The Challenge of Emergency Abortion Care Following the Dobbs Ruling

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A central tenet of critical care medicine is that early intervention reduces morbidity and mortality, as exemplified by the “golden hour” of trauma care, antibiotic administration within 1 hour of presentation for sepsis, or a door-to-balloon time of less than 90 minutes for myocardial infarction. Every hour of delayed care substantially increases a patient’s risk of adverse outcomes or death. Until recently, the same principle was applied to treating pregnant individuals who needed emergency termination of pregnancy. Some clinical conditions that may require emergency abortion services include sepsis from intrauterine sources, hypertensive disorders of pregnancy before fetal viability, and obstetric hemorrhage before fetal viability.

Following the Dobbs v Jackson Women’s Health Organization ruling by the US Supreme Court on June 24, 2022, provision of evidence-based emergency abortion care became legally complicated. The ruling revoked the constitutional right to abortion, even in life-threatening medical emergencies. The states now have legislative control of abortion. However, within the next year, nearly half of US states are expected to ban or restrict access to abortion, and not all states are known as the Texas Heartbeat Act, prohibits abortion after approximately 6 weeks of gestation with an exception for medical emergencies. However, since this law was enacted in September 2021, physicians have reported that abortions deemed necessary to protect the health or life of the mother (hereafter referred to as “emergency abortions”) are often delayed until pregnant patients are in extremis. Some women with high-risk infectious complications of pregnancy reportedly have been sent home and developed sepsis before abortions were deemed legally permissible, and some hospitals have stopped offering timely, evidence-based abortions for certain types of ectopic pregnancies.

“Emergency” exists on a continuum, and prevention of anticipated critical events is not explicitly addressed. It is no longer clear whether physicians can intervene to prevent progression to critical scenarios, as is the standard in critical care medicine, or instead, if a physician must withhold evidence-based care until a patient develops an unambiguous emergency with significantly increased morbidity and mortality, such as septic shock and multisystem organ failure. Many pregnant individuals are young and healthy; thus, they are able to compensate for severe physiologic derangements and might not appear ill until very late in their course of critical illness. However, withholding evidence-based care to have clear documentation of an unambiguous threat to life is dangerous. Between 2% and 14% of critically ill patients (all patients, including men and women) die in the hospital, and each hour of delayed care increases a patient’s likelihood of dying by approximately 4%. Therefore, the longer emergency abortions are delayed, the greater the risk that lifesaving interventions might not be effective and pregnant individuals could experience morbidity and mortality.

The key barrier to timely, evidence-based emergency abortion care is that the patient-physician relationship has an unwelcome third party and has become the patient-physician-lawmaker relationship. Now, physicians must weigh an intolerable trade-off between the medical risk to pregnant patients and the legal risk to themselves. Offering evidence-based abortion care in anticipation of an emergency prioritizes a patient’s safety but risks criminal litigation in states with restrictive abortion laws. On the other hand, waiting to offer an abortion until a related medical emergency occurs increases health risks for the patient and exposes the physician and hospital to civil monetary penalties for violating the federal EMTALA mandate. Furthermore, each physician’s assessment of an emergency may...
understandably be influenced by their degree of legal risk averse, creating undesirable practice variation.

Providing care for patients with medical emergencies who require abortion services should prioritize several principles. First, it is vitally important to protect physician autonomy, both to determine what constitutes a medical emergency and to engage in shared decision-making with patients. Allowing the legal system to interfere in these core aspects of physicians’ duties, and particularly to do so by promoting delayed treatment in emergency situations at the risk of criminal prosecution, is unconscionable and sets a dangerous precedent. Second, the federal government must protect patient safety and autonomy by providing patients with recourse if they are unable to access emergency abortion care despite EMTALA. While physicians and hospitals have legitimate legal concerns about providing emergency abortions, pregnant individuals must have alternate care pathways available to them. For example, these could include identifying “safe haven” hospitals with guaranteed emergency abortion access in states with restrictive abortion laws, or galvanizing health payers to provide no-cost medical transport to states without restrictive abortion laws.7,8 Third, hospitals must support rapid and standardized decision-making about emergency abortion care. This could help physicians offer evidence-based care without concerns about legal jeopardy, thereby reducing delays and variation in patient care.

Protecting access to emergency abortion care is only one step to prevent maternal critical illness and death. Laws restricting abortion have had no effect on the incidence of elective abortions; thus, unsafe abortions are also likely to become more common in the US.9 Additional solutions, such as expanded access to contraception and harm-reduction campaigns about self-managed abortions, are needed to mitigate the potential life-threatening health effects of unintended pregnancies and unsafe abortions.10 In addition, it is necessary to quantify the consequences of laws restricting access to emergency abortion services, for example, by creating a national database of patients who experience preventable complications or death associated with delayed emergency abortion care.

The Dobbs ruling has created tremendous uncertainty and concern about emergency abortion care and has inhibited and limited physicians’ actions at exactly the moment critically ill patients need them to intervene decisively. The greatest potential negative health effects involve pregnant individuals who may experience increased risks of morbidity and mortality when necessary care is delayed or precluded. There are also important implications for how physicians practice critical care medicine and emergency medicine. Core aspects of physicians’ professional duties, such as making decisions about medical risk and lifesaving treatments, are now threatened. Physicians must stand together for patients and the profession. Every hour counts.

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REFERENCES

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