ▶ Nevada
- ▶ New Hampshire
- ▶ New Jersey

- ▶ New Mexico
- ▶ New York
- ▶ North Carolina
- ▶ North Dakota
- ▶ Ohio
- ▶ Oklahoma
- ▶ Oregon
- ▶ Pennsylvania
- ▶ Rhode Island
- ▶ South Carolina
- ▶ South Dakota
- ▶ Tennessee
- ▶ Texas
- ▶ Utah
- ▶ Vermont
- ▶ Virginia
- ▶ Washington
- ▶ West Virginia
- ▶ Wisconsin
- ▶ Wyoming

Professional groups



American College of Obstetricians and Gynecologists

Policy on abortion, revised May 2022

All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care. As the leading medical organization dedicated to the health of individuals in need of gynecologic and obstetric care, the American College of Obstetricians and Gynecologists (ACOG) supports the availability of high-quality reproductive health services for all people and is committed to protecting and increasing access to abortion.

ACOG strongly opposes any effort that impedes access to abortion care and interferes in the relationship between a person and their healthcare professional. Because the patient-clinician relationship is a critical component of the provision of the highest quality healthcare, any efforts interfering in this relationship harm the people seeking essential healthcare and those providing it. As such, clinicians should not be subject to criminal penalties, lawsuits, fines or other punishments for providing the full spectrum of evidence-based care. ACOG condemns stigma, violence, intimidation and threats against doctors, clinicians, and members of their professional teams and families.

ACOG supports every person's right to decide whether to have children, the number and spacing of children, and to have the information, education, and access to health services to make these decisions. Individuals seeking abortion must be afforded privacy, dignity, respect, and support, and should be able to make their medical decisions without undue interference by outside parties. ACOG advocates to improve access to full-spectrum reproductive services, to integrate abortion as a component of mainstream medical care, and to oppose and overturn efforts restricting access to abortion.



American College of Radiology

The American College of Radiology (ACR) supports the privacy and integrity of the physician-patient relationship. Physicians have a responsibility to recommend appropriate care for all clinical circumstances based on the best available evidence and careful consultation with their patients. The relationship between physicians and their patients is sacred; it must not be jeopardized by non-medical outside interference, including federal, state and local government intrusions beyond public health measures. Instead, physicians, legislators, regulators and patients must work together to ensure access to safe, effective and equitable healthcare for all patients.



American College of Surgeons

The American College of Surgeons (ACS) has long opposed governmental interference in the clinical practice of medicine and in the privileged physician-patient relationship. The Supreme Court's decision in *Dobbs v. Jackson Women's Health* will allow states to eliminate access to reproductive services for women and will jeopardize the autonomy of this relationship. We are concerned that this decision will impact the availability of comprehensive and safe reproductive healthcare services.

Patients, along with their physicians, must be primarily in control of medical decisions unimpeded by government interference. All patients must be afforded the right to make individual, informed healthcare choices, including reproductive services.

Surgeons, and physicians of all specialties, must be free to practice medicine, informed by medical education, experience, and scientific evidence, without fear of the care being criminalized. Physicians must not be placed at risk of persecution or prosecution for providing patient-centered care.

Access to healthcare is essential for optimal quality and safety. The American College of Surgeons recognizes that the health of patients suffers when access to care is restricted. Moreover, when health care access is restricted, the impact is greater on those who are already underserved. Accordingly, the ACS urges the passage of legislation that

ensures full access to safe reproductive healthcare for all patients.

The American College of Surgeons will always advocate for the practice of evidence-based care, and oppose any interference by the government or any other entity in the patient-physician relationship.



American Medical Women's Association

AMWA Opposes Decision to Overturn *Roe v. Wade*

Prohibiting Access to Abortion Endangers Patients Lives and Prevents Physicians from Practicing Evidenced-Based Care

The American Medical Women's Association (AMWA) is gravely concerned about the far reaching impact of today's Supreme Court decision to overturn *Roe v. Wade* and the restriction of access to reproductive healthcare. This decision allows legislators to make healthcare decisions on behalf of patients.

Contrary to what was stated in the majority opinion, abortions performed by trained healthcare practitioners are safe and can be life-saving. Medication abortions, which are done early in pregnancy, can be performed safely in the clinic or at home. As history has shown illegal abortions can be dangerous and life-threatening.

AMWA supports access to the full spectrum of reproductive healthcare. Decisions about abortion —

just as with all medical decisions — should be made between patients and their physician or healthcare practitioner. The nuances and considerations involved in abortion care go far beyond what can be addressed through public discourse. Just as other complex healthcare decisions cannot and should not be decided by politicians or justices, neither should decisions about abortion.

This Supreme Court decision will have unintended consequences in other areas, such as in vitro fertilization, the care of frozen or unsuccessful embryos, treatment of ectopic pregnancy and miscarriage, cancer therapy, and other life saving measures. These factors impact the decision regarding abortion.

The American Medical Women's Association stands firm in the right of individuals to access comprehensive reproductive healthcare, which includes abortion.



Association of American Cancer Institutes

Last week's Supreme Court decision on *Dobbs v. Jackson* reversed the 1973 ruling on *Roe v. Wade*, allowing individual states to determine access to abortion.

The Association of American Cancer Institutes (AACI) advocates for state and federal policies that promote health equity for people with cancer.

Restricted access to abortion services disproportionately impacts communities of color, sexual and gender minorities, residents of rural communities, and other groups that experience cancer disparities.

As state leaders weigh the implications of the Supreme Court decision, we urge them to consider its ripple effects on access to quality cancer prevention, screening, and treatment services.

Screening and early detection

AACI opposes any restrictions on health facilities that also jeopardize access to life-saving, affordable cancer screenings and early detection tools, including mammograms and Pap tests.

Treatment

In some cases, cancer treatment requires access to abortion. For example, chemotherapy is not safe in the first trimester and some other cancer therapies are unsafe at any stage of pregnancy. The decision to terminate a pregnancy in order to pursue cancer treatment should rest with the patient and their treating physician. AACI supports timely access to effective treatment for all patients with cancer, regardless of pregnancy status.

Fertility preservation

Because many cancer treatments can affect fertility, young adults with cancer are often advised to freeze fertilized embryos before initiating treatment. AACI supports access to assisted reproductive technologies for patients whose cancer treatments may impact their fertility.

ASCO®

American Society of Clinical Oncology

An editorial by Julie Gralow, chief medical officer and executive vice president of ASCO, appears on [page 26](#).



National Academy of Sciences, National Academy of Medicine

For decades, the National Academy of Sciences and the National Academy of Medicine have advised the nation on many issues related to maternal and reproductive health, unintended pregnancy, prenatal care, racial and ethnic disparities in health care, and abortion. In light of the decision to overturn *Roe v. Wade*, the National Academies are committed to mobilizing the scientific, medical, and health care communities to identify actions that can mitigate the potential negative impacts of this decision and that can advance health equity.

The U.S. Supreme Court's ruling to overturn *Roe v. Wade* will likely make it even more difficult for women* to access high-quality health care in this country. The risks are especially acute for women of color, women from low-income backgrounds, and women living in rural areas.

The U.S. already has one of the [highest maternal mortality rates](#) of any developed country, especially for women of color, and state laws and regulations [limiting or impacting](#)

[abortion](#) create more barriers to obtaining safe and effective reproductive care. In addition, women with [unintended pregnancies](#) are less likely to receive needed prenatal care, can be at higher risk for medical complications, and are more likely to experience poor neonatal outcomes. In states that [ban or severely limit](#) access to abortion, geographic inequities are likely to worsen and widen the gap between women who can access safe abortion and those who cannot.

The nation must act urgently and redouble efforts to improve maternal and reproductive health and increase access to quality health care for all.

Marcia McNutt
President, National Academy of Sciences

Victor J. Dzau
President, National Academy of Medicine

*The term 'women' is used for the purposes of this statement; however, the National Academies recognize and understand that the term 'pregnant women' or 'woman' may not reflect how some pregnant individuals or others seeking reproductive health care may identify.



Oncology Nursing Society

On June 24, 2022, the Supreme Court of the United States issued its ruling on *Dobbs v. Jackson*, reversing the decision from the 1973 case, *Roe v. Wade*. Many nursing, medical, and health organizations issued statements in reaction, and

opinions among ONS stakeholders and constituents will differ on the decision. As it leads an organization that represents oncology nurses and advocates for patient-centered care, the ONS Board of Directors reviews social and political issues through the lens of the Society's mission. With that perspective, the ONS Board believes that two statements from other organizations are important for members to know.

First, the American Cancer Society (ACS) [issued a statement](#) regarding the potential impact on patients with cancer and their families outside of the legal aspects of the case. ACS's position is in alignment with the ONS mission, and the ONS Board endorses it. The statement identifies three specific concerns for consideration and possible action at the state level. Many ONS chapters are active in their communities and may want to discuss adding these to their advocacy efforts.

Second, the American Nurses Association (ANA) [issued a statement](#) expressing concerns about the ruling, including the potential that subsequent laws could jeopardize the patients-provider relationship, including those with nurses. In the statement, ANA also reminded nurses of their ethical obligations and the importance of showing empathy and respect to all.

Finally, for additional perspective on how the decision relates to ONS's mission, members should refer to the [diversity, equity, and inclusion \(DEI\) commitment statement](#) authored by the ONS, Oncology Nursing Foundation, and Oncology Certification Corporation Boards. Our corporations are committed to supporting all oncology nurses and ensuring an inclusive environment where all opinions and perspectives are shared and heard.



Society for Gynecologic Oncology

SGO commits to policy action and advocacy in defense of reproductive rights

May 4, 2022 - The Society of Gynecologic Oncology (SGO) denounces the draft U.S. Supreme Court opinion released by the media on Monday, May 2, that would potentially overrule the landmark *Roe v. Wade* decision, which has been the legal precedent in this country since 1973. Consistent with [SGO's mission](#) and [Principles for Health Care Reform](#), SGO opposes any ruling that restricts a person's access to health care and criminalizes the practice of medicine. This ruling ultimately poses a serious threat to the physician-patient relationship, and subsequent decision making necessary to ensure optimal outcomes for patients. As practitioners, we should be free to provide what is in the best interest of our patients. Given that this ruling could result in near-total bans on abortion in over 25 states, the SGO opposes this decision and, along with like-minded organizations such as the American College of Obstetricians and Gynecologists (ACOG), the Collaborative for Reproductive Equity (CORE) and others, commits to policy action and advocacy to ensure that every patient's medical treatment is managed by professional health care practitioners instead of elected officials and politically-appointed judges.

Advocacy groups



American Cancer Society

The American Cancer Society Highlights Impact of *Dobbs v. Jackson Ruling on Cancer Patients and Their Families*

June 24, 2022 - Today, the Supreme Court of the United States issued a long-awaited decision on *Dobbs v. Jackson*, which reverses the 1973 ruling on *Roe v. Wade* and returns the issue of the right to access abortion services to the states.

As a nonprofit entity whose mission is improving the lives of people with cancer and their families, the American Cancer Society isn't taking sides on the decision. However, the decision will impact cancer patients and their families and is likely to disproportionately affect communities of color.

We believe everyone, no matter where they live, should have a fair and just opportunity to prevent, find, treat, and survive cancer. Therefore, we ask states to address the following considerations:

Cancer treatment for pregnant patients

When someone receives a cancer diagnosis, it is critical they receive immediate care. Up to 1 in 1,000 pregnant women each year receive a cancer diagnosis. We know timely cancer treatment improves a person's chances of survivorship. As

some states signal a determination to define personhood at fertilization, we are concerned about potential threats to a pregnant woman's ability to receive rapid cancer treatment. Every patient should be able to increase their likelihood to survive cancer by having the option to start cancer therapy immediately, regardless of pregnancy status.

Fertility preservation

Cancer patients should also have the right to preserve fertility prior to initiating cancer treatment. More than 60,000 young adults aged 20-39 are diagnosed with cancer each year in the US. Treatments for many of the younger adults may directly impact their ability to conceive children. For this population, fertility preservation becomes an important medical consideration. Approximately 5%-6% of the population in childbearing age consists of cancer survivors. Experts recommend freezing fertilized embryos for fertility preservation. The American Cancer Society Cancer Action Network (ACS CAN) currently supports state policies to expand insurance coverage of fertility preservation services for cancer patients.

Screening and prevention

We also understand the vital importance of early screening and detection of cancer in improving a person's chances of surviving the disease. We oppose any action that results in limiting the number of institutions or clinics where people can receive access to affordable screening and early diagnosis.

We urge all states to consider the above ramifications for cancer patients. The American Cancer Society and ACS CAN will be actively

monitoring the implications of the Supreme Court's decision and will continue to advocate for timely access to affordable screening services, evidence-based treatment, and fertility preservation for all, regardless of geography.

An editorial by Karen Knudsen, CEO of the American Cancer Society, appears on [page 22](#).



Komen Foundation

Susan G. Komen works tirelessly to eliminate barriers to care. Advancing health equity and eliminating barriers to care is one of our strategic imperatives. We strive to empower cancer patients to know the facts and partner with us as a trusted resource so they can get access to high-quality care—and they never have to face cancer alone.

Everyone deserves the best possible care when you are dealing with breast cancer.

Any ruling or other actions that add another barrier to much-needed care could have devastating effects on cancer patients throughout the country.

Research indicates that timely cancer treatment improves a person's chances of survivorship. When someone receives a cancer diagnosis, it is critical they receive immediate care, regardless of pregnancy status.

Stupid Cancer

The following joint statement was issued today by Stupid Cancer's Board of Directors and co-signed by Bright Spot Network, Cactus Cancer Society, Cervivor, Elephants and Tea, Escape, Family Reach, Fuck Cancer, Imerman Angels, Living Beyond Breast Cancer, Teen Cancer America, True North Treks, and The Ulman Foundation.

Stupid Cancer and its Board of Directors is committed to the empowerment of people affected by adolescent and young adult (AYA) cancer. As patient advocacy organizations serving AYA patients, we join the medical community in fully renouncing any efforts to limit or remove access to safe abortion care. Abortion is a safe and essential healthcare right. Patients with cancer may face many difficult choices in their treatment journey. Patients who learn of a cancer diagnosis during pregnancy often must choose between continuing pregnancy (delaying essential life-saving treatments) and termination of pregnancy. Surgeries or medical treatment for cancer that could also result in loss of pregnancy would be considered abortion under certain state laws. This threatens the patient's ability to receive cancer care in a timely fashion. Additionally, the continued interference of state legislatures into individuals' personal healthcare decisions undermines the principles of the patient-physician relationship. These decisions are personal and should be made by patients in discussion with their medical team and not limited by legal consideration.

Changes occurring in state laws ([Texas SB8](#), [Oklahoma HB4327](#)) and the recent ruling of the Supreme Court of the United States regarding *Dobbs vs. Jackson Women's Health*

Organization raise grave concerns regarding access to abortion care in this country. Multiple leading medical organizations including American College of Obstetrics and Gynecology (ACOG), Society for Gynecologic Oncology (SGO), [American Society of Reproductive Medicine \(ASRM\)](#), [North American Society of Pediatric and Adolescent Gynecology \(NASPAG\)](#) and Society for Adolescent Health and Medicine (SAHM) have denounced the opinions of this ruling. Given trigger laws in effect in at least 25 states, swift and immediate loss of abortion access is expected. A joint statement from NASPAG/SAHM4 outlines how these changes would affect adolescent and young adult (AYA) patients in particular.

AYA patients undergoing cancer care often consider options for preserving their fertility prior to cancer therapies, including freezing embryos. Given the confusion and misconceptions that anti-abortion legislation has caused and more recent bans starting with fertilization, we also have grave concerns that these laws and those that follow will limit the ability of patients to access fertility preservation techniques and have control over reproductive decision making of their stored tissue in the future. Finally, given misconceptions about the mechanisms of actions of many of the most effective contraceptive methods (including emergency contraceptives), we have serious concerns about the potential for limitations on AYA patients' access to the best form of contraception for them.

We, the undersigned, are patient advocacy nonprofit organizations supporting AYA patients and their loved ones. We remain committed to advocating for the AYA community to have resources to navigate treatment and survivorship on their

own terms, inclusive of access to abortion care.

- Signed
- Stupid Cancer, Inc.
- Bright Spot Network
- Cactus Cancer Society
- Cervivor
- Elephants and Tea
- Escape
- Family Reach
- Fuck Cancer
- Imerman Angels
- Living Beyond Breast Cancer
- Teen Cancer America
- True North Treks
- The Ulman Foundation

The following list is broken down alphabetically by state, with *New York Times* [data](#) on the current status of abortion bans and gestational limits. This is accurate as of Friday, July 1.

States where no cancer center or health system could be reached for comment are included.

Alabama
(ban in effect)

Alaska
(legal)

Arizona
(ban blocked, gestational limit goes into effect in September)

Arkansas
(ban in effect)

California
(legal)

evidence-based health care services and to make decisions about their own care in consultation with their medical team. Despite this decision by the Court, we will continue to provide the full range of health care options possible in California, including reproductive health services, and to steadfastly advocate for the needs of our patients, students, staff, and the communities we serve. We will also continue to offer comprehensive education and training to the next generation of health care providers, and to conduct life-saving research to the fullest extent possible.

This is a sobering moment for many of us at the University of California and throughout the nation. Today, we stand with California leaders and health care advocates who are taking critical steps to protect Californians' human rights and their access to affordable and convenient health care choices.

Michael V. Drake, MD
President, University of California

Medical journals



New England Journal of Medicine

Editorial: "Lawmakers v. The Scientific Realities of Human Reproduction"

nature

Nature

Editorial: "The US Supreme Court abortion verdict is a tragedy. This is how research organizations can help"

U.S. cancer centers, health systems, and academic hospitals



University of California



For nearly 50 years, people in the United States have had the right to make private, informed choices about their health care and their futures. I am gravely concerned that today's U.S. Supreme Court decision removes that right and will endanger lives across the country. This decision overturns decades of legal precedent and could pave the way for other fundamental rights to be removed.

The Court's decision is antithetical to the University of California's mission and values. We strongly support allowing individuals to access

UC San Diego

UC San Diego Health

We are deeply troubled by the long-term ramifications for reproductive rights following the U.S. Supreme Court's opinion in *Dobbs v. Jackson Women's Health Organization*.

With this decision, the Court has overturned the 1973 *Roe v. Wade* and the 1992 *Planned Parenthood v. Casey* decisions that have protected a woman's right to reproductive healthcare for nearly 50 years. Many are rightfully troubled that this reversal may mean the Supreme

Court will review—and potentially overturn—cases relying on similar reasoning that led the federal government to recognize other civil rights.

Earlier today, President Michael V. Drake released a statement expressing the University of California's grave concern regarding the Court's ruling, which is antithetical to the University of California's mission and values. The University of California strongly supports allowing individuals to access necessary health care services and to make decisions about their own care in consultation with their medical team.

UC San Diego Health will continue to provide patients and students with access to comprehensive reproductive health services and will continue to partner with community organizations and Planned Parenthood for more complex cases.

UC San Diego is investigating the development of wrap-around services to alleviate difficulties created by the Supreme Court's ruling.

We are grateful that lawmakers in California have introduced a bill that would protect reproductive rights in our state and grateful that Gov. Gavin Newsom has indicated his complete support.

Support Resources for Students and Employees

News of this nature affects members of our community in different ways. Your Triton community is here for you and ready to help. Students seeking immediate mental health and coping support may reach out to Counseling and Psychological Services (CAPS) at (858) 534-3755.

Campus employees can contact the Faculty and Staff Assistance Pro-

gram at (858) 534-5523. UC San Diego Health employees can call (866) 808-6205, company code UCSDMC or review information pertaining to the Employee Assistance Program on Health HR's website.

Our country has made great strides over the past 50 years, yet as we are experiencing today, that progress is fragile and being threatened. We must all continue toward making a reality an envisioned future that is more just and equitable, protecting and advancing human and civil rights for all people.

Pradeep K. Khosla
Chancellor

Becky R. Petitt
Vice Chancellor for Equity, Diversity,
and Inclusion

Patricia S. Maysent
Chief Executive Officer for
UC San Diego Health

USC Norris Comprehensive Cancer Center

USC Norris Comprehensive Cancer Center
Keck Medicine of USC

The USC Norris Comprehensive Cancer Center supports the statement of the Association of American Cancer Institutes (AACI). Restricted access to abortion services may disproportionate impact vulnerable communities that experience health disparities, including cancer. We urge state leaders to consider carefully the effects of their decisions on access to quality cancer prevention, screening, and cancer care.

Colorado

(legal)

Connecticut

(legal)

Yale Cancer Center

Yale Cancer Center

Dear Colleagues:

For many of us, the recent Supreme Court decision threatening a woman's right to have control over her reproductive health is intensely disturbing. There are profound consequences of this ruling, and we have already seen reflex laws enacted in 11 states, which ban or severely restrict a woman's ability to terminate a pregnancy. The social inequities and health care disparities resulting from this decision are monumental: the impact will be far, far greater for poor women than those with financial resources, far greater for women lacking an education than those who are well-educated, and far greater for underserved minorities—largely Black and Latina women—than those who are white. And we are all struck and saddened by our intensely divided nation.

As a cancer physician, a cancer patient advocate, and a cancer researcher, I want to focus on the impact of the Supreme Court ruling on patients with cancer, their families, and their clinicians. Sadly, there are settings in cancer medicine where the politics of abortion rights directly collide with what may be best for our patients. First, it is estimated that approximately one in a thousand pregnancies is complicated by a diagnosis of can-

cer. This can be a new diagnosis of cancer or a recurrence of a previous diagnosis. In either case, pregnancy may complicate the optimal course of cancer therapy. For example, can we effectively treat a 24-year-old woman with a new diagnosis of acute myelogenous leukemia who is also 8 weeks pregnant? Moreover, being pregnant may simply be more than a woman can sustain emotionally or physically in the context of a cancer diagnosis, even if the appropriate therapy can be administered. Second, a pregnant woman may be confronted with a cancer diagnosis in her partner, child, parent, or another close relationship. The situations will vary, but it is possible that some women will want to choose whether to be pregnant while providing intensive support and care to a loved one. Finally, a woman with a history of cancer, albeit in good health, may decide that having a child is simply not the right choice for her. In each of these cases, there is an impact on the family as well as the patient. As health care professionals trying to take the best possible care of our patients, we are all denied the ability to counsel our patients and participate in shared decision-making about one of the most important areas of a woman's life.

There is little question in my mind that the Supreme Court decision and subsequent laws passed by individuals states will threaten our ability to provide the best care to pregnant women who are also touched by cancer. Tragically, the impact of the Supreme Court ruling will disproportionately affect those who are already faced with health care and cancer disparities. No matter what your own personal views are about abortion rights, I hope you will join with me in raising concern about the potentially harmful effects of *Roe v. Wade's* overturn

on patients and families who are affected by cancer. YCC/Smilow will be honored to provide cancer care to any woman who moves to Connecticut to exercise her reproductive rights and is in need of our services.

Kind regards,

*Eric P. Winer, MD
Alfred Gilman Professor of
Medicine and Pharmacology
Director, Yale Cancer Center
Physician-in-Chief, Smilow
Cancer Network
President, American Society
of Clinical Oncology*

Delaware
(legal)

District of Columbia
(legal)

Florida
(gestational limit goes
into effect July 1)

Georgia
(gestational limit expected soon)

Emory University



Dear Emory Community,

Today, the Supreme Court made a historic ruling that overturned *Roe v. Wade*, ending nearly 50 years of constitutional protection for women seeking abortions across the United States. The significance of this decision is being processed across the country and also within the Emory

community. I recognize and respect that there are a wide range of perspectives, but today, many people are shaken by the understanding that women may no longer have access to the reproductive care they need—count me among them.

The Supreme Court ruling will affect legislation in many states, including Georgia. As a university and as an employer, Emory is highly likely to face new limits on the reproductive health care coverage we can offer our students, faculty, and staff. We are working closely with partner organizations throughout the state to review and adapt to these changes. We are also collaborating with national associations to make sure health care students, residents, fellows, and providers can continue to train in—and practice—world-class obstetrics at Emory.

A university is a place where we can discuss and study the issues that so often divide us—abortion is no exception. Many of Emory's scholars have brought their expertise to what has, and will continue to be, a long-running debate.

The role of higher education is to create and share knowledge and, in this moment, we cannot look away from what the facts and data tell us. Peer-reviewed studies and research, including scholarship led and authored by Emory faculty, have shown, time and again, that limiting access to reproductive health care has a range of negative ramifications. The effects of restrictive abortion laws have the greatest impact on low-income women and women of color, who are often underserved by our nation's health care system.

Many women in America today have lived all, or most, of their lives with *Roe v. Wade* as the law of the

land. Now there will be less protection in place for women's rights, and it's hard to see this as anything but a painful regression.

I realize that many members of the Emory community will not appreciate this message because of strongly held beliefs that do not align with the sentiments I've shared above. I want you to know that I and the university unequivocally support your right to hold and express your views.

To everyone, please show consideration for your colleagues and fellow community members. I ask that we treat each other with compassion and understanding. We each have different experiences and perspectives at Emory, but we are united by the same mission—to serve humanity.

Sincerely,
Gregory L. Fenves
 President

Emory Healthcare



Dear faculty, staff, and students,

Earlier today the [U.S. Supreme Court issued a decision in *Dobbs v. Jackson Women's Health Organization*](#), which overturned *Roe v. Wade*. This ruling ends the constitutional right to abortions for women in the United States and grants states individual autonomy to set their own laws regarding abortion access and restrictions. We hope you read the [message President Fenves sent today](#) and we wanted to provide addi-

tional information as leaders in the health sciences.

We recognize and respect that there are strongly held beliefs within our community on both sides of this decision. This is a deeply emotional and personal issue, and we understand that people are responding from their own viewpoints and experiences. It is important that we treat each other with respect, no matter our differing points of view, and that we continue our mission to promote and improve health at a local and global level.

As leaders in educating future health care and public health professionals, researching reproductive health equity and delivering clinical care, our perspective on abortion and all aspects of reproductive health is based on data and science. The overwhelming evidence from research conducted here at Emory and elsewhere shows women's health improves when health services are safe and accessible. This same research shows that when access is limited, there are detrimental effects on women's health, most notably among underrepresented minorities and those from low-income homes who are historically underserved by our nation's health care system. At the same time, we also understand that for some, science does not define when life begins and that there are those for whom consideration of this timing rises above all others.

We remain steadfast in our commitment to support and train the public health, nursing, and medical workforce who conduct research, deliver clinical care, and promote the health and wellbeing of individuals and communities at home and throughout the world. We are similarly unified in supporting health

care delivery systems that increase health equity and access to care and decrease health inequities. This includes providing academic offerings, clinical services, and research programs facilitated by our schools as it relates to women's health.

The legal and medical landscape at this time is uncertain. We are assessing the impact this decision will have on our programs, students, faculty, staff, and patients and will keep you updated on how the unfolding situation will affect us.

We recognize this news may be distressing to some and welcomed by others—creating a challenging environment for our community. Below is a list of Emory-provided mental health and wellness services that are available. Please continue to treat yourselves and each other with kindness, respect and grace.

Sincerely,

James W. Curran, MD, MPH
James W. Curran Dean
of Public Health

M. Daniele Fallin, PhD
Incoming James W. Curran
Dean of Public Health

Linda A. McCauley, PhD, RN, FAAN
Dean and Professor
Nell Hodgson Woodruff
School of Nursing

Vikas P. Sukhatme, MD, ScD
Dean and Woodruff Professor
Emory School of Medicine

Jonathan S. Lewin, MD, FACR
Executive Vice President for Health
Affairs, Emory University
Executive Director, Woodruff
Health Sciences Center
CEO and Chairman of the
Board, Emory Healthcare

Hawaii
(legal)

Idaho
(ban expected soon)

Illinois
(legal)

Northwestern Medicine



All patients have a fundamental right to comprehensive health care. And, at Northwestern Medicine, we believe these decisions should be made by patients in collaboration with their physicians. We will continue to offer access to all reproductive health care in compliance with state and federal law.

UChicago Medicine



As an academic health system based in Illinois, where abortion remains legal, and the only hospital-based abortion provider on Chicago's South Side, the University of Chicago Medicine plays an essential role for the community and for patients needing high-quality care.

Our organization has a lengthy record of providing high-quality, evidence-based reproductive healthcare and a strong reputation of training the brightest future physicians to offer these clinical

services to patients. This involves a broad range of medical care, including abortion, contraception/family planning, fertility treatment, care for general and high-risk pregnancies, and miscarriage management. These are common services that are integral to obstetrical and gynecological medicine and a vital part of comprehensive medical education for physicians in training.

Our health system remains committed to providing the full spectrum of safe reproductive healthcare and is preparing for how we can best serve patients who travel to Illinois to seek our care and services.

Indiana
(uncertain)

Iowa
(uncertain)

UI Health Care



As of today, Iowa law has not changed: medications and procedures that prevent and terminate pregnancy remain legal and accessible, as well as in vitro fertilization (IVF).

If you have reproductive health questions, talk to your doctor to learn about your options and available resources. You can schedule an appointment with our [OB-GYN clinic](#) at 319-356-2294.

Kansas
(uncertain, ballot initiative in August)

Kentucky
(ban in effect)

UK Healthcare



Following today's Supreme Court decision, the University of Kentucky, including UK HealthCare, is reviewing and analyzing all aspects of the decision to determine any implications in our current practices and procedures. However, state law already had prohibited the University of Kentucky from performing abortions except where the mother's life is at risk.

Louisiana
(ban blocked)

Maine
(legal)

Maryland
(legal)

Johns Hopkins Medicine



Dear Johns Hopkins Community,

As you have seen, the U.S. Supreme Court released its long-anticipated decision in the case of *Dobbs v. Jackson Women's Health Organization*, which signals a profound shift in

laws governing access to abortion, with significant and variable ramifications in states across the nation. As a major employer in Maryland with a presence in the National Capital Region and in Florida, and as a leading provider of clinical care, including health and well-being services to our students, we take seriously our obligation to the many populations we serve. We have been monitoring closely the outcome of this decision and its implications for the provision of reproductive health care.

To the fullest extent allowed under the law, our institutions will continue to be guided by the evidence-based best practices established by medical and public health faculty experts and practitioners, which make clear that access to safe, legal abortion is critical for the health of individuals, families, and communities. We will continue to keep all of you informed in the coming days of any further impacts of this change in the legal landscape, but at this time we can offer the following guidance on the implications of the court's decision on Hopkins employees, students, and patients:

- We will continue to offer the same full range of services and support that we do today in accordance with legal requirements for our patients, including for all students who receive health care through university-based health services.
- We are currently reviewing the decision and its impacts on other areas in which we operate. You will hear more from your divisions and our HR Benefits teams regarding any potential changes to benefits for employees who may be in states where access to services is curtailed.

We recognize that members of our community will experience this decision and its impacts in profoundly different ways. As always, we care deeply about the well-being and health of all members of our community. If you require further guidance or have more questions about the decision and its affect on your work, our HR colleagues are standing by at the health system's HR Solution Center (443-997-5400 or hrsc@jhmi.edu) and at JHU Benefits Services (410-516-2000 or benefits@jhu.edu). We also urge any staff and faculty members who would benefit from mental health support to seek the care they need through JHU mySupport and JHM Resources. Students should refer to this list of current services provided by the Office of Student Health and Well-Being, including mental health services.

Sincerely,

Inez Stewart
Senior Vice President and Chief
Human Resources Officer
Johns Hopkins Medicine

Pierre Joanis
Vice President, Human Resources
Johns Hopkins University

Kevin Shollenberger
Vice Provost, Student
Health and Well-Being
Johns Hopkins University

Massachusetts (legal)

Dana-Farber Cancer Institute



I stand alongside many of you who are feeling grave trepidation at the U.S. Supreme Court decision to overturn *Roe v. Wade*. The dissolution of this 1973 landmark decision means that millions of people across America have been denied the right to private, accessible, and safe reproductive health care services as abortion rights will now be determined at the state level.

As a country, we now stand in the face of a perilous public health and human service crisis, and an issue of social and economic justice with momentous and far-reaching implications that will affect each of us differently, but undoubtedly affect us all.

For many of us or our loved ones, autonomy over our bodies, empowerment over reproductive health care, and the privacy associated with both are now vulnerable in new and foreign ways. The added barriers to services create an unnecessary emotional toll to the already difficult circumstances of those in our care. This is especially poignant for historically marginalized groups who already face a myriad of unfair and unnecessary barriers that limit their access to care.

We remain fully committed to being an inclusive organization and a leader in eliminating health disparities in our communities. We are working closely with our elected officials and others to determine how we can use our voice as an advocate for each other, our patients, and our mission—protecting access to critical health care and reducing the barriers to care for all.

Laurie H. Glimcher, MD
President and CEO Dana-Farber Cancer Institute

Michigan
(uncertain)

Minnesota
(legal)

Masonic Cancer Center



The Masonic Cancer Center and the University of Minnesota support comprehensive health care for women and access to high-quality care for all. As a medical oncologist, I know that women facing a new diagnosis of cancer while pregnant have critical, life-altering decisions that need to be made.

Having a full choice of options, including pregnancy termination, must be maintained if we are to provide the highest standard of cancer care available. I am fortunate to practice in a state where our governor is fully committed to defending abortion rights.

*Douglas Yee, MD
Director, Masonic Cancer Center,
University of Minnesota*

Mississippi
(ban goes into effect July 7)

Missouri
(ban in effect)

Siteman Cancer Center



Siteman Cancer Center aligns with BJC HealthCare and Washington University Physicians in our commitment to providing safe and medically appropriate care for our pregnant patients in accordance with federal and state law. As we navigate new legal bounds, we fully support our physicians, nurses and medical staff responsible for these complex decisions.

Montana
(uncertain)

Nebraska
(uncertain)

Nevada
(legal)

New Hampshire
(legal)

Dartmouth Health



Dartmouth Health is unwavering in its belief in the sanctity of the patient-provider relationship to make the best-informed decisions for patients to reflect their needs and healthcare priorities.

We also strongly believe that abortion is an essential component of healthcare. Like all medical matters, decisions regarding abortion should be made by patients in consultation with their healthcare providers. Abortion remains legal and accessible in New Hampshire and Vermont, and Dartmouth Health will continue to provide this care as part of our commitment to our patients.

New Jersey
(legal)

New Mexico
(legal)

University of New Mexico Health



UNM Health remains committed to providing accessible, high-quality, safe and comprehensive care to its patients. This includes reproductive health care services. We will continue to monitor volumes and capacity in this regard and work with other local organizations to meet the need.

We are dedicated to continuing to provide reproductive health care services to all those who need it in New Mexico. We are also committed to teaching tomorrow's doctors, advancing medicine and fulfilling the mission of the University.

New York
(legal)



Dear Columbia Nursing community,

I write in the wake of the Supreme Court's overturning of the federal right to seek an abortion—guaranteed nearly 50 years ago by the 1973 *Roe v. Wade* decision but reversed by their recent ruling in the case of *Dobbs v. Jackson Women's Health Organization*.

In light of Friday's ruling, I want to reaffirm our school's and our profession's commitment to advancing health equity and social justice for our patients, our communities, and vulnerable populations everywhere. As clinicians invested in the mental and physical health of our patients—and also as researchers, policy-makers, and educators—we must not be deterred from this mission.

Friday's ruling runs contrary to years of progress in reproductive health and of respect for personal choice. It is a grave and costly reminder that we, as nurses, must remain steadfast in our dedication to advocating for our patients and to defending the basic human right of access to safe and affordable health care for all people. As nurses, there is no other way for us to move forward.

In fact, "abortion is health care" is the unequivocal phrase invoked by a number of organizations, including the World Health Organization and the American College of Obstetricians and Gynecologists. Longitudinal research has shown that women who wish to have an abortion but are denied one fare less well on nearly all measures—physical health, short-term mental health, employment status, life aspirations, and ability to care for their other children—than women who seek an abortion and are able to have one.

We will, I am sure, learn more about the impact of this ruling in the coming days and weeks. In the meantime, I want to highlight the words of wisdom issued by Dean Katrina Armstrong in CUIMC's statement on the ruling: "As an institution we bear a special responsibility for leadership in this moment; our values of patient autonomy, privacy, and equal access to medical care

will continue to guide us through this challenging period."

Like Dean Armstrong, I am thankful to be your dean and part of this exceptional community at this critical juncture in our nation's history. Let us all recommit to continuing our work providing each and every patient with the health care that they choose.

Dean Frazier

*Lorraine Frazier, RN, PhD, FAAN
Dean and Mary O'Neil
Mundinger Professor,
Senior Vice President, Columbia
University Irving Medical Center*

Northwell Health



Northwell Health is disappointed by the US Supreme Court's ruling that overturned *Roe v. Wade*, which made access to safe and legal abortion a constitutional right for five decades.

This decision is a setback for women's reproductive health. Our concern as the region's largest health care provider is that this ruling will succeed in ending access to safe abortions and disproportionately cause harm to those who already have limited access to health care.

In New York State, we already have laws that establish a woman's right to an abortion. Governor Hochul recently signed a series of bills that preserve this right and, importantly, offer protections for health care providers in the state who perform

this procedure legally. But we will vigorously monitor any developments related to this very important issue in the coming months and we will continue to advocate in the name of raising women's health.

North Carolina

(uncertain)

Duke Health



Duke Health is committed to providing a full range of the highest quality family planning services, including abortion, in full compliance with current state laws. This care is designed for the complex and highly sensitive health and emotional needs of people who are making childbearing decisions. Safe and reliable access to these services is a critical part of women's health, and it is also a vital component of our educational mission to train physicians to deliver comprehensive care. We value the ability to deliver these critical services safely and compassionately, and we will assess changes if required by law.

North Dakota

(ban expected soon)

See [South Dakota](#).

Ohio

(gestational limit in effect)

Cleveland Clinic



Our strongly held conviction is that women's healthcare decisions are best made between a patient and their healthcare provider—a relationship based on privacy and trust. It is a privilege for us to serve patients with such an intimate understanding of their lives.

We are deeply concerned about the consequences that restrictive abortion laws will have on women and families.

The United States already has among the poorest infant and maternal mortality rates in the developed world. Minority and low-income women in particular will be disproportionately affected by restrictions to reproductive healthcare, which were swiftly put into effect in Ohio.

We remain committed to the health and well-being of our communities and will continue to support women and reproductive health while also following the law.

In support of our patients and communities, our leaders are working on recommendations for improving access and removing barriers to contraception, guiding patients on interstate travel and developing partnerships with other health systems and organizations.

In support of our caregivers, we are reviewing how benefits under the Employee Health Plan may be expanded to cover out-of-state reproductive health services for all members.

This is continuing to evolve as we come to better understand the new law.

Ohio State University



THE OHIO STATE
UNIVERSITY

The Ohio State University is closely examining the decision from the Supreme Court and changes in state law. If necessary, the medical center and College of Medicine will make adjustments to be in compliance with the law.

Oklahoma (ban in effect)

Oklahoma University Health



As an academic health system, OU Health provides comprehensive care for women and children of all ages and stages of life. The healthcare we provide complies with state and federal laws along with healthcare regulatory and compliance. OU Health will continue to monitor state and federal legislation and legal changes and ensure full alignment as new laws are enacted.

Oregon (legal)

Pennsylvania (uncertain)

University of Pennsylvania



Today, Friday, June 24, the United States Supreme Court revoked *Roe v. Wade*, which for nearly 50 years has protected the right to safe abortions and reproductive care. This ruling leaves the decision of abortion access to individual states and is a threat to health care access, basic human rights, and health equity.

As Centers dedicated to public health, we understand and acknowledge the radical policy implications of this announcement, and the fear and anxiety generated as a result. Together, we join the Penn Community and those across our nation to defend access to safe health care for all, including people who are marginalized because of gender, race, ethnicity, sexual and gender identity, and economic status. Restricting access to safe abortions will lead to increased maternal mortality, childhood poverty, and poor mental health outcomes, and will undoubtedly exacerbate racial inequities.

Providing inclusive public health services for all in our community means providing access to safe and legal reproductive care, including abortions. The World Health Organization recognizes abortion care as an essential healthcare service. Continuing to reinforce comprehensive abortion care is lifesaving, affirming, and critical to the nation's public health. In light of this

decision, the Penn public health community will continue to educate and promote access to comprehensive and safe reproductive care.

Visit the [The Center for Public Health Initiatives and Wellness at Penn](#) for more information.

Rhode Island

(legal)

South Carolina

(gestational limit in effect)

South Dakota

(ban in effect)

Sanford Health



Sanford Health is committed to meeting the maternal health care needs of the communities we serve. While as a matter of policy we do not offer elective abortions, we are carefully evaluating any potential impact of the Supreme Court decision on the ability of our providers to deliver medically necessary care to our patients. Our focus remains on ensuring our providers, alongside our patients and their families, can continue to make the best clinical decisions for the health and safety of those we serve.

Editor's note: Sanford Health is headquartered in South Dakota but also serves patients in North Dakota, Minnesota, and some of Iowa.

Tennessee

(ban expected soon)

Vanderbilt University Medical Center



For over a century Vanderbilt University Medical Center (VUMC) has been committed to providing comprehensive, evidence-based, and personalized care to patients throughout our region, and increasingly to the entire nation. We will continue to do so to the best of our ability while remaining in full compliance with federal and state law.

The U.S. Supreme Court decision (*Dobbs v. Jackson Women's Health Organization*) has substantial negative health implications for our region's women and their families. The rate of maternal and perinatal morbidity and mortality in Tennessee is among the highest in the country. Women of color and who are socioeconomically disadvantaged are at the greatest risk. Laws that have already been passed in Tennessee, but not implemented due to *Roe v. Wade*, will now take effect, and will likely exacerbate these health care disparities.

VUMC will soon begin instituting policy changes intended to mitigate some of the [health care and health equity concerns](#) that are anticipated due to changes in the law. Our goal is to support our clinicians to provide comprehensive reproductive health care to women in need, including facilitating appropriate care for our patients who are pregnant, consistent with federal and state law.

VUMC will continue to monitor future legislative efforts and strong-

“

Restricting access to safe abortions will lead to increased maternal mortality, childhood poverty, and poor mental health outcomes, and will undoubtedly exacerbate racial inequities. Providing inclusive public health services for all in our community means providing access to safe and legal reproductive care, including abortions.

”

– University of Pennsylvania

ly advocate for legislative solutions that evidence has shown are in the best interest of women's health.

Texas

(ban expected soon)

Utah

(ban blocked)

Huntsman Cancer Institute



Dear colleagues,

The U.S. Supreme Court's decision to overturn *Roe v. Wade* has had a deep impact on our community. This is a rapidly changing situation across the country, with varied responses in different states. Here in Utah, we are in the midst of a collection of complex legal, legislative, and community-driven actions, and I think it is safe to say that we don't know exactly where this will ultimately land in our state.

What is certain is that Huntsman Cancer Institute remains committed to our core value of "patient and community first", and we will do everything we can to ensure our patients continue to have access to the care that they need. We will utilize our voice to advocate for our patients and the critical decisions they face when navigating a cancer diagnosis and a pregnancy. And we will work to advance access to compassionate, state-of-the-art care, without regard to socioeco-

omic status, geographic location, or other factors.

I want to acknowledge the obvious: there are extremely strong feelings on these issues. Regardless of our individual views about abortion, I hope we will come together to focus on compassion, the recognition that our patients have unique circumstances and challenges, and our Huntsman Cancer Institute commitment to advance health and well-being for all. I am committed to advocate for and support our patients as they make some of the most difficult decisions in their lives along with their care providers.

Our partners on campus, including the Department of Obstetrics and Gynecology, and its Division of Maternal and Fetal Medicine, among others, are actively convening discussions on the implications of these decisions and how to ensure our patients can continue to receive safe and effective medical care for the myriad health conditions that arise alongside or as a result of pregnancy. We are engaging our colleagues for their guidance on how we can best support and advocate for maternal medical care in light of the Supreme Court ruling.

This is a dynamic and challenging situation and we are grateful for the engagement of our community in navigating the many ways this decision will impact our patients, our community, and our colleagues in medicine, research, and training. Thank you for your understanding that we don't have all the answers at this time due to the rapidly changing environment. But know that no matter what the environment brings to us, we will be steadfast in our commitment to advance health for all.

Sincerely,

*Mary C. Beckerle, PhD
Jon M. Huntsman Presidential
Endowed Chair
CEO, Huntsman Cancer Institute
Associate Vice President for Cancer
Affairs, University of Utah*

Vermont

(legal)

University of Vermont Health Network



As a health care safety net provider for more than 1 million people, including critical services that our patients cannot receive elsewhere in our region, the UVM Health Network supports preserving access to the full range of reproductive health care. Our policies and our practices regarding abortion services focus on the importance of the patient-provider relationship, and the right of patients to make their own health care decisions. Today's ruling by the U.S. Supreme Court in *Dobbs v. Jackson Women's Health Organization* infringes on that long-established right, and will undermine access to important health care services across the nation. We will continue to stand up for reproductive health care rights and equitable access to that care.

*John R. Brumsted, MD
President and CEO, The
UVM Health Network*

UVM Larner College of Medicine



The University of Vermont
LARNER COLLEGE OF MEDICINE

The Larner College of Medicine affirms its commitment to educating all of our students and trainees regarding the ethical and practical considerations of early considerations of early pregnancy care including issues of contraception, conception (both spontaneous and assisted), as well as informed decisions around management of ongoing pregnancies.

Situations in which the physician-patient relationship is not given primacy will inherently create risk for patients and increase inequity in health care delivery across our society, at a time when our focus should be on eliminating the barriers that exist and expanding the delivery of quality care to all.

*Richard L. Page, MD
Dean, UVM Larner College of Medicine*

*Jan K. Carney, MD, MPH
Associate dean for public health and health policy,
Senior advisor to the dean*

*Brian Cote, MBA
Senior associate dean for finance and administration*

*Gordon L. Jensen, MD, PhD
Senior associate dean for Research*

*Jason Sanders, MD, MBA
Senior associate dean for clinical affairs,
President & chief executive officer, The University of Vermont Health Network Medical Group;
Executive vice president for*

clinical affairs, The University of Vermont Health Network

*Margaret Tandoh, MD
Associate dean for diversity, equity and inclusion*

*Christa H. Zehle, MD
Senior associate dean for medical education*

Virginia (uncertain)

University of Virginia



To the University Community:

Earlier today, the Supreme Court of the United States issued an opinion in the case of *Dobbs v. Jackson Women's Health* overturning the constitutional right to an abortion originally established in *Roe v. Wade* in 1973. Regardless of how one feels about this opinion, it represents a fundamental shift in constitutional law that will affect the lives of people within this community and across the nation in real and lasting ways, and we are writing to share some information about its expected impact on our community.

Because there is currently no federal statute guaranteeing or prohibiting abortion services, this opinion means that individual states can determine whether, and under what conditions, a woman can legally access an abortion. In some states, this decision will have near-immediate effects due to laws already

on the books banning or restricting abortions in the event *Roe v. Wade* is overturned.

Under existing laws in Virginia, and in many other states around the nation, there will be no immediate change. That means at UVA and UVA Health there will be no changes to current services.

As mentioned above, the court's decision in this matter is a major change in our country's stance on one of the most contentious issues in public life—and one of the most personal. While people are obviously free to voice their opinions about this ruling based on their beliefs and experiences, we urge members of our community to do so with empathy and understanding for all.

For those seeking additional information about this ruling, UVA Today and UVA Law have developed a [helpful resource](#) about this ruling and what it means for abortion rights in Virginia and around the nation.

Finally, the University is committed to providing a safe and healthy environment for its employees, students, and patients. For those in need of support, the University offers many resources including [Counseling and Psychological Services for Students](#) and the [Faculty and Employee Assistance Program](#).

Thank you,

*James E. Ryan
President*

*Ian Baucom
Executive Vice President and Provost*

*Jennifer (J.J.) Wagner Davis
Executive Vice President and
Chief Operating Officer*

K. Craig Kent
Chief Executive Officer, UVA
Health and Executive Vice
President for Health Affairs

Washington

(legal)

Fred Hutchinson Cancer Center



Based on today's ruling, it's anticipated that 26 states are certain or likely to move quickly to ban abortion, with 13 of those states having trigger laws that could bring immediate change and consequences for our patients, our employees and our communities.

As we process the implication of this ruling, it's important to acknowledge that patients with cancer and other serious illnesses often face incredibly difficult decisions related to reproductive health and their long-term well-being. These choices are deeply personal, and they vary, depending on factors such as a patient's diagnosis, the available treatment options, the urgency of treatment and known treatment side effects.

We share the view of the American Medical Association and dozens of other professional medical organizations that individual health care decisions should be made privately by the patient after fully-informed consultation with their physician.

West Virginia

(ban to be in effect soon)

Wisconsin

(ban in effect)

UW Health

UWHealth

The U.S. Supreme Court decision in the *Dobbs vs. Jackson Women's Health Organization* case will have profound impacts. The loss of access to abortion and critical reproductive healthcare will be felt everywhere in Wisconsin, particularly by underserved rural areas or marginalized populations that are disproportionately affected by barriers to safe and effective reproductive healthcare.

As we enter a time of rapid change and uncertainty, UW Health will put the needs of our patients first and foremost to ensure they receive not just the best care, but the best medical advice related to their care options. We will support our thousands of providers and staff, many of whom never expected to face a challenge like this in their careers and are deeply affected by the news.

While reverting to a 173-year-old state law on abortion will create some legal uncertainties, we recognize that this court decision has effectively banned abortions in Wisconsin except to save the life of the mother, and UW Health will continue to comply with the laws related to reproductive healthcare.

“

The loss of access to abortion and critical reproductive healthcare will be felt everywhere in Wisconsin, particularly by underserved rural areas or marginalized populations that are disproportionately affected by barriers to safe and effective reproductive healthcare.

”

– UW Health

Wyoming

(ban in effect)

IN BRIEF



Selwyn M. Vickers named MSK president and CEO



Selwyn M. Vickers was named president and chief executive officer of Memorial Sloan Kettering Cancer Center.

Vickers will succeed Craig B. Thompson, who announced his intention to step down earlier this year (*The Cancer Letter*, Feb. 11, 2022). The transition will occur in September 2022.

Vickers will join MSK from the University of Alabama at Birmingham, where he

serves as senior vice president for medicine and dean of the Heersink School of Medicine. He is also the chief executive officer of both the UAB Health System and the UAB/Ascension St. Vincent's Alliance.

“Dr. Vickers is an extraordinary surgeon-scientist with a proven track record of success in leading complex academic medical centers, building innovative academic and research programs, and strengthening clinical care. Throughout his career, he has demonstrated a passion for unlocking treatments and cures for cancer,” Scott M. Stuart, chair of the MSKCC boards of trustees and governing trustees, said in a statement. “Dr. Vickers is a charismatic and compassionate leader who is uniquely qualified to shepherd this great organization into the future.”

Prior to becoming the dean of Heersink School of Medicine, Vickers served on the faculty of the University of Minnesota Medical School, where for seven years he was the Jay Phillips Professor and chair of the Department of Surgery. He spent 13 years as a surgeon and educator at UAB, including six years as John Blue Chair of the Division of Gastrointestinal Surgery.

Vickers continues to see patients and conduct clinical and health disparities research. He is a board-certified surgeon and the past president of the American Surgical Association. Vickers is a member of the National Academy of Medicine and the Johns Hopkins Society of Scholars. He previously served on the Johns Hopkins board of trustees.

Alicia M. Terando named San Gabriel Valley regional medical director for surgical oncology at Cedars-Sinai



Alicia M. Terando was named the San Gabriel Valley regional medical director for surgical oncology at Cedars-Sinai Cancer at the Huntington Cancer Center.

Terando served at the Ohio State University's Division of Surgical Oncology for eight years. She joined the USC Keck School of Medicine in 2018 as an associate professor of clinical surgery, chief of the Division of Breast, Endocrine, and Soft Tissue Surgery, and program director of the USC Breast Surgical Oncology Fellowship.

As regional medical director, Terando will be responsible for providing clinical oversight and evaluation. She will also serve as a breast oncology surgeon, taking part in clinical and programmatic activities at Cedars-Sinai Cancer at Huntington Memorial Medical Center.

Terando is a fellow of the American College of Surgeons, a fellow of the Society of Surgical Oncology, and a member of the American Society of Breast Surgeons.

Colleen Lewis named vice president of nursing and research at Florida Cancer Specialists and Research Institute



Colleen Lewis was named vice president of nursing and research at Florida Cancer Specialists and Research Institute, LLC.

Lewis will oversee the direction of nursing practice activities as well as the clinical research and care management departments. Lewis is joining FCS from Emory Healthcare, where she served as director of clinical operations and interim director of the Ambulatory infusion Center.

Justin F. Klamerus named EVP, chief medical officer at McLaren Health Care



Justin F. Klamerus was named executive vice president and chief medical officer at McLaren Health Care.

He will assume the position previously held by Michael McKenna, McLaren Health Care's first CMO, who died in May 2022.

Klamerus has served as president of Karmanos Cancer Hospital and Network, a subsidiary of McLaren Health Care, since January 2017.

Klamerus' history with McLaren began in 2009. He served as the program director of cancer services at McLaren Northern Michigan in Petoskey, MI, before becoming president of the McLaren Cancer Institute. In 2014, when McLaren acquired the Karmanos Cancer Institute, he assumed the role of executive vice president and chief quality officer at Karmanos. He was then named president of the organization.

While at Karmanos, Klamerus oversaw the expansion of the Karmanos Cancer Network and led business and clinical partnerships with community physicians, academic faculty, and graduate medical education partners.

In 2020, Klamerus was appointed to the Public Health Advisory Commission by Michigan Governor Gretchen Whitmer.

Jeffrey M. Rosen to receive 2022 William L. McGuire Memorial Lecture Award

Jeffrey M. Rosen will receive the William L. McGuire Memorial Lecture Award at the 2022 San Antonio Breast Cancer Symposium, to be held Dec. 6-10, 2022.

Rosen will present a lecture titled "Leveraging Preclinical Models for Translational Breast Cancer Research" during the symposium.

The William L. McGuire Memorial Lecture Award was established in 1992 to commemorate McGuire's contributions to breast oncology. McGuire, along with Charles A. Coltman, founded SABCS in 1977.



Rosen is a distinguished service professor of molecular and cellular biology and the co-leader of the breast cancer program at the Dan L Duncan Comprehensive Cancer Center of Baylor College of Medicine.

Rosen is being recognized for his contributions to preclinical and translational breast cancer research, and for his commitment to transdisciplinary collaboration and mentoring of early-career scientists.

Throughout his 53-year career, Rosen has focused on understanding hormonal regulation of mammary gland development, tumorigenesis, and milk production; developing widely used animal models to study normal development and tumorigenesis of the breast; elucidating the mechanisms underlying self-renewal and differentiation of mammary stem cells and cancer stem cells; clarifying the roles of epithelial-to-mesenchymal transition in breast cancer metastasis and therapeutic resistance; and characterizing the tumor immune microenvironment associated with different subtypes of breast tumors.

Rosen joined the faculty at Baylor College of Medicine in 1973 and was a

founding member of the Department of Cell Biology. While on sabbatical in the laboratory of George Stark, Rosen was involved in the early studies that elucidated the mechanisms of interferon action, which helped lead to the discovery of the JAK/STAT pathway. In addition, Rosen has mentored more than 100 graduate students, postdoctoral fellows, and junior faculty members.

Rosen was elected a Fellow of the American Academy of Arts and Sciences in 2015. He received the American Association for Cancer Research Distinguished Lectureship in Breast Cancer Research in 2017, the Susan G. Komen Brinker Basic Science Award in 2010, the Michael E. DeBakey, MD, Excellence in Research Award in 2004, and the Barbara & Corbin J. Robertson Jr. Presidential Award for Excellence in Education in 2002, among others.

ASTRO announces 2022 Fellows

The American Society for Radiation Oncology selected 27 members to receive the ASTRO Fellow designation. The 2022 class will be recognized at an awards ceremony in San Antonio Oct. 25, during ASTRO's 64th annual meeting.

Since its inception in 2006, the FASTRO designation has been awarded to 421 of ASTRO's 10,000 members worldwide.

The 2022 Fellows are:

- Mark K. Buyyounouski, Stanford University
- Daniel T. Chang, Stanford University
- Bhashamjit S. Chera, Medical University of South Carolina
- Deborah E. Citrin, National Cancer Institute

- Thomas Dilling, Moffitt Cancer Center
- Suzanne Evans, Yale University
- Steven J. Frank, The University of Texas MD Anderson Cancer Center
- Alan C. Hartford, Geisel School of Medicine, Dartmouth Health
- Karen Hoffman, The University of Texas MD Anderson Cancer Center
- Randall J. Kimple, University of Wisconsin-Madison
- Bridget F. Koontz, GenesisCare US
- Alexander Lin, University of Pennsylvania
- Douglas Martin, The Ohio State University Wexner Medical Center
- Charles Mayo, University of Michigan
- Michael T. Milano, University of Rochester
- Eduardo Moros, Moffitt Cancer Center
- Firas Mourtada, Sidney Kimmel Medical College at Thomas Jefferson University
- Paul Nguyen, Dana-Farber Cancer Institute
- Peter Orio, Dana-Farber Brigham Cancer Center
- William F. Regine, University of Maryland School of Medicine
- Peter J. Rossi, Calaway Young Cancer Center at Valley View Hospital
- Scott Soltys, Stanford University
- Roy Tishler, Dana-Farber Cancer Institute

- Minh-Tam Truong, Boston University School of Medicine
- Richard Tsang, Princess Margaret Cancer Centre
- Jonathan Tward, Huntsman Cancer Institute at the University of Utah
- Fen Xia, University of Arkansas for Medical Sciences

ACCC supports CMS Enhancing Oncology Model but says it may disadvantage small practices

The Association of Community Cancer Centers released the following statement in response to a new payment model proposed by the Centers for Medicare and Medicaid Services.

The Association of Community Cancer Centers is pleased that the Centers for Medicare and Medicaid Services has announced a new, voluntary alternative payment model as a successor to the Oncology Care Model, which is due to sunset later this month.

We are hopeful that the Enhancing Oncology Model will allow ACCC programs and practices to progress in their value-based care transformation journeys and continue to deliver high-quality, equitable, and affordable cancer care to the communities they serve.

ACCC appreciates that CMS has made participation in EOM voluntary, and that the agency has taken feedback from ACCC and its members participating in OCM to make improvements to the price prediction models and attribution methodology for this new model.

We also applaud the model's focus on improving health equity by requiring participants to implement new redesign activities, such as screening patients for social needs and developing health equity plans to mitigate disparities within their own patient populations.

These initiatives align well with the administration's efforts to address inequities as part of President Biden's renewed Cancer Moonshot, and the model provides a fresh opportunity to reach additional patients in underserved and under-resourced communities.

At the same time, we are concerned with some of the structural elements of the program. For example, the requirement for participants to accept downside risk from the start of the model will be a significant barrier to enrollment given the current reimbursement landscape.

Two-sided risk models may not make financial sense for smaller oncology programs, particularly those who care for underserved patients and those that have not previously participated in OCM.

CMS should endeavor to provide as much information on proposed payment methodologies, cost data, and benchmark amounts as early as possible so that practices can make informed decisions around participation.

ACCC stands ready to support CMS in the implementation of this new model. We are eager to work with our members to ensure that EOM can be successful in improving care coordination, quality, equity, and outcomes for patients, while managing the total cost of oncology care.

FOLLOW US ON TWITTER



@TheCancerLetter

FOLLOW US ON FACEBOOK



facebook.com/TheCancerLetter

THE CLINICAL CANCER LETTER

CLINICAL ROUNDUP



OSUCCC – James study identifies molecular factors driving melanoma development

Researchers at The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute identified key features of a gene mutation responsible for 15-20% of all melanomas.

Using a preclinical laboratory model, the team established that the frequency at which a specific NRAS gene mutation occurs in human melanoma is directly related to the ability of that gene mutation to initiate spontaneous melanoma formation.

The [findings](#) were published in *Nature Communications*.

“This means that properties of the mutant itself—rather than the ease at which that specific gene mutation occurs—is the cause of cancer formation,” corresponding author Christin Burd, associate professor of molecular genetics in The Ohio State University College of Arts and Sciences, Department of Molecular Genetics and member of the OSUCCC – James Molecular Carcinogenesis and Chemoprevention Program, said in a statement.

The researchers developed genetically engineered models that allowed them to activate one of nine different NRAS-mutant variations in melanocytes.

“Amazingly, when we activated these gene mutations, only those found in the human disease caused melanoma to develop,” Burd said. “Some mutants never led to melanoma, yet we know that they cause leukemia. This finding shows that selection of NRAS mutations is specific to each tumor type and occurs during cancer initiation, rather than in response to a specific mutagenic event like sun exposure.”

Collaborating with NIH, Burd’s team found that slight variances in the outward-facing structure of NRAS mutants capable of initiating melanoma made these proteins better able to interact with the signaling pathways that drive melanoma growth.

The team also generated eight new and publicly available genetically engineered mouse models that can be used to activate and study the role of NRAS in other relevant cancer types, such as colon cancer, leukemia, myeloma, and thyroid cancer.

SWOG-nCartes pilot collaboration shows significant expected time savings for study data entry

The SWOG Cancer Research Network has partnered with cloud clinical research software company nCoup to pilot and deploy the company’s nCartes platform at SWOG sites to help advance data collection.

In late-phase pilot testing, the results of data entry using the nCartes platform were compared to the current practice of manual data entry, showing significant time savings and improvements in data quality.

The [results](#) were presented at the Society for Clinical Trials 43rd annual meeting.

With nCartes, research sites pull data available in the electronic medical record, such as labs and medications, and automatically transfer the data directly into the research sponsor’s electronic data capture system.

To measure data entry time using the nCartes platform, a study coordinator was timed entering 43 forms. It took 100 minutes to complete all forms, or 2 minutes and 20 seconds per form—a sizable time savings compared to current standard practice. Data quality also improved.

DRUGS & TARGETS



FDA approves Breyanzi in relapsed or refractory large B-cell lymphoma after one prior therapy

FDA approved Breyanzi (lisocabtagene maraleucel), a CD19-directed CAR T-cell therapy, for the treatment of adult patients with large B-cell lymphoma (diffuse large B-cell lymphoma not otherwise specified—including DLBCL arising from indolent lymphoma—high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B) who have:

- Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or
- Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplant due to comorbidities or age.

Breyanzi is sponsored by Bristol Myers Squibb.

In 2021, Breyanzi received FDA approval for adult patients with certain types of large B-cell lymphoma who have not responded to, or who have relapsed after, at least two other types of systemic treatment (*The Cancer Letter*, Feb. 12, 2021).

The recent approval for Breyanzi was based on results from the pivotal phase III TRANSFORM study, in which adults with LBCL that was primary refractory or relapsed within 12 months of front-line therapy were randomized to receive Breyanzi or standard therapy consisting of salvage immunochemotherapy—and, if responsive, high-dose chemotherapy and HSCT.

The study [results](#), published in *The Lancet*, showed that Breyanzi (n=92) more than quadrupled median EFS compared to standard therapy (n=92) (10.1 months vs. 2.3 months [HR: 0.34; 95% CI: 0.22-0.52; p<0.0001]).

The majority of patients achieved a CR with Breyanzi compared to less than half with standard therapy (66% [95% CI: 56-76%] vs. 39% [95% CI: 29-50%]; p<0.0001), with median duration of CR not reached in the Breyanzi arm (95% CI: 7.9-NR).

Results also showed that Breyanzi more than doubled PFS versus standard therapy (median PFS: 14.8 months vs. 5.7 months [HR: 0.41; 95% CI: 0.25-0.66; p=0.0001]). In the study, 97% of patients in the Breyanzi arm received treatment, compared to less than half (47%) of patients who completed high-dose chemotherapy and autologous HSCT in the standard therapy arm.

The efficacy of Breyanzi in the second-line setting was also based on data from the phase II PILOT study, in which 61 adults with primary refractory or relapsed LBCL who were not considered candidates for stem cell transplant were treated with Breyanzi. The PILOT study

enrolled a broad patient population based on age, performance status and/or organ function, and comorbidities, and regardless of time to relapse following first-line treatment.

Breyanzi showed an overall response rate of 80%, the study's primary endpoint, and a CR rate of 54%, with median time to CR of one month (range: 0.8-6.9 months). Median duration of response was 11.2 months, with the median duration of response not reached for those patients who achieved a CR.

Full prescribing information for Breyanzi can be found [here](#).

EMA CHMP adopts positive opinion for Lynparza in germline BRCA-mutated, HER2-negative high-risk early breast cancer

The European Medicines Agency's Committee for Medicinal Products for Human Use adopted a positive opinion recommending approval of Lynparza (olaparib) for the adjuvant treatment of patients with germline BRCA-mutated, HER2-negative high-risk early breast cancer who have been treated with neoadjuvant or adjuvant chemotherapy.

Lynparza is sponsored by AstraZeneca and Merck.

The CHMP based its positive opinion on [results](#) from the phase III OlympiA trial presented during the 2021 American Society of Clinical Oncology annual meeting and published in *The New England Journal of Medicine*.

In the trial, Lynparza demonstrated a statistically significant and clinically meaningful improvement in the pri-

mary endpoint of invasive disease-free survival, reducing the risk of invasive breast cancer recurrences, second cancers, or death by 42% (HR=0.58; 99.5% CI: 0.41-0.82; $p<0.0001$) versus placebo.

Overall survival data showed Lynparza demonstrated a statistically significant and clinically meaningful improvement in the key secondary endpoint of OS, reducing the risk of death by 32% (HR=0.68; 98.5% CI: 0.47-0.97; $p=0.0091$) compared to placebo.

The safety and tolerability profile of Lynparza in this trial was in line with that observed in prior clinical trials.

In March 2022, Lynparza was approved by FDA for the adjuvant treatment of patients with gBRCAm, HER2-negative high-risk early breast cancer, based on results from the OlympiA trial. Full prescribing information can be found [here](#).

Lynparza is also approved in the US, EU, Japan, and several other countries for the treatment of adult patients with gBRCAm, HER2-negative metastatic breast cancer previously treated with chemotherapy and, if hormone receptor-positive, endocrine therapy if appropriate, based on results from the phase III OlympiAD trial. In the EU and Japan, this indication also includes patients with locally advanced breast cancer.

Community Health Network, GRAIL to offer Galleri MCED test in Central Indiana

Indianapolis-based Community Health Network and GRAIL LLC have partnered to offer Galleri, GRAIL's multi-cancer early detection blood test, to individuals at Community Health Network's sites of care.

Through the partnership, Community Health Network will provide the Galleri test to individuals at elevated risk for cancer, including those over the age of 50. The test will be offered to eligible individuals through their primary care providers at select Community Health Network sites as a complement to existing single cancer screenings.

In a clinical study, the Galleri test demonstrated the ability to detect a shared signal from more than 50 types of cancers. The test also determines the origin of the cancer signal.

FDA issues draft guidance on patient-focused drug development

FDA issued a draft guidance, "Patient-Focused Drug Development: Selecting, Developing, or Modifying Fit-for-Purpose Clinical Outcome Assessments."

This [guidance](#) is the third in a series of documents intended to facilitate the advancement and use of systematic approaches to collect and use robust and meaningful patient and caregiver input that can more consistently inform medical product development and regulatory decision-making.

When final, this guidance will represent the current thinking of FDA's Center for Drug Evaluation and Research, Center for Biologics Evaluation and Research, and Center for Devices and Radiological Health on this topic.

The purpose of this guidance is to help sponsors identify or develop fit-for-purpose COA measures of patients' health that are appropriate for use in a medical product development program.

For information on the draft guidance and how to submit comments, please see the [Federal Register Notice](#).

In addition, FDA issued two final guidances for [bladder cancer](#) and [renal cell carcinoma](#).

**NEVER MISS
AN ISSUE!**

Get e-mail alerts now.



CLICK HERE

or sign-up at:
<https://cancerletter.com/news-alerts/>