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PREGNANCY

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SMFM SPECIAL STATEMENT

Society for Maternal-Fetal Medicine Special Statement: Considerations for management of high-risk pregnancies when abortion care is restricted

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Abstract

Individuals at high risk for pregnancy-associated morbidity and mortality have unique needs for reproductive health services, including abortion care. Legal restrictions on abortion care in many states make it challenging or impossible for clinicians to practice standard-of-care, evidence-based medicine and for institutions to implement evidence-based clinical guidelines for reproductive healthcare. This Special Statement suggests actions clinicians and institutions can take to build consensus and create systems to ensure patients can receive optimal care. In addition, it addresses counseling about maternal and fetal health that (1) recognizes that risk and patient preferences may change or evolve during pregnancy; (2) incorporates informed patient preferences in a shared decision-making process between the patient and provider; and (3) includes abortion among the options for pregnancy management. We also discuss how abortion restrictions affect training, which will result in shortages of skilled providers who can offer the level of care needed for high-risk pregnancies. Abortion care is a core component of practice for maternal-fetal medicine subspecialists, both to reduce the burden of maternal morbidity and mortality and to operationalize reproductive justice for pregnancy-capable people.

KEYWORDS

abortion access, fetal anomalies, health policy, maternal morbidity, maternal mortality, maternal-fetal medicine, reproductive justice

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1 | INTRODUCTION

Only ten states and the District of Columbia allow for abortion care unrestricted by a gestational ban [1]. In many other states, increased restrictions since the Supreme Court's *Dobbs v Jackson Women's Health Organization* decision have impacted all aspects of reproductive healthcare, with more patients forced to travel for or forgo care and trainees interested in obstetrics and gynecology less likely to pursue opportunities in states with abortion restrictions [2–4]. These factors impact both pregnant and pregnancy-capable people as well as the clinicians who provide high-risk pregnancy care, especially in states with restricted or no legal protection for abortion care.

Individuals at high risk for pregnancy-associated morbidity and mortality have unique needs for reproductive health services, including abortion care. Variations in state and institutional policies and environments make it impossible to provide overarching, prescriptive guidance for specific clinical scenarios. However, this Special Statement provides suggested topics for discussion at the practice, institutional, and regional levels. In addition, the Society for Maternal-Fetal Medicine (SMFM) offers online resources to assist in responding to clinical scenarios in restrictive environments and encourages clinicians to access individualized, no-cost legal services available to navigate any legal concerns (see "Legal Resources for MFMs Providing Abortion Care" at https://www.smfm.org/reproductive-health-legal) [5].

2 | BACKGROUND

Legal restrictions on abortion care in many states make it challenging or impossible for clinicians to practice standard-of-care, evidence-based medicine and for institutions to implement evidence-based clinical guidelines for reproductive healthcare [6–8]. 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 [9]. Abortion restrictions disproportionately impact pregnant people who experience systemic racism and economic injustice and will likely exacerbate existing inequities in severe maternal morbidity and mortality rates [10–12]. The chaos introduced into medical decision-making by non-evidence-based and clinically ambiguous legal restrictions, alongside litigation concerns, poses an enormous burden to the risk assessment, counseling, and care of individuals at high risk for pregnancy morbidity and mortality. These restrictions will ultimately result in increased rates of both short- and long-term morbidity and mortality.

For example, in Texas, following the 2021 enactment of Senate Bill 8, which prohibits abortion care after detection of fetal cardiac activity, and Senate Bill 4, which restricts medication abortion care, a case series at two hospitals demonstrated that state-mandated expectant management of periviable preterm prelabor rupture of membranes resulted in significant morbidity for the majority of patients (57%) [13]. This rate of maternal morbidity is higher than the rate observed in published cohorts of patients declining expectant management under similar clinical circumstances in states without restrictive legislation (33%) [14, 15]. Furthermore, perinatal outcomes were poor, with 27 of 28 patients (96%) in this series having a stillbirth or neonatal death [13]. Another study assessing the impact of Texas' legislation examined maternal morbidity in pregnancies diagnosed with severe life-limiting fetal anomalies at less than 22 weeks of gestation at a single center in Texas [16]. Before the legislation, patients were offered pregnancy termination or expectant management; after, only expectant management was offered. Composite maternal morbidity doubled between cohorts before versus after restrictions on abortion (35% vs. 72%), and state-mandated expectant management was associated with higher rates of cesarean delivery and preeclampsia. All expectantly managed pregnancies ended in stillbirth or infant death [16]. Additional studies examining maternal outcomes associated with fetal anomalies have similarly shown increased morbidity and complications with continuing pregnancies [17, 18]. This and other early evidence from a state restricting abortion suggest significant risks of severe maternal morbidity without improvements in fetal or neonatal outcomes [19]. Importantly, hospitals and clinicians caring for patients with complex pregnancies have diverse interpretations of the laws' narrow exceptions, ultimately resulting in inequitable outcomes and access to care [9, 20–22].

3 | IMPROVING CLINICAL CARE THROUGH COLLABORATION AND COMMUNICATION

It is difficult for national organizations and professional societies to create evidence-based approaches universally responsive to state-specific restrictions and the needs of individual patients, clinicians, and institutions. However, local efforts may improve care and maintain access to legally permissible reproductive healthcare. An effective approach has been to convene interdisciplinary discussions among critical stakeholders at the institutional, community, regional, and state levels to achieve consensus regarding legal interpretation of abortion restrictions, to optimize the provision of reproductive healthcare in

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medical emergencies or in legal "grey zones," and to solidify clinical partnerships to minimize preventable morbidity and mortality [23]. Communication and consensus-building at the institutional, community, and state level are essential and can result in a shared understanding of relevant laws and regulations, reduce variations in clinical care, and standardize clinical practice in situations of legal uncertainty. Maternal-fetal medicine (MFM) subspecialists play an important role in this process because of their expertise in severe obstetrical complications, and they should be included in communications and collaborations to minimize the impact of abortion restrictions on patient care and outcomes [24, 25]. Additionally, MFM subspecialists often hold leadership positions within institutions, and as such have a unique ability to provide institutional advocacy to maintain access to evidence-based reproductive healthcare, including abortion care [24]. Ultimately, each pregnancy is unique and requires access to individualized care in which decisions are made between the patient and clinician. Advanced planning and discussion may provide the institutional support needed for such individualized care and mitigate fear of legal repercussion.

4 | INSTITUTIONAL AND REGIONAL APPROACHES TO CONSENSUS-BUILDING AND CLINICAL CARE

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 can facilitate the development of protocols and clinical pathways for healthcare providers who may be directly impacted by abortion restrictions (e.g., obstetrics and 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 and may mitigate some concerns among providers regarding the boundaries of legal clinical management. In addition, developing a process for the inevitable, unpredictable, and 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 positions [23, 26]. It is critical to emphasize that, in conversations with hospital leadership and other staff, MFM subspecialists and their obstetrics and gynecology specialist and complex family planning subspecialist colleagues are the high-risk pregnancy and abortion care experts; no other personnel are better trained to assess the risk of pregnancy complications to maternal and perinatal health.

As an institutional approach is developed, engagement of and communication to the full clinical team is necessary. Optimal management of severe complex obstetrical complications frequently involves multidisciplinary care teams that include an obstetrician-gynecologist and MFM subspecialist when available. Therefore, shared communication is key among all members of the care team, including those representing other specialties, such as anesthesiology, critical care, emergency medicine, genetic counseling, and complex family planning.

The following actions can improve access to reproductive healthcare:

- Create an institutional advisory group to address relevant clinical needs: access to abortion care, contraception, management of early pregnancy loss, destigmatization of abortion care, educational and training needs of healthcare staff at all levels (e.g., residents), across specialties (e.g., internal medicine) and disciplines (e.g., nursing, pharmacy) [23, 27].
- Establish a task force that can take on challenging and unpredictable clinical scenarios as they arise and determine an immediate course of action, including issues related to abortion care.
- Develop legal partnerships and collaborations, including discussion and engagement among the legal counsels of various hospitals and institutions and with nonhospital legal experts and reproductive health legal experts. These legal partnerships and discussions should extend beyond professional liability and address the potential need for criminal legal representation, depending on state laws related to providing abortion care.
- Establish referral networks within and between institutions and states to ensure patient access to care.
- Create an institutional provider toolkit to centralize relevant clinical, legal, and educational information, and update it regularly.
- Expand access to abortion care to the legal limit allowed by state law, including providing medication abortion, offering services at later gestations, and working to eliminate institutional restrictions on reproductive healthcare that are more restrictive than state law.
- Work to eliminate obstacles that limit patients' ability to obtain desired contraception, including permanent contraception, emergency contraception, and postpartum long-acting reversible contraception.
- Engage with institutional legal teams to understand how to apply the federal Emergency Medical Treatment and Labor Act (EMTALA) [28, 29].
- Develop standardized patient resources for access to financial and logistical assistance for out-of-state care.

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5 | COUNSELING AND ASSESSING RISK WITH THE PREGNANT PATIENT

Risk assessment and counseling have an important role in optimizing care and reducing pregnancy-related morbidity and mortality, and MFM subspecialists are often the primary providers of high-risk pregnancy counseling, care, and management [30, 31]. SMFM recommends that during prepregnancy, prenatal, or postpartum counseling, individuals who have an increased risk of medical complications during pregnancy should be provided with accurate, evidence-based information about these risks, all treatment options, and the availability of these options [32]. This counseling should employ strategies that incorporate informed patient preferences in a shared decision-making process between the patient and provider [33]. Counseling regarding abortion should be included in options for pregnancy management [32–34]. Providing information and referrals about lawful abortion care enjoys strong First Amendment protections [35].

Pregnancy carries a risk of severe morbidity or mortality for all pregnant people, and published data demonstrate that abortion is statistically safer than continuing a pregnancy to term [32, 36, 37]. 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, and 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 [31]. However, all pregnant individuals, even those who early in pregnancy would be deemed to have lower risk for complications, are at risk for developing a condition during pregnancy that would be considered high risk. Because of the number of physiological changes that occur during pregnancy, many conditions have the potential to increase the likelihood of experiencing morbidity during pregnancy, during labor and delivery, or in the postpartum period. Examples of conditions 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 do not include all health conditions that might elevate risk.

Additionally, some conditions, such as multifetal gestation, increase both maternal and perinatal risk of an adverse outcome. Multifetal and selective pregnancy reduction, which are health-promoting, evidence-based management options that can mitigate these risks, may be subject to abortion restrictions, though termination may satisfy a restriction or ban's health- or life-preserving exceptions. All patients with higher-order multifetal pregnancies should be offered nondirective counseling regarding risks unique to multifetal pregnancy as well as the option to continue or reduce the pregnancy [38].

Because of their expertise and leadership positions within institutions, MFM subspecialists have a critical role in shaping the provision of obstetrical care and are in a unique position to uplift core tenets of reproductive justice – in particular, the ability to choose to be pregnant or not [39]. Reproductive justice not only hinges on patient-centered risk assessment [31] and supporting the patient's views and tolerance of risk, but also on building systems that can optimize care when abortion is restricted [40, 41]. This approach includes advocacy to remove legal barriers to reproductive healthcare and eliminating institutional policies on abortion care that are stricter than state law or otherwise restrict access to care [34].

6 | ASSESSING RISKS TO MATERNAL WELL-BEING WHEN FETAL ANOMALIES ARE DIAGNOSED

Marked variation exists in prenatally diagnosed conditions, from those that are mild or amenable to prenatal or postnatal treatment, to those that may be survivable but will result in serious lifelong health impairments, to those incompatible with long-term postnatal survival. Unbiased, accurate, and evidence-based counseling on treatment and prognosis is critical when a new diagnosis of a fetal anomaly is made. However, by the nature of the limitations of fetal imaging and genetic testing, long-term health issues are often difficult to prognosticate. Therefore, abortion care is one of several options that should be discussed with patients in the setting of an unexpected fetal diagnosis, such as a fetal anomaly or early-onset severe fetal growth restriction.

Earlier diagnosis of fetal anomalies may allow for more timely provision of abortion care, especially in states with gestational duration restrictions [42, 43]. Earlier diagnoses can be accomplished by expanded access to prenatal screening and diagnosis, including early noninvasive genetic screening and first-trimester anatomy ultrasonography [40]. Several private insurance plans and state Medicaid programs only cover noninvasive prenatal screening for high-risk patients or do not cover it at all. A number of major imaging and reproductive health medical societies, including SMFM, support reimbursement for detailed first-trimester ultrasonography when indicated to ensure equitable access to reproductive healthcare [44, 45]. Advocating for greater access to early prenatal screening

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and diagnosis for all patients could ultimately allow those with suspected or confirmed fetal anomalies more time to consider treatment options and seek abortion care if desired [46, 47]. To support this approach, it is critical to ensure continued exposure and training of MFM fellows in chorionic villus sampling to allow for early prenatal diagnosis. Further, clinicians can also advocate for comprehensive reproductive health counseling, inclusive of abortion care, as well as facilitation of abortion care, as an essential part of fetal care centers or fetal therapy programs [48, 49].

All patients with a new diagnosis of a fetal anomaly should have the option of abortion care. Clinicians are ethically bound to provide accurate prognostic information, discuss the variety of treatment options supported by medical evidence, and assist families in making treatment plans that align with the goals and values of the pregnant individual [50–52]. The clinical team should support and assist the patient in meeting their treatment goals, regardless of the reason that the pregnant patient arrived at their choice. In these scenarios, some families may choose to pursue a perinatal palliative care approach, wherein interventions to prolong extrauterine life are limited. However, offering perinatal palliative care is not a substitute for providing or enabling access to abortion care [51–53].

Assessing maternal risk when a fetus has an anomaly is challenging [31]. 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. Further, providers have an ethical obligation to discuss the mental health and health resource utilization (i.e., economic) implications of having a child with one or more health issues [54]. Ethical criteria that healthcare practitioners may consider when assessing the risks of expectant management or maternal-fetal intervention (e.g., transplacental medication treatment, maternal-fetal surgery) include the following: (1) the proposed 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, when compared with expectant management or postnatal treatment; 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 [48]. However, abortion care should always be discussed as a management option for any person diagnosed with a fetal congenital anomaly during pregnancy. Furthermore, the availability of maternal-fetal surgery for a particular congenital anomaly does not preclude abortion care as an option, either at the time of diagnosis or even after maternal-fetal surgery [55].

Discussion regarding treatment options available to patients should be informed by evidence, and treatment decisions should be driven by the values and desires of the patient. Arbitrary gestational duration and other restrictions imposed by lawmakers have no place in the process. The collaborative efforts described above can help clinicians and patients understand how restrictions and institutional guidance may impact treatment options.

7 | CARING FOR PATIENTS AFTER SELF-MANAGED ABORTION

Self-managed abortion (SMA) refers to steps taken to end pregnancy outside of the formal healthcare system [56]. After SMA, patients may seek clinical care for potential complications or to confirm the abortion is complete. Patients may be reluctant to share details about the SMA out of fear of judgement or criminalization. Clinicians should respect patient decisions to withhold such details and only request information essential to patient care [56]. Although serious complications from SMA can occur, they are rare [57]. In most cases, clinical management is the same as for those with spontaneous pregnancy loss, and there is no need to ask about or document in the medical record whether the person took intentional steps to end the pregnancy. If the patient has signs of potential physical trauma, the method of SMA may be clinically relevant, but the provider's documentation should avoid putting the patient at legal risk [56]. The American College of Obstetricians and Gynecologists notes that "the greatest risk of harm related to SMA often is the harm resulting from potential criminalization" [58].

States' abortion restrictions may complicate a clinician's ability to care for a patient following an SMA attempt – for example, if there is continued fetal cardiac activity [56]. Anticipating the need for clear institutional protocols related to abortion restrictions and establishing processes to address challenging clinical scenarios will help clinicians in their efforts to provide evidence-based, compassionate care in such situations.

8 | TRANSFER AND REFERRAL

Access to abortion care may require referral and transfer/transport services [59]. Pre-transport services may include ultrasound examinations, blood work, and advance consultation to ensure that patients with underlying illnesses can be safely transported and receive immediate care upon arrival at the receiving facility. Collaborative partnerships with institutions and clinics in surrounding states that provide abortion care

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should be developed to quickly facilitate transfer of care, including a formal mechanism for safely sharing pertinent medical records [60]. Abortion funds serve as an essential resource for patients to cover the costs of transport, housing, food, and the procedure itself. Illinois' Complex Abortion Regional Line for Access (CARLA) program provides an example of a coordinated care model [61]. This program facilitates abortion care for medically complex pregnant individuals from freestanding abortion clinics to hospital-based abortion care, using nurse case managers to coordinate support from the Chicago Abortion Fund and care at several hospitals.

Under EMTALA, Medicare-participating hospitals with emergency services must provide stabilizing care, including needed abortion care, to individuals with emergency medical conditions or those in labor. However, EMTALA has recently been subject to litigation, and it remains to be seen how future actions on EMTALA may affect the ability of clinicians to care for patients who require emergency abortion care.

9 | WORKFORCE ISSUES

Given the changes in the legal landscape, at least 40% of obstetrics and gynecology resident trainees will have limited experience in abortion care [62]. Data from recent surveys of MFM fellows obtained both before and after the *Dobbs* decision demonstrate a high frequency of interest in providing procedural abortion care [63, 64]. However, a minority of MFM faculty endorse the need for training in and provision of abortion care as part of MFM fellowship training [64], highlighting a critical discordance between MFM faculty and fellows on the role of MFM subspecialists. The provision of abortion care and counseling is central to the practice of clinical MFM and cannot be separated from high-risk pregnancy care. Restrictive legal environments will result in significant, chronic shortages of abortion providers that will have negative consequences for patients, providers, and healthcare systems [3, 34, 65]. Comprehensive pregnancy options counseling, including counseling about abortion care, should be considered a core competency of MFM training and practice and formally incorporated into MFM fellowship training institutionally and through accreditation and certifying organizations. For institutions located in states with abortion restrictions, supporting out-of-state medical licenses for residents and fellows to learn to provide abortion care has been identified as an important facilitator for continued training [66]. Lastly, preliminary data derived from MFM subspecialists practicing in states with abortion restrictions demonstrate experiences of moral injury in the wake of the *Dobbs* decision [9, 20, 67, 68]. Given the potential downstream consequences of moral injury on the reproductive healthcare workforce, future attention should be directed to evaluating moral distress among MFM subspecialists as well as methods of combatting this distress, including psychosocial and behavioral health support networks [69].

10 | CONCLUSION

Abortion care is a core component of practice for MFM subspecialists nationwide, both to reduce the burden of maternal morbidity and mortality and to operationalize reproductive justice for pregnancy-capable people. However, because of judicial, legislative, and institutional barriers, abortion care is difficult to access for many individuals living in the United States. Though preliminary data are available demonstrating harms associated with lack of abortion care and the risk of maternal and perinatal morbidity and mortality in a post-*Dobbs* world, there are still multiple research topics that need to be addressed, including the impact of abortion restrictions on

- Outcomes for patients with severe obstetrical complications
- Maternal morbidity and mortality, fetal mortality, and infant mortality
- Training goals and competencies for MFM fellows
- Patient volume and transport to states without restrictions

The practice of MFM includes navigating complex clinical scenarios at the intersection of high-risk pregnancy and abortion care. MFM subspecialists should harness their clinical expertise and institutional leadership to optimize patient safety and work to create approaches that maximize the provision of reproductive healthcare under state restrictions.

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