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Democracy Dies in Darkness

Confusion post-Roe spurs delays, denials for some lifesaving pregnancy care

Miscarriages, ectopic pregnancies and other common complications are now scrutinized, jeopardizing maternal health

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A woman with a life-threatening ectopic pregnancy sought emergency care at the University of Michigan Hospital after a doctor in her home state worried that the presence of a fetal heartbeat meant treating her might run afoul of new restrictions on abortion.

At one Kansas City, Mo., hospital, administrators temporarily required "pharmacist approval" before dispensing medications used to stop postpartum hemorrhages, because they can also be also used for abortions.

And in Wisconsin, a woman bled for more than 10 days from an incomplete miscarriage after emergency room staff would not remove the fetal tissue amid a confusing legal landscape that has roiled obstetric care.

In the three weeks of turmoil since the Supreme Court overturned the constitutional right to abortion, many physicians and patients have been navigating a new reality in which the standard of care for incomplete miscarriages, ectopic pregnancies and other common complications is being scrutinized, delayed — even denied — jeopardizing maternal health, according to the accounts of doctors in multiple states where new laws have gone into effect.

While state abortion bans typically carve out exceptions when a woman's life is endangered, the laws can be murky, prompting some obstetricians to consult lawyers and hospital ethics committees on decisions around routine care.

"People are running scared," said Mae Winchester, a specialist in maternal-fetal medicine in Ohio who, days after the state's new restrictions went into effect, sought legal advice before she performed an abortion on a pregnant woman with a uterine infection. "There's a lot of unknowns still left out there."

The need to intervene in a pregnancy with the same medication or surgical procedure used in elective abortions is not unusual.

As many as 30 percent of pregnancies end in miscarriage, the spontaneous demise of a fetus, commonly because of chromosomal abnormalities. The methods of managing a miscarriage are the same as for abortion, using a combination of drugs — mifepristone and misoprostol — or a brief surgery known as dilation and curettage, or D&C, to dilate the cervix and scrape tissue from the uterus. Left untreated, some miscarriages resolve naturally; others lead to complications such as infection or profuse bleeding.

"It's important for people to realize early pregnancy failure is common," said Rashmi Kudesia, a fertility specialist in Houston.

Doctors in Texas — where since last September abortion has been illegal after the detection of fetal cardiac activity, around six weeks of pregnancy — report that pharmacists have begun questioning patients about miscarriage medications, suspecting they may be used instead for abortions.

“It is traumatizing to stand in a pharmacy and have to tell them publicly that you are having a miscarriage, that there is not a heartbeat,” Kudesia said.

Carley Zeal, an OB/GYN in southern Wisconsin and a fellow with Physicians for Reproductive Health, said she recently treated a woman at risk of infection after a miscarriage. Zeal said providers at another hospital had wrestled with what services they could perform — with an 1849 law banning almost all abortions back in effect — and ultimately refused to remove the fetal tissue from the patient’s uterus.

“It really delayed her care,” Zeal said. “I saw her a week and a half later with an ongoing miscarriage and bleeding, increasing the risk of severe bleeding as well as infections.”

Zeal gave the patient abortion medication to expel the fetal tissue.

Some doctors are feeling pressure to seek second opinions in their treatment of ectopic pregnancies, which account for between 1 and 2 percent of pregnancies and are never viable.

Zeal said another physician in her practice contacted her the week after the Supreme Court decision as she treated a patient with a ruptured ectopic pregnancy. “She knew exactly what she had to do because [the woman] was bleeding and was clearly going to die if nothing was done,” Zeal said. “But she wasn’t sure what she needed to document to be sure she wouldn’t be charged with a felony.”

Some lawyers have advised physicians in her practice to get two additional doctors to sign off that a patient’s life is indeed in danger; other lawyers say no additional signature is needed. To protect herself from criminal prosecution, Zeal’s colleague Elana Wistrom turned to an emergency room physician who treated the patient and a radiologist who reviewed the ultrasound showing the rupture — a process that took more than an hour.

“It turned my attention away from the bedside of the critical-care patient toward documentation,” Wistrom said.

Ectopic pregnancies — when the fetus implants outside the uterus, usually in one of the fallopian tubes and sometimes on the ovaries or in the cervix — don’t always show up on scans. They can be terminated with an injection of the drug methotrexate, which stops the cells from growing, or through surgery. If the procedure is delayed, the tube may rupture, causing sudden and life-threatening blood loss.

Many state laws with new restrictions on abortion make exceptions for ectopics, but uncertainties can arise if a fetus implants on Caesarean scar tissue on the uterus wall or if it cannot be located.

Patricia Nahn, another OB/GYN in Zeal’s practice, said she recently had a patient displaying signs of an ectopic pregnancy, including abdominal pain. But because this was not a clear-cut case in which an ultrasound showed the fetus developing outside the uterus, Nahn faced the potential of terminating a fetus that was in the uterus and violating Wisconsin’s abortion ban.

Instead of prescribing medication to terminate the pregnancy in the safest manner, as she would have done before last month’s ruling, Nahn said, she was forced to perform a riskier, invasive surgical procedure to confirm the location of the ectopic pregnancy before ending it.

“If you had just waited and done nothing because you were afraid, she could have died,” Nahn said.

Antiabortion groups such as Live Action and LifeNews.com say that overturning *Roe v. Wade* does not stop doctors from treating ectopic pregnancies or miscarriages.

“Those procedures would remain legal and would not be considered abortion,” said Eric Scheidler, executive director of the nonprofit Pro-Life Action League. “No physician can claim not to know that.”

In South Carolina, where state lawmakers are considering new restrictions on abortions in a July special session, state Rep. John R. McCravy III supports a ban with no exceptions for rape or incest. But the Republican said that he favors exceptions to save the life of the mother and that concerns about limiting care for ectopic pregnancies and miscarriages are overblown.

“To use a word used often by the left, it’s disinformation,” McCravy said. “It’s never been a pro-life tenet to constrain the doctors when it comes to medical emergencies.”

New abortion bans oversimplify the reality of obstetric care, physicians say, placing a binary on what is a continuous spectrum of increasing risk. Pregnancy puts huge stress on a patient’s body, sometimes exacerbating existing health problems such as diabetes or hypertension until they become life-threatening.

“With a patient with heart disease, at what point in her pregnancy is she going to die?” said David Hackney, a specialist in high-risk pregnancies in Ohio. “You don’t want to reach that point, where things are that clear.”

Lisa Harris, associate chair of obstetrics and gynecology at the University of Michigan, said doctors are discussing creating a national registry of cases ranging from ectopic pregnancy to cancer and heart disease in which “people may not get what is currently standard of care in counseling or treatment.”

Stories of dangerously delayed care, promoted on Twitter and other online forums, are often hard to verify. And many of the two dozen doctors interviewed by The Post about their experiences since the Supreme Court overturned the right to abortion were hesitant to describe details of individual cases for fear of running afoul of lawyers and hospital administrators, violating patient privacy or prompting a criminal investigation.

In the current political climate, some physicians say antiabortion colleagues are on the lookout for any decision that they believe could contravene new laws.

“Right now, there are risks of exaggeration and possibly even misinformation from many different quarters,” said Leslie Francis, a professor of law and an expert in medical ethics at the University of Utah, who is concerned about a lack of data on the impact of the new laws.

Delaying treatment for an ectopic pregnancy is so dangerous it would amount to malpractice, said Pamela Parker, an OB/GYN in Texas’s Rio Grande Valley, who has decided to practice in Arizona because of Texas’s restrictions and the overturning of *Roe*.

Rachel Hicks, 26, knows from personal experience and as a medical student in Indianapolis how important swift action is. During an April emergency room visit, she discovered she had an ectopic pregnancy that had ruptured and was bleeding into her abdominal cavity. Within two hours, she was in surgery to remove the fetal tissue and the fallopian tube where the pregnancy had implanted.

“Had I waited another day or slept through the night, I could have bled out in my body and I wouldn’t have known it,” said Hicks, a fourth-year medical student who aspires to be a surgeon.

With *Roe* overturned, she wonders how that night would have gone differently under more restrictive laws. Indiana lawmakers are considering new restrictions on abortion in a special session in late July. At least one legislator has floated a total ban with no exceptions to save the patient's life. Hicks worries that doctors may not have been so quick to terminate her doomed pregnancy if they had had to scrutinize whether such care would violate the law.

Then there are the complex but not uncommon cases in which a patient's water breaks early, putting the fetus — no longer sustained by ample amniotic fluid — at risk of severe developmental problems and the mother at heightened risk of sepsis. Some of those pregnancies result in live births; in others, the patient goes into preterm labor. In many cases, doctors terminate the pregnancy, particularly if the patient develops an infection.

A few days after Ohio's abortion ban took effect last month, Winchester, the maternal-fetal medicine specialist, treated a patient whose water had broken at 19 weeks. The woman hoped to continue the pregnancy despite the increased risks to her fetus and herself. But a day later, she spiked a fever, and had an elevated heart rate and high white blood cell count — all signs of infection. Winchester checked with her lawyer, then performed an abortion.

"She was dying. It was very black and white," Winchester said.

Although Ohio's abortion ban makes an exception to save a patient's life, Winchester considered a pregnant woman she treated last year who had a malignant tumor on her cervix that threatened her life, but not imminently. The woman had two children in high school who begged her to terminate the pregnancy and get treatment for the cancer.

"They wanted her to see them graduate," said Winchester, who performed an abortion on the woman. "That's something I don't know if I would be allowed to do here in Ohio anymore."

Ohio's law makes exceptions for many conditions such as ruptured membranes and preeclampsia. But others such as cancer are less clear, according to Justin Lappen, head of maternal-fetal medicine at the Cleveland Clinic.

"Not all patients with the same conditions have the same risk," Lappen said.

Major health systems like the Cleveland Clinic have been able to harness resources quickly to advise doctors, Lappen said, unlike practitioners in private practices or small, rural hospitals.

Aubrey Shumway, who grew up in deeply conservative Utah, where an 18-week abortion ban is in place while a state law banning most abortions is challenged in court, worries that treatment for miscarriages may change.

The 35-year-old Provo resident and her husband have been trying to start a family since the summer of 2019 and enlisted the help of a reproductive endocrinologist. In February, they were elated to find out she was four weeks pregnant. But two weeks later, she experienced irregular bleeding. By the ninth week, medical professionals confirmed that the fetus had no heartbeat and she would miscarry.

Shumway chose to remove the fetal tissue via surgery.

As she prepares to meet with her fertility specialists again this month, she feels uncertain of her options if another pregnancy fails. She wonders if her doctors would err on the side of caution and avoid procedures and medication also used for abortions.

"It concerns me greatly," Shumway said. "Regardless of how you feel, this also affects people like me who want to have children … but want also to be safe, to be protected, to be cared for medically."

Other women are planning ahead in an effort to avoid situations where they may be denied abortions.

Kelly Walters, 37, who developed preeclampsia in two of her four pregnancies, said she was so rattled by the abortion ban in Missouri, where she lives, that she is now preparing to have a hysterectomy.

“I was told I absolutely can’t get pregnant again,” said Walters, who has residual damage from strokes caused by the preeclampsia.

“I don’t think I could survive it.”

The Post wants to hear from more practitioners and patients about how their experiences in reproductive health have been affected by the Dobbs decision. Here’s how you can share your story.