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Original Research Article

Exploring how California obstetrician-gynecologists interpret the fetal viability concept☆,☆☆

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ABSTRACT

Objectives: To understand how obstetrician-gynecologists (OBGYNs) in California, a state with viability-based abortion legislation, personally define and interpret the concept of fetal viability in their clinical practice and through the lens of hospital and state policy.
Study design: We conducted qualitative audio-only interviews of practicing generalist and Complex Family Planning (CFP) fellowship-trained OBGYNs in varied clinical and geographic environments across California to evaluate clinicians' approaches to obstetric and abortion care within and beyond the peri-viable period. Participants were purposively recruited via online physician message boards and email outreach. Interviews were digitally recorded, transcribed, coded, and iteratively analyzed for relevant themes.
Results: We interviewed nine CFP-trained and 12 generalist OBGYNs (nine of whom did not routinely provide abortion care). Most interviewees were white women practicing in urban areas, split among Northern and Southern California. All CFP OBGYNS were familiar with the state's viability-based abortion restriction, while understanding varied among the 12 generalist OBGYNs. Many generalists equated viability with 24 weeks, commonly due to institutional policies. Accordingly, some physicians did not provide abortion care near or beyond 24 weeks for personal, professional, and political reasons. Overall, physicians approached peri-viable care through one or more of three frameworks: fetus-centered, institution-centered, and, rarely, person-centered.
Conclusions: Many California OBGYNs are unaware of state abortion legislation and practice peri-viable pregnancy care within the more conservative policies of their institutions that apply specific gestational duration limits to abortion care. Differing institutional and provider interpretations of viability result in inequitable access to abortion past 24 weeks in California.
Implications: Varied interpretations of "fetal viability" as a medico-legal concept among obstetrician-gynecologists and their institutions contribute to inequitable peri-viable abortion access across California.

1. Introduction

Fetal viability lacks a single formally accepted clinical definition, but this concept and gestational duration as its proxy are frequently used in abortion legislation [1]. The term was coined during Supreme Court deliberations of *Roe v. Wade* but was not considered absolute [2,3]. The state could override this right at a "compelling point" determined to be the onset of fetal viability, defined as "the point at which the fetus has a reasonable chance of independent life" once delivered [4]. The Court favored the concept of viability as a less controversial alternative to defining the beginning of life itself [2,3].

Thirteen states, including California, currently prohibit abortion after fetal viability (Table 1). California law defines viability as "a reasonable likelihood of the fetus' sustained survival outside the uterus without the application of extraordinary medical measures" and prohibits abortion past that point except to protect the "life or health" of the pregnant person [5,6]. Such a definition requires clinical interpretation; while some may interpret the ambiguity of the concept of viability to broaden abortion access beyond a strict gestational cut off, others might adopt a more conservative reading that denies care.

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Table 1
Legislative abortion restrictions by U.S. state (as of 12/31/2025)

Law/restriction	Number	States/District
Prohibited at any gestation	13 states	Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, West Virginia
Prohibited prior to pre-viable gestational duration	7 states	**6 weeks 0 days**: Florida, Georgia, Iowa, South Carolina **12 weeks 0 days**: Nebraska, North Carolina **18 weeks 0 days**: Utah
Prohibited at peri-viable gestational duration	8 states	**20 weeks 0 days**: Ohio*, Wisconsin* **22 weeks 0 days**: Kansas **24 weeks 0 days**: Massachusetts, Nevada*, New Hampshire, Pennsylvania **26 weeks 6 days**: Virginia
Prohibited at "viability" with viability defined in legal statute†	9 states	Arizona, California, Delaware, Illinois, Maine, Missouri, New York, Rhode Island, Washington
Prohibited at "viability" with viability not defined in legal statute	4 states	Connecticut, Hawaii, Montana, Wyoming
Legislation prohibits government interference in abortion care throughout entire pregnancy	9 states and Washington D.C.	Alaska, Colorado, New Jersey, Maryland, Michigan, Minnesota, New Mexico, Oregon, Vermont, Washington D.C.

*Gestational duration defined from fertilization
†Legal definitions of viability:
Arizona, Illinois: "…Significant likelihood of the fetus's sustained survival outside of the uterus without the application of extraordinary medical measures"
California, Delaware, Missouri, Rhode Island, Washington: "…Reasonable likelihood of the fetus' sustained survival outside the uterus without the application of extraordinary medical measures"
Maine: "…State of fetal development when the life of the fetus may be continued indefinitely outside the womb by natural or artificial life-supportive systems"
New York: "…Within 24 weeks from the commencement of pregnancy or there is an absence of fetal viability"

Prior qualitative studies have investigated when and why obstetrician-gynecologists (OBGYNs) classify ending a pregnancy as abortion in the peri-viable period [7,8] and others have examined neonatologists' and OBGYNs' beliefs about timing of peri-viable neonatal resuscitation [9–12]. Across studies, clinicians demonstrated inconsistency in how they interpreted scenarios, resulting in widely varying decisions about abortion versus resuscitation at the same gestational durations. No prior research has directly addressed how OBGYNs interpret the medico-legal concept of viability in states where abortion restrictions rely on that definition. Therefore, we conducted a qualitative study to explore how California OBGYNs interpret viability in their clinical practice and how this influences their provision of peri-viable obstetric and abortion care.

2. Materials and methods

We performed a qualitative study using semi-structured interviews. Eligible participants included generalist and Complex Family Planning (CFP) fellowship trained OBGYNs currently practicing in California. We included both generalist and CFP-trained OBGYNs as they are likely to be among the types of physicians to encounter pregnant patients in the peri-viable period. We excluded trainees including residents and fellows. The University of California, Davis Institutional Review Board considered the study exempt.

The research team developed a semi-structured interview guide using a socioecological model, which understands behavior as influenced by individual, interpersonal, organizational, community, and political factors [13]. We reviewed existing qualitative literature on peri-viable obstetric and abortion care to inform the interview guide (Appendix) which was refined after pilot testing with eligible OBGYNs who were not recruited for study participation.

We recruited participants through online physician specialty organization message platforms (e.g. American College of Obstetrics and Gynecologists District IX, Society of Family Planning), and purposive email outreach via professional networking to capture responses from academic and community physicians in diverse institutional and geographic settings across California. We introduced the study as a qualitative investigation of California OBGYNs' thoughts about fetal viability. We used maximum variation sampling to recruit a heterogenous participant group until thematic saturation was reached [14].

Data collection took place from October 2024 to March 2025. One interviewer (ND), a white female physician and current CFP fellow trained in qualitative methods, conducted all audio-only interviews by telephone or video conference, lasting 30–90 min. Her professional role as a CFP fellow was not disclosed to interviewees. Interviews included open-ended questions about participants' understanding of viability and clinical approach to care in the peri-viable period and discussion of knowledge and interpretation of institution and state abortion policy. Near the end of the interview, ND informed participants about the specific language of California viability-based abortion legislation. Participants provided verbal consent and received a $50 gift card.

We digitally recorded, transcribed verbatim, de-identified, and analyzed interviews thematically using qualitative research software. ND wrote reflexive memos during and after each interview to inform data analysis. The first four transcripts were analyzed collaboratively among all investigators (ND, KD, MG) and informed an initial coding scheme. As data collection progressed, new insights informed modifications to the interview guide and participant recruitment. All transcripts were independently reviewed by at least two investigators and inter-coder agreement was used to ensure consistency until reaching thematic saturation, which we suspected after 19 interviews and confirmed after 21 interviews. We followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [15].

3. Results

3.1. Participant characteristics

The 21 participants included 12 generalist OBGYNs (nine of whom did not routinely provide abortion care) and nine CFP-trained OBGYNs (who performed abortion care as a significant part of their clinical practice). Table 2 presents participant demographics; most participants identified as cisgender White women between the ages of 32–67 working in urban areas.

3.2. Participant understanding and interpretation of viability under California law

When the interviewer asked participants to explain their knowledge of California legislative abortion restrictions near the end of the interview, all nine CFP-trained and two generalist OBGYNs reported familiarity with the law's viability language. Among the remaining generalists, two were uncertain of the law, one believed there was no written limit, and seven assumed abortion was

Table 2
Demographic characteristics of California obstetrician-gynecologists participating in a survey about the definition of viability in 2024–2025 (N = 21)

Participant Characteristics		N (%)
Specialty	Generalist obstetrician-gynecologist	9 (43)
	Generalist obstetrician-gynecologist who performs abortions	3 (14)
	Complex Family Planning Fellowship-trained	9 (43)
Geographic setting	Northern California	12 (57)
	Southern California	9 (43)
Patient population	Urban	19 (90)
	Rural	2 (10)
Institution type	Academic	8 (38)
	Academic-affiliated community hospital	4 (19)
	Community hospital	4 (19)
	Religious-affiliated community hospital	3 (14)
	Military hospital	1 (5)
	Private clinic	1 (5)
Age	30–39	9 (43)
	40–49	5 (24)
	50+	5 (24)
Self-identified gender	Female	18 (86)
	Male	3 (14)
Self-identified race/ ethnicity	White	14 (66)
	Asian	2 (10)
	Middle Eastern	2 (10)
	Black	1 (5)
	Mixed	1 (5)
	Chicana	1 (5)

restricted after 24 weeks. After the interviewer disclosed the actual legislative language and definition of "viability", this segued to further discussion of participants' understanding of viability as a medical and legal concept. Many conflated viability with 24 weeks and a natural cut-off for abortion despite lacking a clear source for this belief. Many attributed these assumptions to lingering perceptions from clinical training that this definition was an evidence-based professional guideline or community standard.

> "I guess I based that 24 weeks off of something that was taught to me in training. […] The reason why abortions were done only up until 24 was because that was, like, a hard and fast rule? […] I assumed that there at some point along the way there was some, uh, meta-analysis that determined that at *this* point in time it was high enough survival rate that resuscitation should be considered for every time." (Generalist)

When asked if they would feel legally protected providing abortions after 24 weeks in California after reviewing the language of the law, most generalists and two CFP OBGYNs expressed uncertainty. Many cited fear of legal repercussions due to possible conservative interpretation of vague language.

> "California's blue […] but I feel like because that's up to so much different interpretation, it would almost make me nervous to provide an abortion to anyone around what we consider in the peri-viable period. […] It makes me think about how someone might say, well, you know, other places are resuscitating at 22 and 0, so why are you doing an abortion at 24 weeks?" (Generalist)

Several expressed that removing the viability term from the law would clarify protections, but worried about potential political backlash should all legislative abortion restrictions be removed. Later abortion providers commonly felt confident in the law's current protections. Others acknowledged its shortcomings, including lack of understanding by the broader medical profession.

> "I think if any part of it that has any interpretation…. that's where we go wrong. […] As long as it says viability, there's going to be anxiety about what that means. […] We're in an unknown time. There's a lot of known unknowns and unknown unknowns now." (CFP)

Some generalists reported feeling empowered to view abortion after 24 weeks as legally and medically permissible upon learning that others in California interpreted the law more liberally.

> "Immediately when you tell me that others in California do abortion over 24 weeks, that makes me feel like *okay, it would be ethical and morally okay to do that* because there was a precedent that was already set […] Because there is a collective understanding and a standardized approach that would help me feel reassured." (Generalist)

Participants often endorsed the idea of a widely accepted community standard among California OBGYNs to guide abortion provision and reduce potential medicolegal ambiguity by practicing in alignment with peers.

3.3. Clinical frameworks for navigating peri-viable care

Three overarching frameworks emerged in how participants navigated abortion near or beyond viability: (1) fetus-centered, (2) institution-centered, and (3) person-centered. These frameworks shaped how participants communicated options, whose perspectives were prioritized, and whether they offered abortion. Participants often shifted and moved among frameworks based on clinical scenarios and evolving policies or beliefs, with viability acting as a clinical and ethical point of contention among the three.

3.4. Fetus-centered framework

Most participants instinctively defined fetal viability through the lens of obstetric and neonatal care and defined it as the earliest potential for "intact" fetal survival, which was simultaneously anticipated as the threshold for abortion restriction. This constituted a *fetus-centered framework* of viability.

> "It depends what gestational age the neonatologist is comfortable providing resuscitation given the resources available in that hospital. Where I work, 22 weeks is the age of viability." (Generalist)

In times of clinical or ethical uncertainty in the peri-viable period, physicians often favored recommendation toward neonatal resuscitation over abortion. Many participants felt conflicted or uneasy about abortion occurring during the same gestational window in which they had provided obstetric care to save peri-viable fetuses. Therefore, they often avoided performing abortions past a certain threshold to avoid this cognitive dissonance.

> "I just find the struggle of, you know, on one end we have the NICU doing all these things they can to save these pregnancies at 23, 24 weeks... so just something about that doesn't really sit well with me, personally." (Generalist)

OBGYNs using a fetus-centered framework often expressed feeling differently about decision-making in the peri-viable period depending on the status of the fetus, rather than the centering the preferences of the pregnant person.

> "Allowing a woman to terminate a pregnancy, if there was no congenital defects or issues, if it was just a healthy pregnancy, to carry it that far along… I would have a hard time." (Generalist)

Many participants understood viability as a gray area dependent on many factors but still defaulted to gestational duration in definition and in practice without an alternative convention. They commonly correlated viability with ability to offer obstetric

intervention and neonatal resuscitation at their institutions, typically between 22 and 25 weeks. Generalists who did not provide abortions were often unfamiliar with institutional and state policy but assumed abortion was restricted after 24 weeks, citing a medical threshold for "intact" fetal survival. Conscious of technological advances allowing progressively earlier potential fetal resuscitation, participants acknowledged viability as a moving target.

> "Periviable care is a fraught area for us… I think it's a vulnerable area for slippery slope negotiations. […] Right now it's gonna be 23 weeks - but what happens when we're able to keep babies alive at 20 weeks, and then 18 weeks?" (Generalist)

Considering this uncertainty, participants routinely deferred to Maternal-Fetal Medicine (MFM) and neonatology specialists for in-depth counseling and management decisions.

> "Our MFM certainly run our L&D […] they're certainly - with NICU, determining those resuscitation and peri-viability spaces - and often they're the people doing the counseling about that, too." (CFP)

Simultaneously, participants worried about patients receiving inadequate, biased, or incomplete counseling, recounting stories of colleagues guiding patients away from abortion rather than providing truly patient-centered counseling. Even when OBGYNs felt conflicted about performing abortions, they became concerned when it was not an option.

3.5. Institution-centered framework

Providers also understood viability through an *institution-centered* framework, prioritizing and deferring clinical judgment to institutional policies. Participant-reported hospital policies involving peri-viable care commonly imposed stricter abortion limits than California law, creating inconsistent abortion access—particularly over 24 weeks—despite legal protections.

When asked about institutional policies regarding peri-viable obstetric and abortion care, participants described that, even in life-limiting circumstances, Catholic hospitals rarely allowed abortion and military institutions required physician, committee, and commanding officer approval under federal policy. Commonly, hospitals prohibited "elective" abortion and only allowed induction abortion on labor and delivery (L&D) for severe medical indications or lethal fetal anomalies, often after additional approval processes and coordination to confirm staff willingness. Institutions providing more expansive abortion care still commonly prohibited "elective" procedures after 24 weeks, while neonatal resuscitation typically began at 22–26 weeks.

Many hospital-based participants expressed apprehension surrounding abortion near or beyond 24 weeks. This apprehension was often attributed to the litigious culture of medicine, scrutiny by the medical board or law enforcement, and reputational and social repercussions within their workplace and community that could impact safety and financial security.

> "I think as doctors, you know, we worked really hard to get our licenses. […] We're like the straight A student who needs to get all the A's and get everything approved and stamped […] Are you going to get fired? Or brought in front of a committee of some sort? […] It could be law enforcement. It could be just somebody coming to do an audit from whatever branch of government. Or if we have a patient reporting you to the medical board." (CFP)

Due to liability concerns amid unclear management recommendations in the peri-viable period of pregnancy, participants utilizing an institution-centered framework were often guided by risk aversion.

> "There's potential for big, different interpretations of every single case that could result in some…. tension between clinical providers […] I do get worried, especially in this political climate, about the ability to - for one provider to interpret it one way, and another provider to interpret it another way - and, you know, possible legal ramifications." (CFP)

Several generalists who performed limited abortion care recalled stressful experiences during medical training in restrictive states that drove them away from providing peri-viable abortion in practice. Others referenced fears of performing abortion in conservative settings or in the event of a future national abortion ban.

> "I'm in a conservative town, and I live here, right? Like if that gets known, is someone going to come threaten me or my family? […] And then what really kind of nailed my hesitation was the election. […] I don't trust that I would be, like, defended by my organization." (Generalist)

CFP-trained and generalist abortion providers universally stated that providing abortion past 24 weeks created significant discomfort among other clinical staff, particularly on a labor and delivery unit. This discomfort was named as the main barrier to expanding later abortion care and a key reason for implementing injections to induce fetal asystole prior to peri-viable abortion. Injections served a dual purpose of preventing others from declining to care for patients and preventing unintended neonatal resuscitation.

Abortion providers commonly described limiting their scope of practice to preserve institutional support for current access and often only offered abortion for certain indications.

> "I can do a D&E to 28 weeks – I just want to have a job the next day, right? I need the institution to accept that what I'm doing is within the limits of the law. I need to know if somebody says something, I have back-up of my institution. It only takes one person to make a complaint." (CFP)

Some abortion providers expressed that institutional limits were helpful for avoiding confrontation of their own hesitations with later abortion care. Many preferred to refer patients over 24 weeks to colleagues rather than putting themselves and their own institutions at risk.

> "It allows me to not have to interrogate more deeply how I personally feel about providing close-to 24-week care… Relying on someone else to say 'this is why we can't take care of you' feels better than me making the decision. And having an institutional cut-off is just helpful day-to-day in keeping our clinic going and scheduling people. […] I have people that I can refer to in my area who feel comfortable going further, and so that sort of takes the pressure off of me and my colleagues, even though that's a barrier for patients." (CFP)

Both generalist and CFP OBGYNs commonly saw themselves as having less power than MFM to "justify" abortion past 24 weeks and were less willing to offer it without documented MFM approval. Although uncommon, formal acknowledgment of the absence of discrete gestational duration limits for abortion by institutional leadership and legal departments helped cultivate alignment between MFM and CFP. When asked whether having institutional support helped participants feel more empowered to provide abortion beyond 24 weeks, one participant said:

> "Yes, and because that's what our lawyers are telling us, and because I think that's how [the law] is being interpreted by our MFM colleagues." (CFP)

3.6. Person-centered framework

A minority, primarily CFP-trained OBGYNs routinely providing abortion past 24 weeks, embraced a *person-centered* approach. These

clinicians defined viability as a decision to be made solely by the pregnant person based on their values and felt comfortable offering abortion regardless of gestational duration.

> "I would define viability as something that is actually defined by the parents of the fetus… I don't think it's a medical determination. […] I think having provided care now - more over 24 weeks - it became even clearer to me that it's a parental determination. Because I've taken care of patients who opted to terminate desired and undesired pregnancies later for a variety of different reasons. […] So that's reinforced to me that it's the parent or the pregnant person that determines the viability of the pregnancy." (CFP)

These clinicians did not see fetal viability as a specific medical determination that should be used to restrict abortion care, and instead recognized its history as a legal construct.

> "Viability is a spectrum and it varies in every single situation […] Viability happens way later in pregnancy than people talk about in the media, or like this number 24 that comes up a lot. […] It came from *Roe*. As soon as people started talking about trimesters, I mean, that's where it came from. And people latched onto it like it was a real thing, but it's a construct. It's something that helps us talk about pregnancy, I guess, but it's not based on anything scientific or real." (CFP)

OBGYNs using this framework provided nonjudgmental care and often deliberately separated personal beliefs from clinical decision-making, providing support regardless of the decision to end or continue the pregnancy.

> "I honestly don't even ask people why – I just ask them what they want to do. […] The ambiguity with pregnancy is very complicated and different for everyone. I don't think we can fully understand it unless you are that person." (CFP)

OBGYNs' approach to peri-viable obstetric and abortion care via a patient-centered lens was principally guided by respect for the pregnant person's autonomy.

> "It's going to come back to where the mother falls on that, since it's her body and the focus on patient autonomy is… the top of the pyramid for me, for making those decisions, and having the discussions with patients." (Generalist)

Many acknowledged the foremost importance of caring for the patient and not the law.

> "A lot of the time, we police ourselves when we're coming up with these rules. They become much more conservative than the actual law." (CFP)

4. Discussion

California OBGYNs approached the concept of fetal viability differently in terms of personal definition, clinical application, and legal interpretation. Many naturally approached viability through a fetus-centered lens and assumed that obstetric and neonatal intervention, rather than abortion, became standard of care at a gestational duration around 24 weeks. Others adopted an institution-centered perspective in which abortion after 24 weeks was not routinely performed to avoid disruption of established norms. In contrast, person-centered clinicians aspired to perform abortion care without limits.

We identified major challenges to person-centered care in the peri-viable period of pregnancy, particularly after 24 weeks when abortion was seldom offered and some OBGYNs assumed it was illegal. We found that ambiguity surrounding viability as either a medical or legal concept created uncertainty among respondents. This ambiguity, along with desire to avoid personal discomfort and potential professional risk, contributes to the fetus-centered and institution-centered frameworks that many clinicians use to approach peri-viable care. Consequently, patients perceived to be in clinical scenarios past "viability" are denied autonomy to make decisions that align with their own needs and values. Our findings contribute to the growing evidence that viability-based restrictions—whether imposed by policymakers or individual healthcare providers or their institutions—undermine equitable abortion access, particularly past 24 weeks [16–18].

In the post-*Dobbs* era [19], some abortion providers have expanded later abortion services to meet increasing demand [20]. However, only a minority of California OBGYNs in our study use the state's full legal breadth to routinely provide care past 24 weeks. Though aligning California legislation with Washington D.C. and the nine states that prohibit government interference in abortion throughout pregnancy would help resolve legal ambiguities, we recognize that legislative revisions do not address all obstacles. In concordance with results from a recent study in New York, institutional policies and staff reluctance maintain barriers to abortion after 24 weeks despite protective state legislation [21], and nationally over half of teaching hospitals impose abortion policies more restrictive than state law [22]. De-coupling abortion care from viability frameworks and de-stigmatization of later abortion care among the broader landscape of reproductive healthcare are critical to eliminating legislative-, institution-, and provider-driven constraints to facilitate person-centered care regardless of gestational duration. Further work is needed to challenge and deconstruct the concept of viability as a medical threshold that defines the option for abortion on one side and obstetric and neonatal intervention on the other side.

An important strength of our study is the focus of our in-depth interviews on OBGYNs' personal interpretation of the medico-legal concept of viability. Limitations include recruitment of only generalist and CFP-trained OBGYNs largely via professional networking. Our resulting sample was somewhat demographically homogenous, so their beliefs may not be representative of those from other backgrounds. Interviews were conducted in the months following the 2024 election and inauguration which may have influenced a sense of heightened political uncertainty. Interviewer positionality may have shaped the results, as participants could have been subtly primed to offer more liberal perspectives on abortion, possibly resulting in an underestimation of conservative sentiments. Researcher bias may have also influenced analysis. Future research should continue exploring the impact of viability-based abortion restrictions nationwide.

In summary, the concept of fetal viability creates barriers to peri-viable abortion care when OBGYNs view later abortion through *fetus-centered* and *institution-centered frameworks*. Dismantling viability-based restrictions within the law, medicine, and broader sociopolitical conscience may reduce later abortion stigma and encourage OBGYNs to move fully toward *person-centered* care within and beyond the peri-viable period of pregnancy.

Author contributions

M.G.: Writing – review and editing, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. Katie Donnelly: Writing – review & editing, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. D.N.M.: Writing – review and editing, Writing – original draft, Visualization, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. M.C.: Writing – review and editing, Supervision, Conceptualization. C.M.J.: Writing – review and editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.contraception.2026.111404.

References

[1] Guttmacher Institute. State bans on abortion throughout pregnancy. Published 07–25-2025. Available at: ⟨https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans⟩. Accessed 12–18-2025.

[2] A History of Key Abortion Rulings of the U.S. Supreme Court. Pew Research Center. Published 01–16-2013. Available at: ⟨https://www.pewresearch.org/religion/2013/01/16/a-history-of-key-abortion-rulings-of-the-us-supreme-court/⟩. Accessed 08–26-2024.

[3] Abortion Rights as a Part of Due Process. Find Law. Published 12–09-2022. Available at: ⟨https://constitution.findlaw.com/amendment5/annotation08.html#:~:text=In%201973%2C%20the%20Supreme%20Court,choose%20to%20have%20an%20abortion⟩. Accessed 08–26-2024.

[4] Roe vs Wade, 410 U.S. 213 (1973). U.S. Supreme Court. Available at: ⟨https://supreme.justia.com/cases/federal/us/410/113/⟩. Accessed 08–26-2024.

[5] Bill Text: California Assembly Bill No. 2223. Legiscan. Published 09–27-2022. Available at: ⟨https://legiscan.com/CA/text/AB2223/id/2609184⟩. Accessed 08–26-2024.

[6] Know Your Abortion Rights and Protections Under California Law. California Department of Justice: Office of the Attorney General. Available at: ⟨https://oag.ca.gov/system/files/attachments/press-docs/Reproductive%20Rights%20Bulletin.pdf⟩. Accessed 08–26-2024.

[7] Flink-Bochacki R, McLeod C, Lipe H, Rapkin RB, Rubin SL, Heuser CC. Classification of periviable pregnancy-ending interventions for maternal life endangerment as induced abortion. Contraception 2023;123:110011. https://doi.org/10.1016/j.contraception.2023.110011

[8] Flink-Bochacki R, McLeod C, Lipe H, Rapkin RB, Rubin SL, Heuser CC. Is it an abortion: classification of pregnancy-ending interventions after 24 weeks in the presence of lethal fetal anomalies. Contraception 2024;137:110492. https://doi.org/10.1016/j.contraception.2024.110492

[9] Di Stefano LM, Wood K, Mactier H, Bates SE, Wilkinson D. Viability and thresholds for treatment of extremely preterm infants: survey of UK neonatal professionals. Arch Dis Child Fetal Neonatal Ed 2021;106(6):596–602. https://doi.org/10.1136/archdischild-2020-321273

[10] Andaya E, Campo-Engelstein L. Conceptualizing pain and personhood in the periviable period: perspectives from reproductive health and neonatal intensive care unit clinicians. Soc Sci Med 2021;269:113558. https://doi.org/10.1016/j.socscimed.2020.113558

[11] Gallagher K, Shaw C, Parisaei M, Marlow N, Aladangady N. Attitudes about extremely preterm birth among obstetric and neonatal health care professionals in England: a qualitative study. Published 2022 Nov 1. JAMA Netw Open 2022;5(11):e2241802. https://doi.org/10.1001/jamanetworkopen.2022.41802

[12] Ramsay SM, Santella RM. The definition of life: a survey of obstetricians and neonatologists in New York City hospitals regarding extremely premature births. Matern Child Health J 2011;15(4):446–52. https://doi.org/10.1007/s10995-010-0613-8

[13] Sallis JF, Owen N, Fisher EB. Ecological models of health behavior. In: Glanz K, Rimer BK, Viswanath K, editors. Health Behavior and Health Education. 4th ed.,,San Francisco: John Wiley & Sons; 2008. p. 465–85.

[14] Crabtree B.F., Miller W.L. Doing qualitative research. Thousand Oaks, Calif.; London: SAGE; 1999.

[15] Tong Allison, Sainsbury Peter, Craig Jonathan. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. (December). Int J Qual Health Care 2007;19(6):349–57. https://doi.org/10.1093/intqhc/mzm042. (December).

[16] The Role of the Viability Line in Pregnancy Criminalization. Pregnancy Justice, Patient Forward. Published 04-2025. Available at: ⟨https://www.pregnancyjusticeus.org/wp-content/uploads/2025/05/Viability-Line-Report.pdf⟩. Accessed 07–08-2025.

[17] Kimport K. Is third-trimester abortion exceptional? Two pathways to abortion after 24 weeks of pregnancy in the United States. Perspect Sex Reprod Health 2022 Jun;54(2):38–45. https://doi.org/10.1363/psrh.12190. Epub 2022 Apr 10. PMID: 35403366; PMCID: PMC9321603.

[18] Kimport K, Weitz TA. Regulating abortion later in pregnancy: fetal-centric laws and the erasure of Women's subjectivity. J Health Polit Policy Law 2025 Feb 1;50(1):47–68. https://doi.org/10.1215/03616878-11516772. PMID: 39118283.

[19] Dobbs vs Jackson Women's Health Organization, 597 U.S. 215 (2022). U.S. Supreme Court. Available at: ⟨https://supreme.justia.com/cases/federal/us/597/19–1392⟩. Accessed 08–28-2025.

[20] Berglas NF, Schroeder R, Kaller S, Stewart C, Upadhyay UD. Changes in availability of later abortion care before and after Dobbs v. Jackson Women's Health Organization. Obstet Gynecol 2025;145(1):e31–6. https://doi.org/10.1097/AOG.0000000000005772. Epub 2024 Oct 24. PMID: 39447180; PMCID: PMC11630660.

[21] Krishna GR, Kohn JE, Bleck R, Westhoff CL. Abortion provision at New York State Regional Perinatal Centers following implementation of the Reproductive Health Act. Womens Health Issues 2025;35(1):7–13. https://doi.org/10.1016/j.whi.2024.10.001

[22] Zeldovich VB, Rocca CH, Langton C, Landy U, Ly ES, Freedman LR. Abortion policies in U.S. Teaching Hospitals: formal and informal parameters beyond the law. Obstet Gynecol 2020;135(6):1296–305. https://doi.org/10.1097/AOG.0000000000003876