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Abortion bans and implications for physician-patient trust



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INTRODUCTION

In December 2021, the US Supreme Court heard oral arguments on *Dobbs v. Jackson Women's Health Organization*, a case which argues the constitutionality of bans on abortion before fetal viability.¹ The law in question is a Mississippi ban on abortion after 15 weeks of pregnancy, but there is also a Texas law currently making its way through the appeals process that bans abortions after 6 weeks.² If *Roe vs. Wade* is overturned, more than 20 states are poised to make abortion illegal. Practically overnight, nearly half of women in the United States will be at higher risk of death or morbidity due to pregnancy-associated complications than they were previously. This is especially true for women of color, those without access to care, and those with chronic conditions. The implications of an abortion ban for the health of American women of reproductive age are so dire¹ that other potential sequelae of abortion bans have been rarely discussed.

Limitations on abortion will ripple far beyond those directly affected by the law. Delivery of health care in the United States—in terms of scope, capacity, and technology—has changed dramatically since 1973, the last time abortion was illegal. Most physicians are taught to provide care and avoid harm for individual patients (and not, for example, to take into account a fetus with personhood rights). We anticipate changes in health care that will affect all women of childbearing age (e.g., because of the need to document presence or absence of pregnancy during all health system contact); changes in the provision of care to women who are known to be pregnant (e.g., because of a possible loss of autonomy as the rights of the fetus are weighed against the wishes of the pregnant woman); and changes in the way that women who were known to be pregnant but now are not can interact with physicians (e.g., because of the perceived risk that the physician helped to end the pregnancy). As a result, abortion bans may impact physician-patient trust on a grand

scale, and have the potential to affect hospital care and the delivery of health care in the United States more generally.

IMPLICATIONS FOR WOMEN OF CHILDBEARING AGE

Countries with abortion bans threaten physicians with criminal penalties if they prescribe diagnostic evaluations or treatments that could inadvertently harm a fetus or result in the loss of a pregnancy.^{3–6} When a woman in a state or country with an abortion ban interacts with the health care system, her physician must always at least consider whether she is pregnant. The result is a tension between patients and physicians and, at the very least, the inconvenience of a pregnancy test during most clinical encounters.

Although many hospital-based physicians test for pregnancy in almost every woman they care for (raising the question of “How different is care really going to be, really?”), countries or states with abortion bans or recognition of “fetal personhood” require that, in the event that a patient is pregnant, the fetus would have equal rights to the person carrying that fetus, depriving the patient of her autonomy (and violating a key tenet of medical ethics). Currently, a pregnant woman may choose to forgo or delay cancer treatment, as an example, but cannot be forced to do so. This “shared decision-making model” (where a woman and her physician discuss pros and cons and come to a decision) will be replaced by a law that mandates consideration of the fetus regardless of the woman's preference. Physicians giving equal consideration to the woman and fetus may limit the woman's access to treatments that are teratogenic or abortion-inducing. Reducing the risk use of such medications will lower the quality of care for a variety of life-threatening illnesses (e.g., autoimmune disease, cancer).^{3,4,6} The impact on the relationship between women and their physicians has the potential be strained as a result.

The realm of reproductive endocrinology is likely to also change dramatically in states with abortion bans. In-vitro fertilization (IVF) uses ovarian stimulation and surgical retrieval to produce many embryos per cycle, some of which are transferred to the woman for possible implantation.⁷ This practice could be curtailed under the proposed abortion restrictions because of the risk of multiple pregnancies and the problem of unused embryos.²

IMPLICATIONS FOR WOMEN WITH KNOWN PREGNANCY

In women with a confirmed pregnancy, diagnostic testing during pregnancy could become fraught and, in some cases, could become state regulated. Genetic testing and imaging such as ultrasound can help to identify the safest options for delivery for the mother and the newborn (e.g., facilities that offer intensive perinatal care), but also may identify abnormalities and may lead women to end their pregnancy. For example, Texas Law SB-8 requires that if ultrasound or genetic testing detected the presence or characteristics of a life-threatening congenital defect. (e.g., Trisomy 18, a condition that results in a median lifespan of 10–14 days with only about 10% of children living to age 5), the woman would still be required by the law to carry to term and deliver unless there was a situation that constituted a “medical emergency.”⁶ To further complicate the issue, the term “medical emergency” is poorly defined in the original law and will likely be contested in court. Taken together, the issues of when and how to provide fetal testing, how or whether to reveal the results of such testing, and how to define “medical emergency” during pregnancy will almost certainly create discord in some physician-patient relationships.⁸

Simultaneously, women who know they are pregnant and considering termination could be motivated to obscure pregnancy from their physicians to prevent documentation in the medical record. This is especially relevant to a current Georgia law awaiting a federal appeals court decision that would allow criminal prosecution of women who have an abortion.⁹ The best way to avoid the risk of a documented pregnancy is to just avoid all health care settings even in cases when the patient is ill enough to require hospitalization and, of course, wait to seek prenatal care until uncertainty is resolved. The result will undoubtedly be increased risk of maternal and fetal harms. Delay of prenatal care can result in conditions such as untreated gestational diabetes that leads to higher rates of obesity in their infants; higher rates of birth defects (e.g., brain, spine, or heart abnormalities); and higher rates of stillbirth or perinatal death.

For women who are ill (e.g., with pneumonia or COVID-19) but delay care because they had hoped to terminate a pregnancy before it could be documented in the medical record, we expect that some proportion will present to the hospital in late-stage acute or even critical illness. The situation will become more complex as, even in the face of critical illness, the law seems to state that physicians must equally weigh the life of the woman and the life of fetus. For example, it remains unclear whether fetal personhood

means that a potentially viable (e.g., 23 weeks and beyond) fetus must be delivered before using invasive or risky therapies (e.g., emergency surgery, chemotherapy) to save the life of the woman. Physicians placed in these situations will be asked to interpret the gray areas of state laws in real-time, introducing personal and organizational legal risks and creating emotional turmoil for physicians, patients, and families.

WHAT IF A WOMAN WHO WAS PREGNANT IS NO LONGER?

The greatest difficulties for physicians will occur when a woman who was known to be pregnant is suddenly no longer pregnant. Around 30% of pregnancies end in miscarriage,¹⁰ with the highest risk for loss in the first trimester. More than 90% of abortions also occur in the first trimester, making it difficult to determine whether a patient reporting a lost pregnancy experienced a miscarriage or elected an induced abortion.⁴ It is conceivable that some states would require physicians to report “suspicious” pregnancy losses (e.g., similar to mandatory reporting of child abuse, as discussed by Clarence Thomas during oral arguments in December 2021).¹ A common consequence described in countries with abortion bans^{5,6} is that women experiencing the physical and emotional impacts of miscarriage frequently choose not to confide in physicians. At least one study of physicians in Nicaragua reported that physicians also felt anxiety about treating women who have had a miscarriage because of the possibility that they would be accused of helping the woman end her pregnancy.⁶

Abortion bans will therefore create a situation in which physicians must choose between upholding the law and maintaining their patients' trust. We suspect that a decision by the Supreme Court allowing states to limit or end abortions will have far-reaching and previously unanticipated consequences for hospitalists, patients and health care in the United States.

CONFLICTS OF INTEREST

Drs. Lagu and Delk conceived of this idea. Dr. Lagu drafted the manuscript. Dr. Lagu, Ms. DeJong, and Dr. Delk critically reviewed the manuscript for important intellectual content and approved its final version. The authors report no potential conflicts of interest.

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