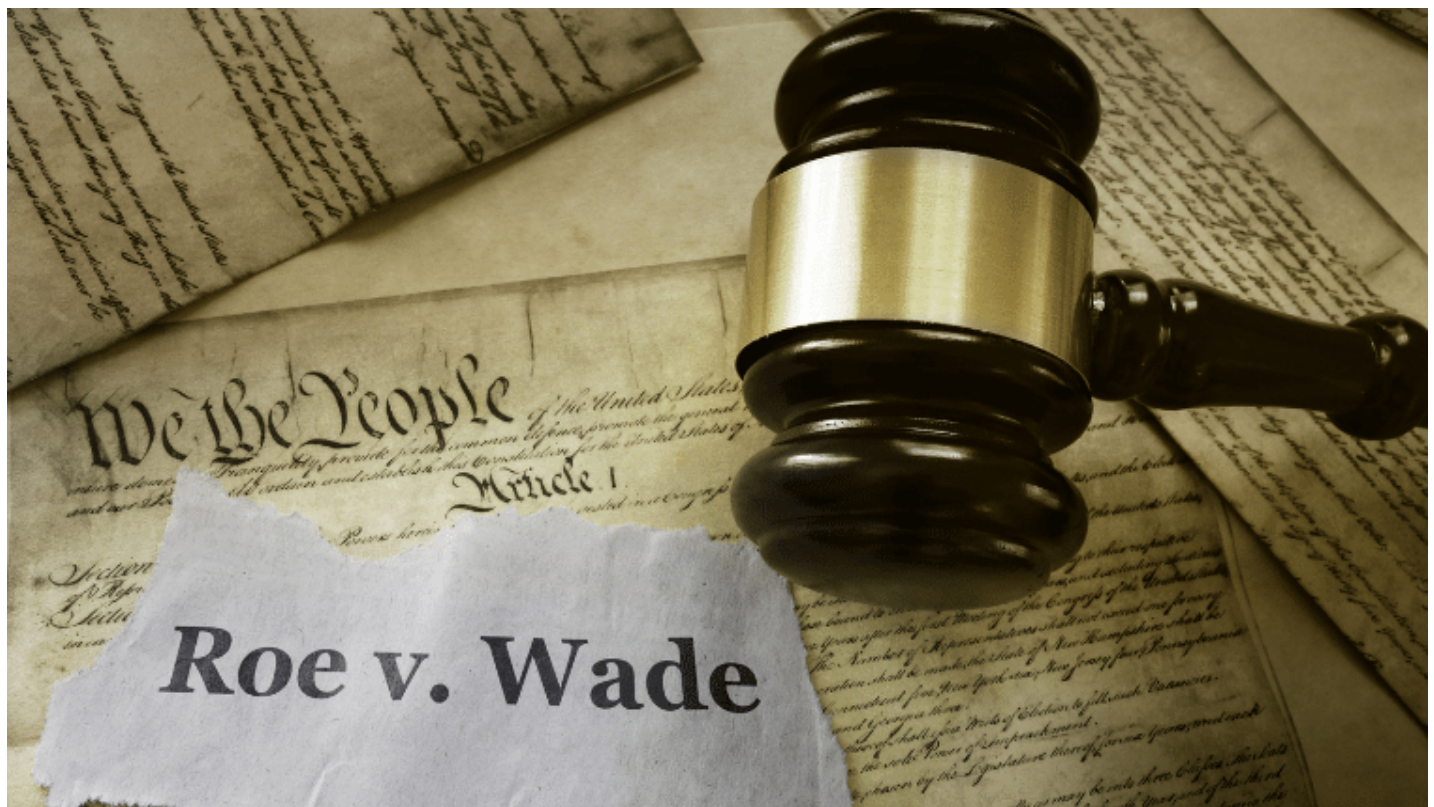


# Penalizing Abortion Providers Will Have Ripple Effects Across Pregnancy Care

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If the United States Supreme Court [reverses \*Roe v Wade\*](#) [https://www.supremecourt.gov/DocketPDF/19/19-1392/193052/20210920164243798\\_19-1392%20Brief.pdf](https://www.supremecourt.gov/DocketPDF/19/19-1392/193052/20210920164243798_19-1392%20Brief.pdf), the ripple effects will be enormous, including greater maternal and infant mortality and a long-lasting impact on women and families. Reversing *Roe* will not only make it immeasurably harder for abortion providers to deliver the care they were trained to furnish, but will further [endanger](https://5aa1b2xfmfh2e2mko3kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_NAF_VD_Stats.pdf) [https://5aa1b2xfmfh2e2mko3kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020\\_NAF\\_VD\\_Stats.pdf](https://5aa1b2xfmfh2e2mko3kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_NAF_VD_Stats.pdf) their well-being and safety.

One of the most disturbing types of fallout from the loss of the federal constitutional right to abortion would be the threat to access to care to manage pregnancy loss. Over [one million people](#)

[https://www.cdc.gov/nchs/data/hestat/pregnancy/2010\\_pregnancy\\_rates.htm](https://www.cdc.gov/nchs/data/hestat/pregnancy/2010_pregnancy_rates.htm)

experience early pregnancy loss, or miscarriage, every year. Miscarriage generally take place in the early part of pregnancy, before 20 weeks, because fetal development has stopped and the [pregnancy is no longer viable](#) <https://www.acog.org/womens-health/faqs/early-pregnancy-loss>. Somewhere between [10 percent and 30](#) <https://www.ncbi.nlm.nih.gov/books/NBK532992/> percent of pregnancies end in miscarriage but estimates vary, in part because many occur before [people know they are pregnant](#) <https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/>.

Some people experiencing miscarriage require immediate medical interventions to prevent [severe health complications](#) <https://pubmed.ncbi.nlm.nih.gov/33915094/>, such as life-threatening infections or tubal rupture. Treatments include medical management (via mifepristone or misoprostol) or uterine evacuation through procedures known as dilation and curettage (D&C) and dilation and evacuation (D&E). These same procedures – requiring the same clinical skills, the same medical training, and the same health care settings – are used for [abortion care](#) <https://www.ncbi.nlm.nih.gov/books/NBK532992/>. In a post-*Roe* world, providers may fear treating pregnancy loss given the overlap between the treatment responses to miscarriage and abortion, even if they have the necessary training and clinical skills.

Withholding treatment, however, carries legal implications of its own. Clinicians who withhold treatment from patients experiencing miscarriage could face liability under state law for abandonment. For example, Texas SB 8 puts EMTALA compliance directly on the line. Under the Emergency Medical Treatment and Labor Act (EMTALA), the definition of medical emergency encompasses situations that go well beyond death; indeed, risk of death is not part of the [EMTALA standard](#) <https://www.law.cornell.edu/uscode/text/42/1395dd> at all, which instead focuses on conditions that seriously jeopardize health or bodily or organ function. Yet Texas SB 8 creates an exception only for emergencies that threaten loss of life, further elevating the risk that providers will fail to respond to the full scope of emergency health risks that arise in a miscarriage situation.

We follow these developments with a growing sense of alarm because of our focus on equitable access to care. The [workforce providing both abortion and management of miscarriage](#) <https://jamanetwork.com/journals/jamainternalmedicine/article->

[abstract/2790325](#)> and access to these services is likely to shrink in coming years, as a result of three factors.

## Institutional Restrictions

First, we know how policy restricts practice in hospital settings. The effect of restricting abortion in Catholic hospitals offers a preview of what we could see in nationally as abortion restrictions go into effect. Catholic hospitals, which make up about 10 percent of the hospitals in the US, follow a set of medical guidelines set by the United States Conference of Catholic Bishops. These guidelines prohibit any procedures that terminate a pregnancy, even if the pregnant person is experiencing pregnancy loss and did not seek an abortion. Both [anecdotal <https://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners>](#) and [research <https://ajph.aphapublications.org/doi/10.2105/AJPH.2007.126730>](#) evidence have found that these guidelines pose unnecessary risks to life and health. In one case, a woman reported being denied a D&C – for a planned and desired pregnancy – until she had lost nearly [40 percent of her blood volume <https://www.nytimes.com/2022/02/25/opinion/sunday/roe-dobbs-miscarriage-abortion.html?searchResultPosition=10>](#) during a miscarriage. Even with the best provider training and state-of-the-art medical equipment, a physician will not be able to offer quality of medical care if the hospital policy does not allow it.

## Loss Of Outpatient Care And Providers

Second, routine outpatient care for pregnancy services may also shrink as abortion restrictions grow. Independent clinics are currently the main providers of abortion services in the US. However, [113 of these clinics closed <https://abortioncarenetwork.org/wp-content/uploads/2021/11/CommunitiesNeedClinics2021-1.pdf>](#) between 2016 and 2021, and those that remain open face substantial financial and administrative [burdens <https://pubmed.ncbi.nlm.nih.gov/25746295/>](#). Abortions are also provided in OBGYN, primary care, or other private provider offices. Many primary care providers, such as [internal medicine <https://pubmed.ncbi.nlm.nih.gov/33894250/>](#) physicians and [family medicine <https://pubmed.ncbi.nlm.nih.gov/24204072/>](#) physicians, believe that abortion is within their scope of practice, and [patients express interest <https://pubmed.ncbi.nlm.nih.gov/22223135/>](#) in obtaining abortion care from their primary care doctor. However, when it comes to actual practice, few family medicine physicians provide abortions. Especially for patients in [rural](#)

[https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(17\)30158-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30158-5/fulltext) areas, a primary care physician or emergency department may be the only potential option for abortion care. Moreover, these providers [may opt not to provide mifepristone, D&Cs, or D&Es](#), <https://www.npr.org/2021/10/01/1042209230/federal-judge-weighs-in-on-biden-administrations-attempt-to-block-texas-abortion> even if they are not directly providing abortion care, because of the perceived association with abortion care.

Abortion providers have historically been targets of violence, and as abortion laws become stricter, violence has worsened. Compared to 2019, [abortion providers in 2020](#) [https://5aa1b2xfmfh2e2mko3kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020\\_NAF\\_VD\\_Stats.pdf](https://5aa1b2xfmfh2e2mko3kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_NAF_VD_Stats.pdf) reported a 125 percent increase in assaults outside of clinics and a 117 percent increase in death threats. Threats to providers' safety may cause providers of abortion services and of other pregnancy-related services to cease providing them. When current providers leave the field because they can no longer care for their patients in the way they were trained, leave the state to practice in less restrictive regions, or retire early, shortages and problems of access to care worsen, not just for abortion but for services related to pregnancy loss. With the additional attrition of providers who are choosing early retirement, we are witnessing the loss of the most experienced providers, creating an additional blow to workforce supply.

## Effects On The Workforce Pipeline

Lastly, having fewer skilled providers could also have long-term effects on the workforce pipeline. Medical residents learn procedural skills from medical faculty. If the faculty do not or cannot provide training on abortion procedures, their trainees will lack the necessary skills to manage pregnancy loss after completing their residency. Under current training programs, residency training that includes abortion care leads to improved [miscarriage management skills](#) <https://pubmed.ncbi.nlm.nih.gov/30401344/>, specifically in-office [uterine evacuation](#) <https://pubmed.ncbi.nlm.nih.gov/21419385/>, and residents report feeling positive about their training [experience](#) <https://pubmed.ncbi.nlm.nih.gov/17549648/>.

In addition to the technical skills that residents pick up during their training, residency experiences may also “imprint” a type of practice or an inclination toward certain practice settings onto providers. For example, medical students who have trained in rural settings and residents who completed their graduate medical education in rural settings were found to be [more likely](#) <https://pubmed.ncbi.nlm.nih.gov/27119328/> to practice



in those areas after completing their training. In the case of abortion restrictions, imprinting may determine the type of medications and procedures these trainees provide and the services they believe they *should* provide. As these providers advance in their careers, the lack of adequate training could reinforce a cycle of lack of trained faculty, leading to an even more constricted pipeline of providers willing and able to provide full-scope pregnancy care.

## Worse Outcomes For Pregnant People

The effect of shrinking the workforce that can safely manage pregnancy loss will undoubtedly be worse outcomes for pregnant people and their families. The availability of a well-trained maternal health workforce more broadly has been tied to improved maternal health outcomes. We know that regions with lower per-population availability of maternal health providers, compared to the national average, have [higher maternal mortality rates <https://pubmed.ncbi.nlm.nih.gov/33253022/>](https://pubmed.ncbi.nlm.nih.gov/33253022/) than the national average. [Increasing rates <http://info.primarycare.hms.harvard.edu/review/obstetric-care-rural-america>](http://info.primarycare.hms.harvard.edu/review/obstetric-care-rural-america) of maternal and infant mortality in recent years, especially for [Black and rural populations <https://www.gao.gov/products/gao-21-283>](https://www.gao.gov/products/gao-21-283), have increased inequities in full-scope maternity care. Structural racism contributes to higher rates of maternal morbidity and mortality for Black women than White women, even with [similar prevalence rates of pregnancy complications <https://ajph.aphapublications.org/doi/10.2105/AJPH.2005.072975>](https://ajph.aphapublications.org/doi/10.2105/AJPH.2005.072975) like preeclampsia; Black infants have [higher rates <https://www.pnas.org/doi/10.1073/pnas.1913405117>](https://www.pnas.org/doi/10.1073/pnas.1913405117) of infant mortality than other racial groups. These same equity concerns apply across pregnancy care, whether abortion, labor & delivery, or management of pregnancy loss.

## Policy Recommendations in Light of Increasing Abortion Restrictions

To avoid pregnancy loss management being undermined in the aftermath of any abortion restrictions, we need policy change at multiple levels. For the future workforce, medical schools and residency programs must continue to provide education and training in the techniques used for both abortion and pregnancy loss. Some programs have already taken specific steps to protect abortion training; for example, the University of Washington OBGYN residency programs only admit residents [committed <https://www.nbcnews.com/health/womens-health/fewer-medical-students-trained-abortion-procedures-rcna21003>](https://www.nbcnews.com/health/womens-health/fewer-medical-students-trained-abortion-procedures-rcna21003) to providing abortion care, a change in policy that previously had allowed two slots for residents who did not wish to provide abortions.

Medical students seeking residency slots are [already considering](https://msmagazine.com/2022/03/16/abortion-rights-medical-student-obgyn-match-day/) [<https://msmagazine.com/2022/03/16/abortion-rights-medical-student-obgyn-match-day/>](https://msmagazine.com/2022/03/16/abortion-rights-medical-student-obgyn-match-day/) whether abortion and pregnancy loss training will be available to them, and both medical schools and residency programs should develop public policies stating their position on these services. Programs such as the [Ryan](https://ryanprogram.org/) [<https://ryanprogram.org/>](https://ryanprogram.org/) and the [RHEDI](https://rhedi.org/rhedi-programs/) [<https://rhedi.org/rhedi-programs/>](https://rhedi.org/rhedi-programs/) Residency Training Programs successfully train residents in fully integrated family planning and abortion care, and expanding this model to all OBGYN and family medicine programs would increase access to this training. Funding could come from federal government grants to ensure competency in the procedures and medication services to appropriately treat pregnancy loss.

In addition, accreditation bodies like ACGME could change accountability requirements for certain specialties. OBGYNs already must demonstrate skills in D&C and D&E but family medicine and internal medicine do not share these requirements; integrating these services into primary care provider training would increase the future workforce able to provide this care. Boards of medicine could establish continuing education requirements that include D&C and D&E, as well as mifepristone and misoprostol, to ensure that providers do not lose the skill set as they get further from their residency training. This training could rely on federal grants that would cover out-of-state travel for providers practicing in restrictive states.

### Insurance And Medicaid Coverage Policies Can Also Play A Crucial Role

While [many states](https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion) [<https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion>](https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion) restrict coverage for abortion under Medicaid and private health plans, management of pregnancy loss is still covered. State Medicaid directors and state insurance commissioners could codify this coverage through policies that specifically require coverage of pregnancy loss even if abortion services are not covered. In addition, the Centers for Medicare and Medicaid Services (CMS) could add a requirement regarding network adequacy for providers. While abortion services are not covered by federal Medicaid dollars except under limited circumstances, management of pregnancy loss is. Requiring a Medicaid provider network to include a minimum number of providers who offer pregnancy loss management would provide a clear avenue for maintaining access to these services among a vulnerable population.

Lastly, CMS should take immediate steps to make the EMTALA duty absolutely explicit. Earlier [guidance](https://www.hhs.gov/about/news/2021/09/17/hhs-secretary-xavier-becerra-announces-actions-protect-patients-and-providers-response-texas-sb.html) [<https://www.hhs.gov/about/news/2021/09/17/hhs-secretary-xavier-becerra-announces-actions-protect-patients-and-providers-response-texas-sb.html>](https://www.hhs.gov/about/news/2021/09/17/hhs-secretary-xavier-becerra-announces-actions-protect-patients-and-providers-response-texas-sb.html)

referred generally to SB 8's EMTALA conflict, along with other federal laws that SB 8 could be found to violate. But this guidance does not go into the detail required to demonstrate to hospitals exactly how the life-threatening standard of SB 8 conflicts with the scope of their EMTALA duties. CMS needs to go further.

Importantly, even if access to services related to pregnancy loss is protected, the loss of abortion services will still deal a huge blow to population health and reproductive justice. Protecting abortion access should also be a priority, as should protecting access to all aspects of whole-pregnancy care.

## Summing Up

When punitive restrictions discourage providers from doing procedures to treat pregnancy loss – on the chance that they will be perceived as abortion procedures – providers will begin to lose their skills in this area. As this workforce shrinks, access to safe and effective management of any type of pregnancy loss will suffer, especially in states where certain procedures are not permitted. [Twenty-one states](https://www.npr.org/2021/12/02/1061015753/abortion-roe-v-wade-trigger-laws-mississippi-jacksons-womens-health-organization) [will be in this situation because of either state-specific laws or trigger laws that would ban or restrict abortion immediately if the Supreme Court overturns \*Roe v Wade\*.](https://www.npr.org/2021/12/02/1061015753/abortion-roe-v-wade-trigger-laws-mississippi-jacksons-womens-health-organization)

While abortion may be the primary target of such restrictions, they will affect a broad spectrum of health professionals. This, in turn, will reduce access to all pregnancy care, especially for minority populations in these 21 states. The health workforce and population health implications of these laws may be far-reaching and long-lasting.

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