Clinical considerations for management of severe complications when abortion care is restricted

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The Society for Maternal-Fetal Medicine (SMFM)

The Society of Family Planning endorses this document.

The highly politicized nature of abortion care in this country can make it difficult for institutions and obstetric providers to thoughtfully remark upon and plan for policy decisions that impact patient care. Individuals at high risk for pregnancy mortality and morbidity have unique needs for reproductive health services, including abortion care. Variations in state and institutional policies make it impossible to provide overarching, proscriptive guidance for specific clinical scenarios. However, below are suggested frameworks for discussion at the practice, institutional, and/or regional levels that can assist members in preparing to respond to clinical scenarios in restrictive environments. As more is learned about the impact of these medically inappropriate abortion restrictions on clinical care, this document will be periodically reviewed and updated. Please forward any suggestions to consider for inclusion and further case studies to: pubs@smfm.org or RHProject@smfm.org.

Background

The legal restrictions on abortion care that now exist in many states have made it challenging for members and institutions to implement evidence-based clinical guidelines in these restrictive environments. These restrictions have created a climate of fear for both clinicians and patients who are concerned that medically appropriate care will be unavailable or illegal. The chaos introduced into medical decision making by non-evidence-based and clinically ambiguous legal restrictions, ongoing litigation and any subsequent litigation poses an enormous burden to the risk assessment, counseling, and care of individuals at high risk for pregnancy mortality and morbidity and will ultimately result in increased rates of both short- and long-term morbidity and mortality. For example, in Texas, since the enactment of restrictions on medical care via Senate Bills 8 and 4 in September 2021, state-mandated expectant management of periviable PPROM resulted in morbidity for the majority of pregnant patients (57%). This rate of maternal morbidity is higher than the rate observed in published cohorts of patients electing immediate pregnancy interruption under similar clinical circumstances in states without restrictive legislation (33%).

Furthermore, fetal outcomes in Texas were poor, with 27 of 28 patients (96%) in this series having a stillbirth or neonatal death. Therefore, this early evidence from a state restricting abortion suggests significant risks of severe maternal morbidity without improvements in fetal or neonatal outcomes. There is also evidence to suggest that health systems and clinicians caring for patients with complex pregnancies will have diverse interpretations of the laws' narrow exemptions, ultimately resulting in inequitable access to care.

Collaboration and Communication Can Improve Clinical Care

Under these circumstances, it is difficult for national organizations to create evidence-based approaches universally responsive to situations impacted by state-specific restrictions and the needs of individual institutions, clinicians, and patients. However, local efforts may improve care. Anecdotally, an effective approach has been to convene discussions at the institutional, community, state and/or regional level to determine consensus regarding levels of acceptable risk, including discussions about required, ethical abortion care. **Communication and consensus- building at the institutional, community, and/or state level are essential and can result in a shared understanding of relevant laws and regulations and reduce variations in clinical care.** A common understanding of general clinical scenarios that require engagement of available exceptions where abortion care is banned can improve confidence within this chaotic environment. MFM subspecialists can play an important role due to their experience with patients with severe obstetric complications and should be included in communications and collaborations. MFM subspecialists in leadership positions within institutions should consider initiating such consensus-building in an effort to minimize the impact of these inappropriate restrictions on patient care and outcomes. Ultimately, each pregnancy is unique and requires access to individualized care where decisions should be made between the patient and clinician. However, advanced planning and discussion may provide a framework for clinicians to approach care in a more confident manner.

Institutional and Regional Approach

Multidisciplinary communication within an institution or health system and region is central to ensuring a shared understanding of relevant laws and regulations. Consensus in interpretation of the law will facilitate the development of guidelines and clinical pathways for healthcare providers who may be directly impacted by abortion restrictions (obstetrics/gynecology, emergency medicine, family medicine). Engaging and partnering with other regional institutions on the interpretation of state law and the implications for clinical practice should enhance consistency in practice and minimize variation (which may reduce legal risk) and may mitigate some concerns from providers regarding the boundaries of legal clinical management. In addition, developing a process for the inevitable unpredictable challenging clinical scenario should also be a collaborative effort. Ideally, these discussions should include representation from relevant leadership within an institution, including medical, legal, and administrative.

As an institutional approach is developed, engagement of and communication to the full clinical team is necessary. Optimal management of severe complex obstetric complications frequently involves a multidisciplinary care team that includes an obstetrician/gynecologist and MFM when available. Therefore, shared communication is key among all members of the care team,

including with other specialties such as critical care, emergency medicine, genetic counseling, and family planning.

Engaging and partnering with other institutions in the region or state to build consensus on interpretation of the local law and the implications and approaches for clinical practice will work towards minimizing variation in interpretation and the impact on practice.

The following list contains examples and suggestions for MFMs in restrictive states to assist in building partnerships, achieving consensus, and advocating at the institutional level to improve access to reproductive healthcare:

- Develop legal partnerships and collaborations, including discussions and engagement between the legal counsels of various hospitals and institutions and with non-hospital legal expertise and reproductive health legal experts.
- Work to build referral partnerships with colleagues in neighboring states and within the region.
- Work to develop an online provider toolkit to centralize relevant clinical, legal, and educational information that can be updated regularly, if possible.
- Advocate within institution to remove barriers to legal reproductive healthcare.
- Advocate and work to eliminate institutional policies on abortion that are stricter than state law.
- Work to expand access to abortion care where able, including medication abortion.
- Work to eliminate barriers to contraception and sterilization.
- Create an institutional Task Force to address relevant adjacent clinical needs: contraception, management of early pregnancy loss, pharmacy needs and issues, resident/fellow/student education and training needs.
- Engage with institutional legal teams to apply the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) locally.

Counseling and Assessing Risk with the Pregnant Patient

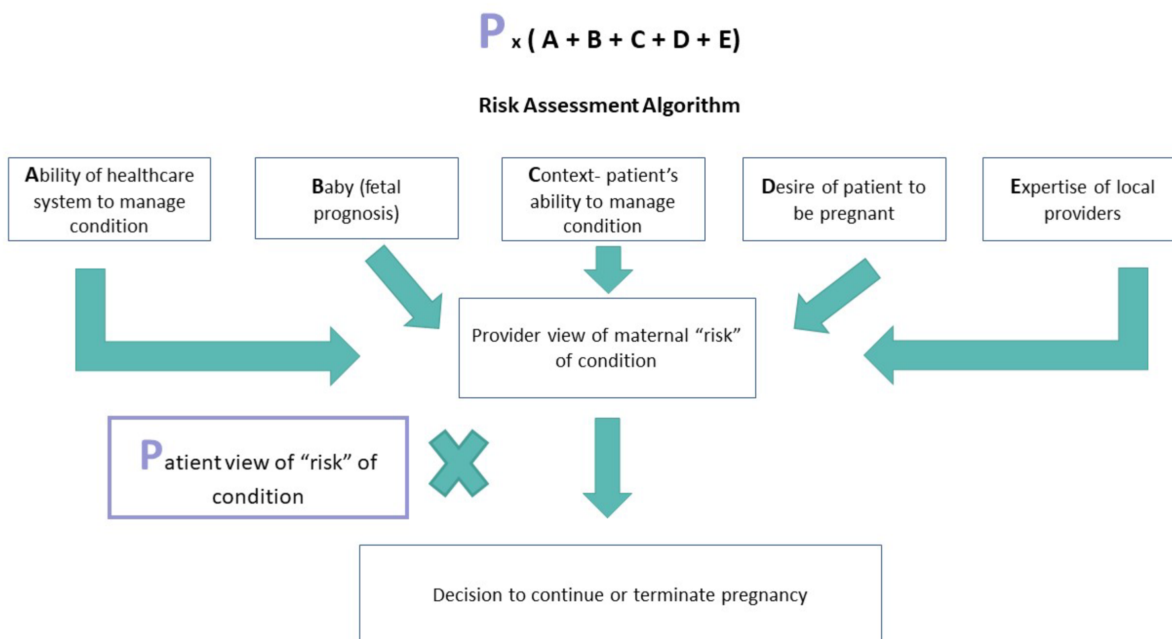
SMFM recommends that during preconception, prenatal, or postpartum counseling, individuals who have an increased risk of medical complications during pregnancy should be provided with accurate, evidence-based information about the risks and all treatment alternatives when considering options for pregnancy management. This counseling should employ strategies that incorporate informed patient preferences in a shared decision-making process between the patient and provider. These aspects of risk assessment and counseling have an important role in optimizing care and reducing pregnancy mortality and morbidity. MFM subspecialists are often the primary providers in the care and management of a high-risk pregnancy and assessing and counseling about the options for pregnancy management. Counseling regarding abortion should be included in options for pregnancy management.

Pregnancy carries a risk of severe morbidity or mortality for all pregnant people, and published data demonstrates that pregnancy continuation poses more risk than abortion. While some individuals may be identified as “high risk” for adverse maternal outcomes based on underlying medical, social, and contextual factors, risk may change or evolve during pregnancy and the

postpartum period such that those with and without underlying conditions or risk factors can develop complications resulting in morbidity or mortality. A high-risk pregnancy can be defined as one that places the pregnant person, fetus, or infant at increased risk for death or residual injury and typically requires additional resources, procedures, or specialized care to optimize outcomes. Because of the number of physiological changes that occur during pregnancy, many conditions have the potential to increase risk of experiencing morbidity during pregnancy and after labor and delivery. Examples of conditions experienced by pregnant people that can result in a high-risk pregnancy include cancer, diabetes, cardiovascular disease, and hypertension. Examples of fetal conditions that can result in a high-risk pregnancy include fetal growth restriction, fetal anomalies, and infections. These examples are not comprehensive of all health conditions that might elevate risk.

Risk assessment should incorporate a patient-centered approach that validates and supports the patient's view and tolerance of risk. The following risk assessment algorithm was proposed by SMFM to facilitate the comprehensive evaluation of both medical and contextual factors (Figure 1). The "C=Context" was intended to encompass patient factors impacting care, including the current state of chronic diseases and potential impediments to care such as insurance, transportation or language or tother access barriers. The risk assessment should incorporate the patient's ("P") own tolerance or view of this risk to help with decision-making.

Figure 1. Maternal Risk Assessment Algorithm.



Society for Maternal-Fetal Medicine. SMFM Consult Series #54: Assessing the risk of maternal morbidity and mortality. Am J Obstet Gynecol 2021.

Assessing Risks to Maternal Well-Being When Fetal Anomalies are Diagnosed

Abortion care is one of several options that should be offered to patients in the setting of an unexpected prenatal diagnosis. Marked variation exists in prenatally diagnosed conditions from those that are incompatible with long-term post-natal survival, to those that may be survivable but will result in serious and lifelong implications, to those that are mild or amenable to successful treatment. When a fetal diagnosis is such that long-term survival is not possible, it should be made clear to patients that gestational age at delivery will have no impact on neonatal outcome and continued pregnancy will increase maternal risk. Clinicians are ethically bound to provide accurate prognostic information, discuss both pregnancy termination and continuation, and assist families in making treatment plans that align with the goals and values of the pregnant individual. The clinical team should support and assist the patient in meeting their treatment goals.

Assessing maternal risk when a fetus has an anomaly is challenging. In these situations, providers should balance the risks to the pregnant individual with risks and benefits to the fetus, while maintaining the autonomy of the pregnant person as the primary decision maker. Ethical criteria that healthcare practitioners may consider when assessing the risks of expectant management, fetal surgery, or termination of pregnancy include the following: (1) the proposed fetal intervention (or lack of intervention) is reliably expected either to be lifesaving or to prevent serious and irreversible disease, injury, or disability for the fetus; (2) the proposed intervention (or lack thereof) involves the least risk of morbidity and mortality to the fetus; and (3) the risk of mortality, disease, injury, or disability to the pregnant person, including for future pregnancies, is reliably expected to be low or manageable.

Discussion regarding treatment options available to patients should be informed by evidence and treatment decisions should be driven by the values and desires of patients and involved family members. Restrictions and arbitrary timelines imposed by elected officials and/or the judiciary have no place in the process. The collaborative efforts described above can help clinicians and patients understand what restrictions and institutional guidance may impact treatment options. See other counseling resources below.

Transfer and Referral

Access to abortion care may require referral and transfer/transport services. Some proposed and enacted state policies may restrict such counseling and referral practices. Pre-transport services may include ultrasound, blood work, and pre-consultation to ensure that patients with underlying illnesses can be safely transported and receive immediate care upon arrival to the receiving facility.

In 1986, the U.S. enacted EMTALA, a law specifying how Medicare-participating hospitals with emergency services must handle individuals with emergency medical conditions or who are in

labor. The US Department of Health and Human Services (HHS) has issued guidance to clarify that such emergency medical care afforded under EMTALA includes abortion services.

Further Research Needs

- Impact of abortion restrictions on patient volume and transport to states without restrictions.
- Impact of abortion restrictions on outcomes for patients with severe obstetric complications.
- Impact of abortion regulations and restrictions on maternal morbidity and mortality, fetal mortality, and infant mortality.

Counseling Resources

Please refer to resources provided locally by your practice, institution, or hospital. Also consider the following resources:

Referrals
Abortion Care Network
Abortion Finder
ACOG Resource Digest: Information for Patients Seeking Abortion Care
All-Options Talkline
I Need an A
Later Abortion Initiative
Later Abortion Initiative: referral for abortion care after 24 weeks
National Abortion Federation hotline
National Network of Abortion Funds
Planned Parenthood Federation of America

Toolkit
Provide Abortion Referrals Tool

State Law Trackers
Center for Reproductive Rights Map: After Roe Fell?
Guttmacher Institute Interactive Map: US Abortion Policies and Access After Roe
New York Times: Tracking the States Where Abortion is Banned

Disclaimer:

This information is designed as a resource to aid SMFM members in providing care, and use of this information is truly voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient or limitations of available resources.

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