SUFFERLESS SNAPSHOT

Restricted vs Broadly Protected Abortion Access in the United States

Full institution / policy audit | Tier 2 | Current-law and evidence review through September 2026

Question audited: Compare policies of restricted versus "unrestricted" access to abortion in the United States.

Terminology correction. "Unrestricted" is not a precise description of U.S. policy. As of September 2, 2026, 13 states had total bans, 28 states had gestational bans, and 9 states plus the District of Columbia had no gestational-duration ban; states in the broad-access group still regulate clinical practice, insurance, providers, and other aspects of care. This report therefore compares **restricted access** with **broadly protected access**, while showing intermediate policy designs. [E1]

Empirical layer. Post-Dobbs evidence indicates that complete or very early bans are associated with more births than expected, substantial interstate travel and telehealth substitution, and higher infant mortality in several analyses. Evidence on maternal or pregnancy-associated mortality is newer and mixed: some 2026 studies find suggestive increases with wide uncertainty, while another found no statistically significant overall increase through 2023. [E3-E8]

Moral layer. The central unresolved premise is the moral and legal status of embryonic/fetal life and how it should be weighed against the pregnant person's bodily autonomy, health, liberty, and responsibilities. The Sufferless framework treats that premise as morally contested rather than pretending empirical evidence can settle it. [S1-S3]

Stakeholder / interest	Empirically observable burdens	Contested value component
Pregnant person	Pregnancy/childbirth health risk; travel; cost; delayed care; economic and family effects	Scope of bodily autonomy and state authority
Embryo / fetus	Development continues if pregnancy continues; abortion ends that development	Moral/personhood status and weight at different gestational stages
Existing children / dependents	Household time, income, caregiving, family-resource effects	How obligations to existing dependents are weighed
Clinicians / health systems	Legal ambiguity, delay, gatekeeping, capacity shifts	Conscience, professional judgment, and legal accountability
Communities	Moral distress, pluralism, trust, political conflict	Different beliefs about life, rights, responsibility, and legitimacy

Neutral audit result: The evidence supports several directional claims about access, travel, fertility, infant outcomes, economic burden, and clinical practice. It does **not** resolve the foundational moral premise. Accordingly, this report does not choose, score, or rank the competing policy positions.

Confidence: High on the September 2026 legal landscape and 2025 travel/access patterns; moderate-high on fertility and infant-mortality associations; moderate/low-to-moderate on newer maternal-mortality estimates because follow-up is short and estimates are heterogeneous. [E1-E8]

1. What "Restricted" and "Broadly Protected" Mean in This Audit

Real U.S. policies form a spectrum; this report does not reduce them to a binary moral label.

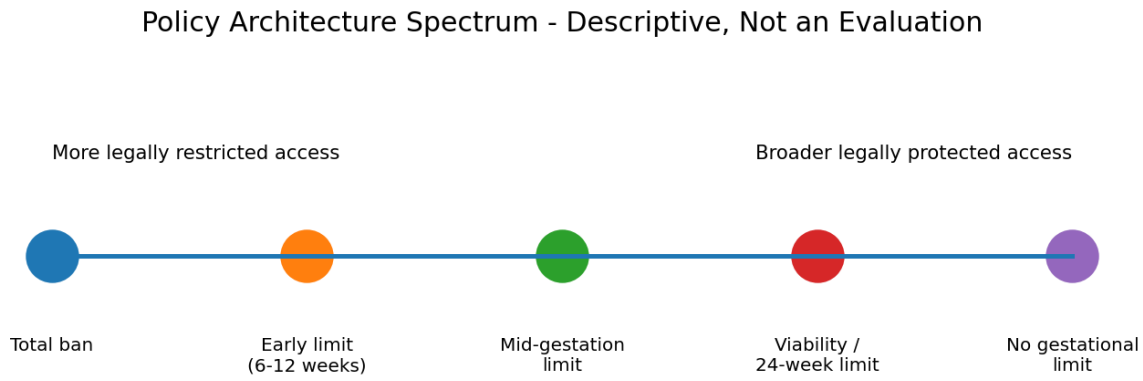

Figure 1. Descriptive policy spectrum. It does not rank or endorse any policy.

Restricted-access archetype

For comparison, the restrictive archetype means a total ban or an early gestational limit (for example, 6 or 12 weeks), with enumerated exceptions that may include life, physical health, rape/incest, or lethal fetal anomaly. Real-state exception wording and availability vary. [E1-E2]

Broadly protected-access archetype

The broad-access archetype means no gestational-duration ban or a limit at/near viability or around 24 weeks, generally with later-pregnancy health/life exceptions where a gestational limit exists. "No gestational-duration ban" is not equivalent to absence of medical, licensing, insurance, or other regulation. [E1-E2]

Why this distinction matters

Calling one side "unrestricted" can hide the regulatory structure that remains in broad-access states. Calling the other side simply "pro-life" can hide variation in exceptions, enforcement, and gestational timing. The audit therefore uses policy mechanics rather than campaign labels.

Legal boundary

This is general policy analysis, not legal advice. State law and litigation change quickly; the legal snapshot is dated and should be re-verified for any real decision. [E1-E2]

> **No verdict rule:** Because abortion is a contested political and moral question, the report compares documented effects and conditional implications without selecting a "better" policy.

2. Current U.S. Legal Landscape - September 2026

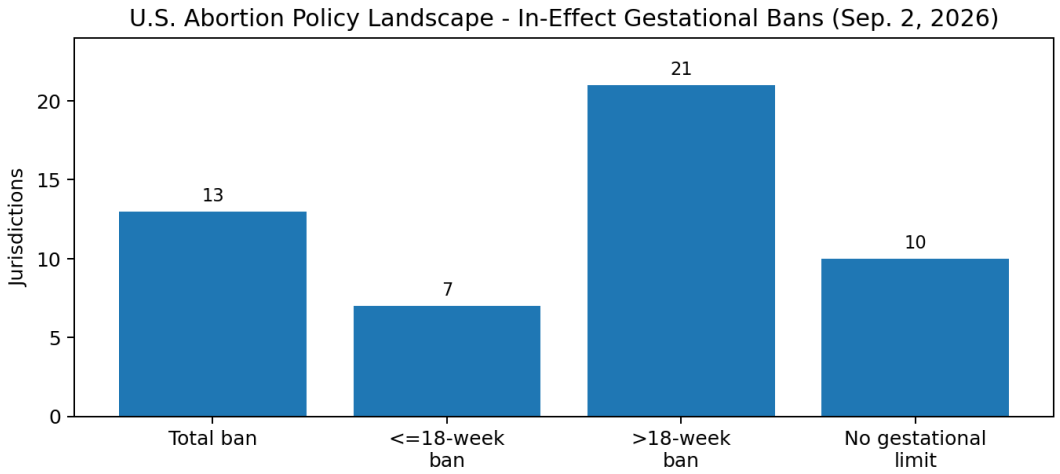

Figure 2. Counts are from Guttmacher's September 2, 2026 state-law table: 13 total bans, 7 gestational bans at or before 18 weeks, 21 bans after 18 weeks, and 9 states plus DC with no gestational-duration ban. [E1]

Guttmacher's September 2, 2026 tracker reports 41 states with some gestational abortion ban in effect: 13 total bans and 28 gestational-duration bans. Nine states plus DC had no gestational-duration ban. [E1] KFF's August 10, 2026 dashboard similarly identified 13 states with total bans, 7 states with 6-12 week limits, 4 states with 15-22 week limits, 18 states with limits at or near viability, and 9 states plus DC with no gestational limit. [E2]

Exceptions are part of the policy, not a footnote

KFF reported in April 2026 that among states with bans or early gestational limits, exception structures differed substantially: some lacked a health exception, some lacked rape/incest exceptions, and some lacked fatal-fetal-anomaly exceptions. [E2] Guttmacher's September tracker likewise shows variation in life, health, rape, incest, and lethal-fetal-anomaly exceptions. [E1]

Audit implication: A national comparison that says only "ban" versus "legal" can miss clinically important differences in timing, exceptions, telehealth, insurance, provider rules, and litigation.

3. Stakeholder and Systemic-Transfer Map

The map identifies where legal rules move burdens and claimed protections. It does not determine whose moral claim prevails.

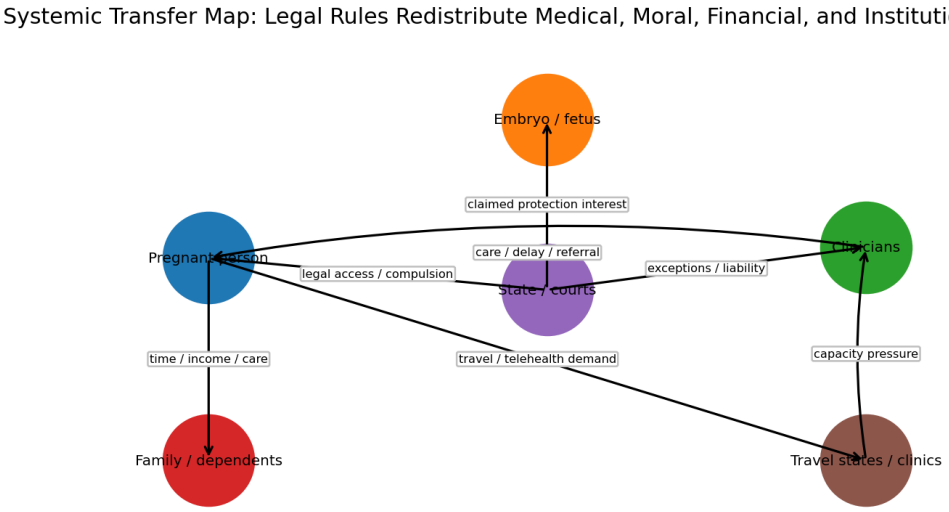

Figure 3. Functional transfer map; arrows describe policy pathways, not intent or blame.

Pathway	What can move	Evidence / uncertainty
State rule -> pregnant person	Access, compelled continuation, travel, legal uncertainty, time and financial cost	Travel and fertility effects documented; individual impact varies. [E3-E5]
State rule -> embryo/fetus	Probability that pregnancy continues to live birth	Birth increases associated with bans are documented; moral status remains contested. [E5,S2]
State rule -> clinicians	Exception interpretation, legal risk, gatekeeping burden	Qualitative multi-state evidence documents delays, fear, and new gatekeeping roles. [E9]
Pregnant person -> family/ dependents	Caregiving, income, household resources	Longitudinal denial evidence documents sustained financial distress. [E10]
Restricted state -> travel state/clinic	Patient travel and provider capacity demand	More than 140,000 people crossed state lines for care in 2025; 98,000 traveled from total/6/12-week-ban states. [E3]
Broad-access state -> moral communities	Moral distress where abortion is viewed as killing a rights-bearing human	Moral claim; empirical magnitude not established nationally. [S2]

Transfer rule: In Sufferless doctrine, a benefit for one group cannot simply be averaged against a severe or irreversible burden on another. In this political audit, the rule is used to expose tradeoffs, not to compute a policy score. [S1-S3]

4. Shared Empirical Layer: What the Evidence Can and Cannot Settle

Question	Evidence-supported direction	Confidence / limitation
Do bans reduce in-state abortion provision?	Yes, especially total and early bans; access shifts to travel, telehealth, or other pathways. [E3-E4]	High directionally; complete counts remain imperfect.
Do bans eliminate abortion nationally?	No. National formal-system abortion volume remained high in 2025, with telehealth/shield-law provision expanding. [E4]	High for formal-system trends; outside-system abortions are incompletely measured.
Do bans increase births?	Complete/6-week bans were associated with an estimated 1.70% fertility increase above expectation in a 2025 JAMA analysis. [E5]	Moderate-high; model-based observational counterfactual.
Do bans affect infant mortality?	A 2025 JAMA study found 5.60% higher-than-expected infant mortality after bans, with larger increases in some already high-mortality groups. [E6]	Moderate-high; observational model, Texas influential.
Do bans increase maternal/pregnancy-associated mortality?	Evidence through 2023 is mixed and imprecise: one 2026 JAMA Network Open analysis found no statistically significant increase; another 2026 AJPH analysis found suggestive increases with intervals crossing zero. [E7-E8]	Moderate/low-to-moderate; short post-ban window and rare outcomes.
Do restrictions affect clinical decision-making beyond elective abortion?	2026 qualitative evidence from physicians in total-ban states describes delays, legal fear, loss of shared decision-making, and new gatekeeping roles in pregnancy-related care. [E9]	Moderate for existence/mechanisms; qualitative, not population effect size.
Does denial of a wanted abortion affect finances?	Turnaway-linked economic research found sustained increases in financial distress after denial. [E10]	Moderate-high for the studied population; pre-Dobbs cohort.
Is abortion itself medically risk-free?	No medical procedure is risk-free. A National Academies consensus review concluded U.S. abortion methods are safe and effective and serious complications are rare, with risk increasing later in gestation. [E11]	High for clinical safety evidence reviewed through 2018; techniques/guidelines continue to evolve.

Evidence cannot settle: when moral personhood begins, how fetal moral status changes with gestation, or how competing rights should be weighted. Those are value premises, not findings that can be read directly from epidemiology.

5. Access, Travel, Telehealth, and Birth Effects

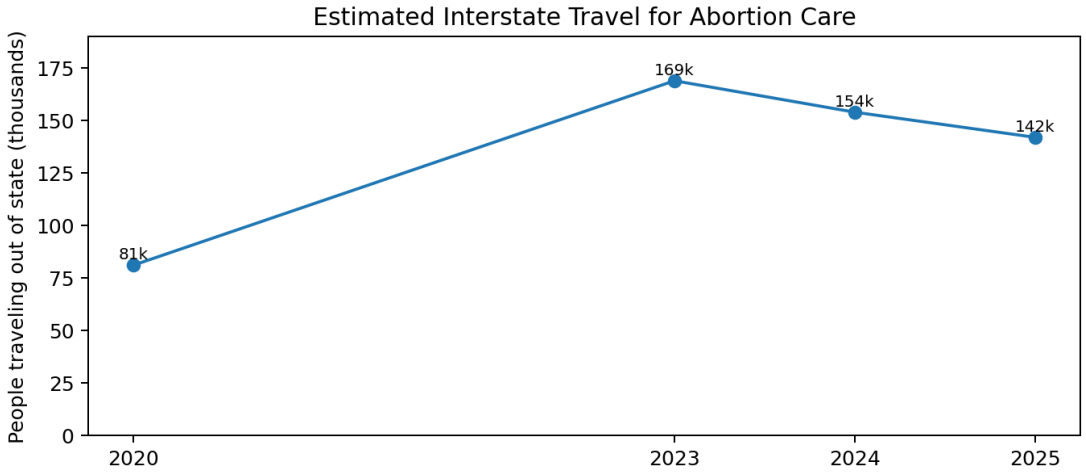

Figure 4. Guttmacher estimates: roughly 81,000 out-of-state abortion patients in 2020, 169,000 in 2023, 154,000 in 2024, and 142,000 in 2025. [E3]

In 2025, more than 140,000 people crossed state lines to obtain abortion care, and about 98,000 of those travelers came from states with total, 6-week, or 12-week bans. Travel declined from the 2023 peak as telehealth access increased, but remained well above the pre-Dobbs 2020 level. [E3]

Society of Family Planning's #WeCount reported about 1.13 million abortions in the formal U.S. health-care system in 2025, with telehealth accounting for a growing share and shield-law provision increasing. The project notes that its counts do not capture all abortions outside the formal system and that imputation increased in 2025. [E4]

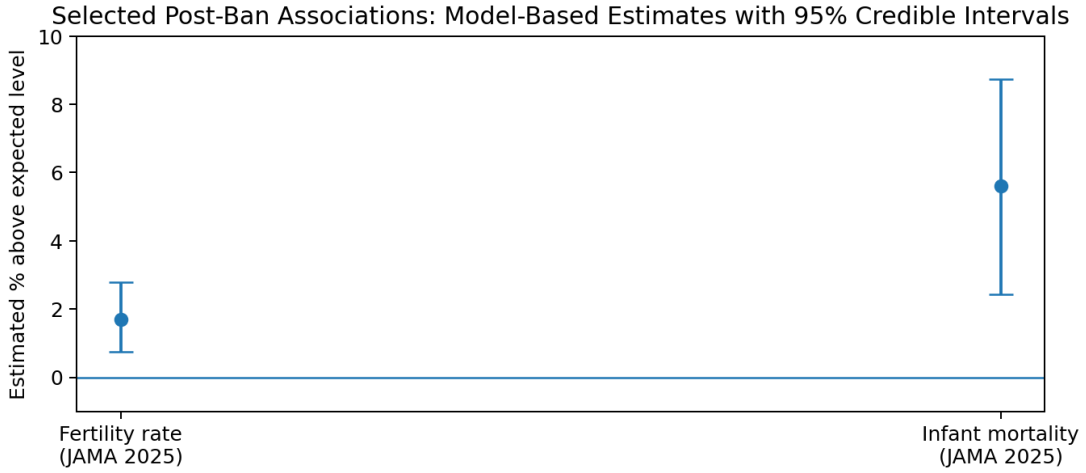

Figure 5. Model-based associations from separate JAMA studies: fertility +1.70% above expected after complete/6-week bans; infant mortality +5.60% above expected after bans. Error bars show reported 95% credible intervals. [E5-E6]

Distributional finding: the JAMA fertility analysis found larger estimated birth increases among some groups facing structural disadvantages, including Medicaid beneficiaries, people without college degrees, unmarried people, younger people, and several racially minoritized groups. [E5] This does not establish the moral meaning of those births; it identifies where policy effects were concentrated.

6. Pregnancy, Maternal, and Infant Health: Stronger Findings and Open Questions

Infant mortality

A 2025 JAMA analysis using 2012-2023 national vital statistics found infant mortality in states after abortion bans was 6.26 observed versus 5.93 expected per 1,000 live births, a 5.60% relative increase. Estimated increases were larger among Black infants, infants with congenital anomalies, and southern states; Texas had a dominant influence on the overall estimate. [E6]

Maternal and pregnancy-associated mortality

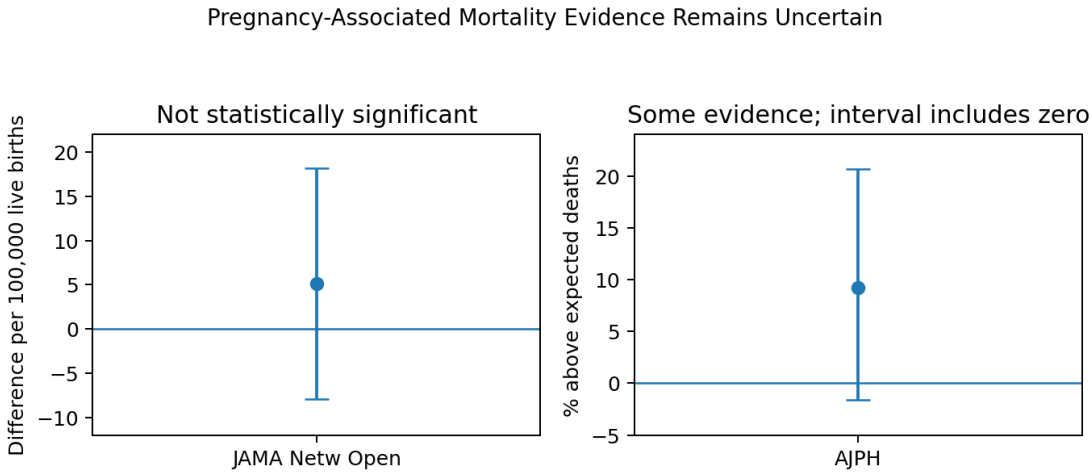

Figure 6. Two 2026 studies illustrate the current uncertainty. Units differ between panels; each is shown against its own null. [E7-E8]

A JAMA Network Open 2026 synthetic-control study found an estimated difference of 5.1 pregnancy-associated deaths per 100,000 live births (95% CI -7.9 to 18.2), which was not statistically significant; pregnancy-related and maternal mortality estimates were also not statistically significant. The authors emphasized the short post-ban observation window and wide intervals. [E7]

An AJPH 2026 Bayesian panel analysis reported some evidence of a 9.2% increase in pregnancy-associated deaths above expectation in 14 ban states, but the 95% credible interval ranged from -1.6% to 20.7%, and no detectable increase in maternal mortality was found. The authors emphasized measurement limitations and chance variation in rare outcomes. [E8]

Even-handedness check: It would be inaccurate to state either that post-Dobbs bans have definitively increased maternal mortality nationwide or that they have definitively had no mortality effect. The current direct post-Dobbs evidence remains uncertain.

7. Economic, Family, and Time Burdens

A linked credit-record analysis based on the Turnaway Study compared people who sought abortions just above versus just below clinic gestational limits. Those denied a wanted abortion experienced a large increase in financial distress that persisted for several years. The published version appeared in the American Economic Journal: Economic Policy. [E10]

Burden pathway	Restricted-access mechanism	Broad-access mechanism / countervailing issue
Travel and time	More travel, lodging, time off, childcare, and delayed care when local access is unavailable. [E3]	Lower geographic barrier where providers exist; later care can still require travel or specialist capacity.
Household finances	Denial may lead to pregnancy, birth, and long-run household financial consequences in some cases. [E10]	Abortion itself can carry cost; broader access does not substitute for childcare, housing, health coverage, or paid leave.
Existing children	Additional caregiving demands can affect household capacity.	Termination can also involve grief or moral conflict for some families; magnitude is heterogeneous.
Partner / family dynamics	Continuation can increase dependency or conflict in some circumstances; may also align with family values.	Access can preserve options but can also create disagreement within families or communities.
Future reproductive planning	Restrictions reduce option set after conception.	Broader access increases option set; this does not answer the fetal-status question.

What the evidence does not justify

The economic evidence does not show that every person denied an abortion will experience poverty, nor that every abortion improves economic outcomes. It supports a population-level causal/near-causal signal in a specific study design and cohort. [E10]

Sufferless reading: Economic hardship is a capacity variable, not a measure of the moral worth of a pregnancy, birth, parent, or child. It should not be used to imply that poor people are better off not having children.

8. Clinicians, Emergency Care, and Exception Design

A 2026 qualitative study of 40 physicians across 9 total-ban states reported six recurring themes: delays/deviations in care for pregnancy-related conditions, ambiguity and fear, loss of patient autonomy/shared decision-making, erosion of trust, new clinician gatekeeping roles, and increased health-system burdens. Participants described additional testing and institutional approvals in some time-sensitive situations. [E9]

Separate 2026 emergency-medicine research in Indiana described legal uncertainty affecting documentation, history-taking, referral, and reliance on OB specialists; these studies are qualitative/observational and should not be treated as national effect-size estimates. [E9]

Policy design issue	Restricted-access implementation question	Broad-access implementation question
Life/health exception	How clear is the threshold? Must deterioration occur before care qualifies? Who bears legal risk?	How are later-pregnancy health decisions defined and documented?
Rape/incest exception	Is reporting required? Is the gestational window usable in practice?	What support and privacy protections exist for survivors?
Fetal anomaly	Which diagnoses qualify and when are they detectable?	What counseling, perinatal palliative care, and continuation support exist?
Clinician conscience	Can clinicians decline participation while preserving lawful patient access?	How are conscience and referral duties balanced under applicable law?
Emergency care	Are standards clear enough to avoid harmful delay?	Are emergency and specialist services available in practice, not just legally?

Policy-neutral mitigation principle: Whatever substantive rule is chosen, ambiguity around emergency care and clinician obligations can itself create avoidable stress and delay. Clear rules, due process, and accountable clinical/legal review reduce that implementation uncertainty without resolving the abortion debate.

9. Contested-Value Protocol: The Premise the Evidence Cannot Resolve

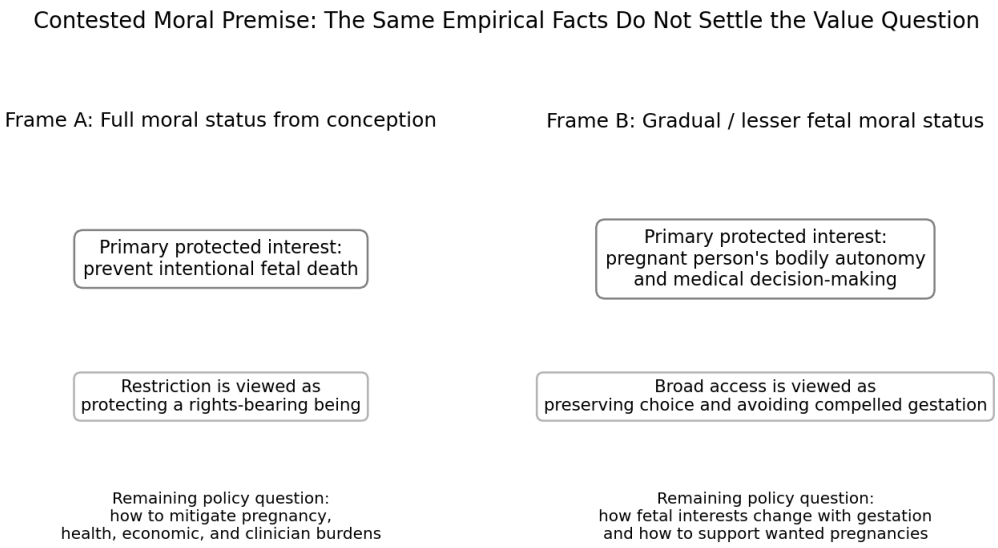

Figure 7. Contested-frame graph. Both panels share the same empirical layer; they differ in the moral premise. The figure is assumption-based and intentionally non-scalar. [S1-S3]

Frame A - full moral status from conception

If an embryo/fetus has the same basic moral status as a born person from conception, abortion is interpreted as an irreversible harm to a rights-bearing human. Under this premise, restrictions are understood as protecting that life, and empirical burdens on pregnant people, families, and clinicians become mitigation problems rather than decisive reasons for broad access. This is a moral premise, not an empirical finding. [S2]

Frame B - gradual or lesser fetal moral status, with strong bodily autonomy

If fetal moral status is gradual, limited, or outweighed before some developmental threshold by the pregnant person's bodily autonomy and medical liberty, compelled continuation of pregnancy becomes the central rights burden. Under this premise, broad access is understood as protecting agency and reducing health, travel, and economic burdens, while fetal interests may gain weight later in gestation. This is also a moral premise, not an empirical finding. [S2]

Shared factual layer

Both frames must still confront the same evidence on birth effects, infant outcomes, travel, economic burden, medical safety, clinical delay, and uncertainty. Neither frame is entitled to invent or suppress empirical evidence because it is morally inconvenient. [S1-S3]

10. Conditional Implications Under Each Moral Frame

This section does not select a frame. It shows how the policy reasoning changes when the disputed premise changes.

Policy question	If Frame A is accepted	If Frame B is accepted	Shared implementation constraint
Early abortion	Preventing abortion carries very high moral weight because fetal death is treated as rights violation.	Pregnant person's autonomy carries greater weight; early fetal interests may not justify compelled gestation.	Accurate information, noncoercion, emergency safety, privacy.
Later abortion	Same core moral status; some may see gestational age as irrelevant to personhood.	Fetal interests may increase with development/viability, allowing stronger later constraints depending on the value theory.	Clinical clarity for maternal/fetal indications; specialist availability.
Exceptions	Exceptions represent conflicts among rights and may be morally difficult under full-status premise.	Exceptions may be viewed as minimum protections rather than sufficient autonomy.	Clear, usable rules; no avoidable emergency delay.
Economic burden	Does not negate fetal rights but strengthens case for social support.	Adds to reasons against compelled continuation and for access.	Maternal care, childcare, housing, income and family supports can reduce burden across frames.
Conscience	Clinician moral objection may receive strong weight.	Patient access and professional duty may receive stronger weight.	Transparent accommodation process consistent with law and emergency obligations.

Over-trigger guard

Contested-value analysis should not become an excuse for saying "nothing can be concluded." Several empirical conclusions are sufficiently supported to inform policy design even though the moral verdict remains contested: bans change access pathways, increase births above expected levels, increase interstate travel burden, and affect clinical practice; infant-mortality evidence is concerning; direct maternal-mortality evidence is not yet conclusive. [E3-E9]

11. Policy Architecture Comparison - Descriptive, Not Ranked

Architecture	Claimed objective	Documented / plausible burdens	Key uncertainty
Total ban with narrow exceptions	Maximize legal protection of fetal life under an early/full-status premise	Travel/telehealth substitution, more births, economic/clinical burdens, exception ambiguity; fetus more likely to continue to birth. [E3-E10]	Actual access under exceptions; maternal outcomes; cross-border enforcement effects
6-12 week limit	Protect fetal life after early gestational point while retaining a short access window	Many pregnancies are not recognized early enough for practical access; travel and timing pressure can remain. [E1-E3]	How many people can realistically use the legal window; exception operation
Mid-gestation limit	Permit more early access while restricting later care	Less early travel burden than earlier limits; later diagnoses/ changed circumstances may be affected	Clinical effect depends on exact gestational threshold and exceptions
Viability / ~24-week framework	Broad early access with later gestational constraint	Later-pregnancy cases require health/life exception design and specialist capacity	Viability is case-specific and medically/ contextually variable [E1-E2]
No gestational-duration ban	Maximize legal discretion for patient/ clinician under other medical law/ regulation	Moral objection may be highest for those assigning full fetal status; access still depends on provider/cost/geography	Actual practice patterns, later-care availability, non-gestational regulations

No criteria-specific winner: The table is intentionally descriptive. Choosing among these architectures requires a value judgment about fetal moral status, bodily autonomy, state authority, and acceptable uncertainty that this audit does not make.

12. Cross-Frame Harm-Reduction Levers and Decision Process

These are not endorsements of a substantive abortion rule. They are design levers that can be evaluated under multiple value frames.

Lever	Potential burden reduced	Value-frame relevance
Effective contraception and pregnancy-prevention access	Unintended pregnancy and need for later conflict/decision	Can reduce abortions and unintended births; compatible with many, though not all, moral views.
Prenatal, maternal, and emergency-care capacity	Health risk when pregnancy continues	Relevant under all frames.
Childcare, paid leave, income/housing supports	Economic and caregiving overload	Especially relevant if policy increases births; also supports freely chosen parenting.
Intimate-partner-violence prevention and survivor support	Pregnancy under coercion; safety risk	Relevant regardless of abortion position.
Clear emergency/health exception rules where restrictions exist	Clinical delay and legal ambiguity	Mitigation within restrictive architectures. [E9]
Privacy and due-process protections	Surveillance, fear, wrongful investigation, clinician uncertainty	Relevant whenever enforcement or cross-state data are implicated.
Perinatal palliative care / fetal-anomaly support	Grief, complex fetal diagnosis, family distress	Relevant whether pregnancy is continued or terminated.
Non-directive, confidential counseling	Decision conflict, coercion, moral distress	Should preserve informed choice within applicable law.

Neutral decision process

1. State the moral premise explicitly rather than hiding it inside medical or legal language.
2. Separate factual claims from value claims and grade evidence quality.
3. Map burdens on pregnant people, fetal life under the chosen premise, existing children, clinicians, and low-resource groups.
4. Test exceptions and enforcement in real-world scenarios, not only statutory text.
5. Publish uncertainty, subgroup effects, and unintended transfers.
6. Revisit policy when new evidence or implementation failures emerge.

Process principles derived from Sufferless Part V / contested-value doctrine [S1-S3]; substantive policy choice remains with legitimate human institutions and citizens.

13. Monitoring, Integrity Pass, and Red-Team Review

Monitoring dashboard

Domain	What to monitor	Why
Access	In-state provision, travel, telehealth, wait time, gestational age at care	Shows whether legal rules shift rather than eliminate demand. [E3-E4]
Births	Fertility and live-birth changes by subgroup	Captures downstream continuation effects. [E5]
Infant health	Infant mortality and cause/subgroup patterns	Tracks downstream infant outcomes. [E6]
Maternal health	Maternal, pregnancy-related, pregnancy-associated mortality and severe morbidity	Evidence is still uncertain and requires longer follow-up. [E7-E8]
Emergency care	Delays, EMTALA-type events, exception approvals, transfers	Tests whether legal ambiguity disrupts care. [E9]
Economic/ family	Financial distress, work, childcare, household resources	Captures burdens not visible in medical data. [E10]
Equity	Income, geography, race/ethnicity, disability, age, rurality	Tests distribution rather than averages.
Moral/pluralism	Conscience conflicts, trust, perceived legitimacy, community distress	Important but difficult to measure without converting beliefs into a score.

Integrity pass

Check	Result
Leading hypothesis	Restrictions likely shift substantial burden onto pregnant people and clinicians while increasing births; broad access shifts the decisive moral burden onto fetal life under full-status premises.
Consider the opposite	Telehealth and travel can blunt restriction effects; some people value birth increases as intended success; broad access may create significant moral injury under certain belief systems.
Disconfirmation search	Included a 2026 JAMA Network Open mortality study finding no statistically significant increase and highlighted uncertainty rather than selecting only harm-confirming studies. [E7]
False-balance check	Empirical claims are weighted by evidence; the moral-status question is treated as genuinely contested.
Pre-mortem	Audit fails if readers mistake evidence labels for moral verdicts or treat one value frame as secretly authoritative.
Reflexivity	Because the Sufferless Manual contains its own abortion discussion, external evidence and platform political neutrality override any tendency to inherit a predetermined policy conclusion. [S1-S3]

Sedation / metric warning: Lower reported distress is not sufficient evidence of improvement if people leave the state, stop seeking formal care, stop reporting, or lose access to a service. Conversely, a higher birth count is not by itself evidence of suffering or welfare; its moral interpretation depends on facts and values not captured by the count.

14. Evidence Appendix, Graph Manifest, Limitations, and Fine Print

ID	Reference	Use
E1	Guttmacher Institute. State Bans on Abortion Throughout Pregnancy. State Laws and Policies, as of Sep. 2, 2026. guttmacher.org/state-policy/explore/state-policies-abortion-bans	Current state policy counts, gestational limits, exception structure.
E2	KFF. Abortion in the United States Dashboard / Exceptions Tracker, updated through Aug. 10 / Apr. 1, 2026. kff.org/womens-health-policy/abortion-in-the-u-s-dashboard/	Independent current policy categorization and exception tracking.
E3	Maddow-Zimet I, Forouzan K. Patterns of Travel for Abortion Care Continued to Shift in 2025. Guttmacher, Jul. 2026.	2025 interstate travel estimates and origin patterns.
E4	Society of Family Planning. #WeCount Report April 2022 through December 2025. Jun. 10, 2026. societyfp.org/research/wecount/wecount-december-2025-data/	Formal-system abortion volume, telehealth and shield-law trends; limitations.
E5	Bell SO, et al. US Abortion Bans and Fertility. JAMA. 2025;333(15):1307-1314. doi:10.1001/jama.2024.28520.	Post-ban fertility estimates and subgroup heterogeneity.
E6	Gemmill A, et al. US Abortion Bans and Infant Mortality. JAMA. 2025;333(15):1315-1323. doi:10.1001/jama.2024.28517.	Infant-mortality association and subgroup estimates.
E7	Abraha HE, et al. US Abortion Bans and Pregnancy-Associated Mortality. JAMA Netw Open. 2026;9(4):e264801. doi:10.1001/jamanetworkopen.2026.4801.	No statistically significant overall/state-specific mortality increase through 2023; short follow-up.
E8	Stuart EA, et al. Abortion Bans and Maternal, Pregnancy-Related, and Pregnancy-Associated Mortality in 14 US States, 2016-2023. Am J Public Health. 2026;116(6):819-828. doi:10.2105/AJPH.2026.308465.	Suggestive pregnancy-associated mortality increase with wide uncertainty; no detectable maternal mortality increase.
E9	Abortion Bans and Pregnancy-Related Care Across Physician Specialties: A Qualitative Study. PubMed PMID 42329649, 2026; plus related 2026 Indiana emergency-care studies.	Clinical delay, legal ambiguity, trust and gatekeeping mechanisms.
E10	Miller S, Wherry LR, Foster DG. The Economic Consequences of Being Denied an Abortion. AEJ: Economic Policy. 2023;15(1):394-437; NBER w26662.	Longitudinal financial consequences of abortion denial.
E11	National Academies of Sciences, Engineering, and Medicine. The Safety and Quality of Abortion Care in the United States. 2018. doi:10.17226/24950.	Consensus review of safety, effectiveness, quality and barriers.
S1	Sufferless AI Runtime Constitution v2.4.1 + Doctrine/Response Patterns v2.4.1.	Tier 2 policy audit, evidence/value separation, floors, transfers.
S2	Sufferless Reference Manual, Part V / abortion discussion.	Sufferless moral-uncertainty and suffering-map source; treated as doctrine, not empirical proof.
S3	Analysis Integrity and Grading v2.4.1 + Graph-Enhanced Report Spec v2.4.	Contested-value protocol, anti-false-balance, graph/report requirements.

Graph artifact manifest

ID	Type	Evidence type	Assumptions / uncertainty	QC
AB-01	Legal landscape	Current fact	Dated Sep. 2, 2026; laws can change	Rendered
AB-02	Interstate travel	Measured/estimated	Guttmacher study estimates; methodology changes over time	Rendered
AB-03	Fertility + infant mortality effects	Model-based observational	Separate JAMA counterfactual models; not randomized	Rendered
AB-04	Mortality uncertainty	Model-based observational	Different units/studies; shown in separate panels	Rendered
AB-05	Transfer map	Illustrative	Pathways, not magnitude or blame	Rendered
AB-06	Contested-frame graph	Assumption-based moral framing	No empirical moral verdict	Rendered
AB-07	Policy spectrum	Descriptive current/policy taxonomy	Not an evaluative scale	Rendered

Update triggers: state-law or court changes; new federal legislation/rule; material post-Dobbs mortality or morbidity studies; changes in telehealth/shield-law practice; updated 2026 abortion/travel data; or major new evidence on exceptions, emergency care, or subgroup effects.

Limitations and fine print. This Sufferless document is a structured reasoning and governance aid, not final moral authority, legal advice, medical advice, political endorsement, psychological advice, emergency support, or a substitute for accountable human and democratic judgment. It depends on current sources, assumptions, evidence quality, stakeholder representation, and moral uncertainty. Political choices are intentionally not scored or ranked. The report does not determine when personhood begins or which rights should prevail. Current law can change rapidly. Observational policy studies are vulnerable to residual confounding, model dependence, short follow-up, spillovers across states, and measurement limitations. Missing facts, unrepresented people, hidden transfers, or new evidence may change the analysis.