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Editorial

Supporting Patients with Cancer after *Dobbs v. Jackson Women's Health Organization*

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Caring for patients with cancer is a profound privilege and responsibility. Our obligation to support and treat people who are at their most vulnerable was an important factor in our choice to work in this field. For patients facing cancer who are pregnant, delivering quality care is highly complex and challenging. As clinicians, we guide care by facilitating access to medical options and doing our utmost to help define the best ways forward. Deciding whether to continue a pregnancy or whether to terminate is often at the heart of those choices. The recent Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*[1] (Dobbs) will reverberate around the nation and remove a key option for many pregnant patients with cancer, with potentially life-threatening consequences.

In the context of cancer, we recognize that whether or not to choose pregnancy termination represents a difficult and

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multifaceted decision. This is weighed by the risks to the woman with cancer, if the pregnancy is continued and cancer treatment is delayed, and the risk to the fetus for serious complications associated with chemotherapy and inherent loss of potential life. Our goal is not to opine on the question of when life begins or the morality of abortion. Rather, as members of the editorial team of *The Oncologist*, we attempt to contextualize the potential implications of *Dobbs* for patients with cancer.

Although rare, a diagnosis of cancer during pregnancy or conception during cancer treatment impacts up to 6,000 patients each year in the US. Exactly 20 years ago in this journal, a review of the topic noted that "the [pregnant] patient, her partner, and her physician are required to make a difficult decision without a clear answer."[2] While that remains true, existing data regarding patient factors, tumor specifics, and gestational age, which interact in determining the relative proportionality of risk to both patient and fetus, can help inform the decision. The ethics of chemotherapy administration during pregnancy have always been complicated,[3,4] balancing risk to the fetus and to the mother. How the ethics apply to different disease sites, specific drugs, and pathologies will vary dramatically. This is particularly true for breast and other cancers that may be specifically influenced by pregnancy.[5] In some situations the risk of treatment delay guides a clear recommendation for pregnancy termination.[6] With novel treatment paradigms, such as immunotherapy, much remains unknown regarding teratogenicity and risk to the mother.[7] At the heart of all these decisions is the importance of the clinician-patient bond and deference to individual patient autonomy.

In cases involving medical and moral complexity impacting the well-being of a pregnant patient as well as the future of a fetus, the clinician-patient relationship is ever more important. As the American Society of Clinical Oncology recently stated, "every patient should have the ability to pursue, in partnership with their oncologist, all treatment options that offer the best chance of a successful outcome for their cancer."[8] The Dobbs decision will limit available clinical options for oncologists and women at times in which consideration of all options is the most important.

Multiple professional medical societies share these concerns. The American College of Obstetricians and Gynecologists deemed the Dobbs decision a "blow to bodily autonomy, reproductive health, patient safety and health equity in the United States."[9] The Association of Bioethics Program Directors expressed its concern (among others) that the case would limit how patients express their autonomy in clinical encounters.[10] The American College of Surgeons has also shared its dismay at another example of governmental interference in the clinical practice of medicine.[11]

States and local jurisdictions will inevitably make and interpret laws differently, with geographically variable implications for clinical practice, and this will likely lead to inequalities in care. Many laws that regulate and restrict abortion stipulate exceptions for the life of the pregnant person. How these laws will be interpreted and what degree of potential harm would qualify for such exceptions will vary.[12]

As oncologists, we are largely protected from the consequences of our recommendations and are less likely to face legal repercussions if our patients choose to terminate their pregnancies (although some states are attempting to criminalize all efforts that aid or abet abortion[13]). We believe that part of our duty, therefore, is to help share the legal and ethical burden with family planning providers and the women with cancer who will need to make these decisions. As a community, we must unite with health care professionals in calling for codification of abortion access for pregnant patients whose health is at risk as federal law, making access feasible irrespective of geography or demography.

In states where abortion restrictions remain in place, oncologists must work to define clinical situations that qualify for legal exception based upon the risk to the pregnant patient. Medical facts and clinical data must determine how laws are interpreted.[14] Statements, position papers, and guidelines from professional organizations will be important in guiding courts and lawmakers, and protecting clinicians and patients who may face criminal liability for making challenging professional and personal decisions in life-threatening scenarios. Articulating a compelling argument for which oncologic scenarios put a pregnant person's life in peril is something our community has the gravitas to establish.

While the legality of facilitating the termination of a pregnancy across state lines remains unresolved, we strongly support clinicians and patients exploring these opportunities while seeking legal advice and guidance given how dynamic the legal landscape remains.[15] We also call on professional cancer societies to advocate for and even provide legal defense when and if their members are accused of a crime when acting in the best interests of their patients.

The Dobbs decision underscores the termination of a pregnancy as a global health concern and reminds us of the gravity of the issues that pregnant patients with cancer in the United States will encounter. According to the Center for Reproductive Rights, almost 90 million women of reproductive age live in countries where abortion is prohibited altogether, and many more in places where laws are highly restrictive or where access to safe abortions is very limited.[16] As a global community, the Dobbs decision should bring us together in advocating for the rights of women with cancer, agnostic of geography.

Herein, we have focused on pregnant patients with cancer; however, we recognize the far-reaching implications of Dobbs on oncology. These include issues of fertility preservation, teratogenic treatments among non-pregnant women of childbearing age, stem cell research, and genome-altering therapies, among others.[17] Our collective obligation requires the fortitude to advocate on behalf of our patients and prevent extrinsic forces from limiting our ability to protect the lives and right to self-determination of those entrusted to our care.

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