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Confusion, Cruelty and Fear

Discussions with Doctors Delivering Reproductive Care to Women in the Wake of Texas' Abortion Ban

Study Context

- The overturning of *Roe v. Wade* and resulting actions to ban abortion in states across the country altered the landscape for both women seeking reproductive health care services and the clinicians that provide those services.
- In Texas, far reaching restrictions on abortion have been in place since the passage of SB8, followed by a near total ban after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization.*
- Recent work by Manatt Health, sponsored by nine independent and non-profit foundations in Texas, highlighted the impact of the state's abortion bans on the state's OB/GYN workforce and the implications for access to reproductive health care.

This new work builds on that study. Manatt is interviewing physicians across the state, including OB/GYNs, emergency medicine (EM) physicians, and family medicine (FM) physicians trained in obstetrics and documenting their stories and common themes emerging across multiple physicians.

This report includes the results of 14 physician interviews, highlighting major themes on how the practice experience has changed after the state's abortion ban and how physicians are managing the practice of medicine and engaging with women seeking reproductive health care services.

Methodology

- Manatt recruited practicing OB/GYN physicians, EM physicians, and FM physicians to participate in one-on-one interviews. Interviewees were not given monetary compensation for their participation.
- The interviews were broad ranging and focused on day-to-day navigation of the state's abortion laws while providing care to pregnant women in the state.
- Interviewees were given the option to remain anonymous; however, certain demographic information was collected on each. All requested to remain anonymous.
- The interviewees represented a mix of early/later-career, rural/urban/suburban, race, and male/female.

A Note About Texas Law

Texas law bans all abortions except those necessary to save the life of the mother or to prevent substantial impairment of a major bodily function. There are two affirmative defenses doctors may assert if they are subject to criminal or civil litigation, including (1) ectopic pregnancy; or (2) previable premature rupture of the fetal membrane (PPROM).

The abortion ban does not provide an exception for a lethal fetal anomaly—that is, where the fetus is diagnosed with a condition that will result in death at or shortly after birth.

Physicians that are found to have violated the abortion ban are subject to loss of their medical license and civil and criminal penalties, including prison time ranging from two years to life in prison.

We asked physicians practicing in rural, suburban, and urban Texas communities to describe the impact of the Texas abortion bans on their treatment of pregnant women.

On the following pages, we summarize the themes that emerged.

Five Cross-Cutting Themes: Confusion, Cruelty, Fear

(1) Legal Standards Have Replaced Medical Guidelines.

(2) The Doctor-Patient Relationship Has Been Impaired.

(3) "It's Just Plain Cruel."

(4) Clinical Expertise is Eroding.

(5) Fear Dominates.

Overview of Emerging Themes

(1) Legal Standards Have Replaced Medical Guidelines.

In evaluating whether or how to terminate a pregnancy, physicians now apply legal standards; clinical standards and medical judgment are secondary at best. Decision-making, including during emergent situations is delayed as physicians consult leadership teams and legal counsel in cases that otherwise would be managed quickly and compassionately. The law's "affirmative defenses" are not well understood and still leave many clinicians questioning their legal liability from providing evidence-based care.

Doctors reported:

- *"In the past, if you were experiencing an ectopic pregnancy, you could be prescribed medicine; but now surgery is the only option. There used to be mifepristone [available], but now the pharmacy does not even stock that anymore—standard of care treatment be damned."*
- *"We now have to worry about whether or not the patient is 'sick' according to the legal definition."*
- *"We are asked to take a 'check the box approach'; but medicine, like life, does not fit into prescribed boxes."*
- *"This is not over, and this is not as bad as it can get—it can get a whole lot worse, and we need to remain vigilant. This can get worse and will get worse."*

(2) The Doctor-Patient Relationship Has Been Impaired.

The trust between patient and doctor is eroding. OB/GYN, EM, and FM physicians report that they are no longer able to practice evidence-based medicine or speak openly to their patients. Patients are not getting the best care, and the doctors are under profound moral stress, unable to live up to their oath to *do no harm*.

Doctors reported:

- *"I was advised to just tell the mother to Google her options."*
- *"My concern for the health of the pregnant woman is tempered by my fear of losing my license or even going to jail."*

(cont.)

- *"I will advise as to her options, but I stop short of making a referral; women with means often choose to travel out of state. Not only is that a costly option, but it requires the pregnant woman to keep her local OB/GYN in the dark and abandon her support system."*
- *"Am I even allowed to tell her any options that she has? Is it my job as a physician to say, 'You must continue on with this pregnancy, whether you like it or not."*

(3) "It's Just Plain Cruel."

Doctors repeatedly described it as "cruel" to require a woman to carry to term and deliver, against her will, a fetus that clearly could never survive outside the womb. In these cases, the pregnant women bear all the risks of pregnancy and the grief over the lost baby and must endure a delivery that may be physically and emotionally traumatic. They have also lost agency to decide the right course for themselves and their families.

Doctors reported:

- *"She would go to work, and people would consistently say to her, 'Oh, my gosh! You look like you're about to pop! What are you having?' and make comments, while she knew that she wouldn't get to take this baby home."*
- *"If the fetus cannot live outside the womb, all we are doing is asking the mother to take on the dangers of pregnancy with no positive ending possible."*
- *"We are asking women to risk their future fertility and health to continue a pregnancy where the fetus has a fatal condition."*

(4) Clinical Expertise Is Eroding.

With increasingly limited opportunity for trainees to manage medically necessary abortions, doctors are not learning how to manage pregnancy terminations, putting all women at risk. Given Texas' standing as a major educator and training site for future physicians, this threatens other states as well, with trainees beginning practice without the requisite skills to manage miscarriages or abortions.

Doctors reported:

- *"Doctors and nurses get little exposure to pregnancy termination and have less expertise, putting all women requiring termination at risk."*
- *"Our residents are now excused from the patient's care once it is determined an induction is required in order to protect them from any potential litigation."*
- *"This has also had significant impacts on our residents. We have taken a lot of responsibility away from our learners and instead have our faculty take over to mitigate any risks."*
- *"I worry about OB/GYNs in training that are going to miss out on the training and experiences of those [like me] that are leaving the profession mid-career due to the current laws. This will have an impact on our profession for a long time. Who will take care of the women of Texas in the coming decades?"*

(5) Fear Dominates.

Fear and confusion manifest in the different approaches doctors and hospitals take in interpreting Texas law. Some doctors believe they are permitted to tell women that abortion is an option outside of Texas, while others believe if they say even that much they will be prosecuted for aiding and abetting an abortion. Some hospitals only permit an abortion for an ectopic pregnancy or PPROM if infection is present or there is no fetal heartbeat. Doctors know the fetus cannot survive but their fear of prosecution overpowers their medical judgment.

Doctors reported:

- *"I do not know – 'Am I going to get in trouble because I did not give my patients options or because I did'?"*
- *"We want to do our job safely, without fear of prosecution. That is all we ask."*
- *"There is an insane amount of fear and uncertainty on the part of ER physicians; the fear aspect has made everyone want to step back from complicated cases and not deal with them."*
- *"I do not know that I feel out of the reach of [Texas officials]. I feel like I have a target on my back."*

(cont.)

- *"The law is vague, and I think it's intentionally vague…if you're faced with a situation where there's ambiguity, and you decide incorrectly, you could end up with a $100,000 fine and in prison for five years or losing your medical license. You are going to err on the side of not doing things [for patients] or referring patient out or delaying care."*
- *"I was recently in a situation in a local ED where I diagnosed a patient with an ectopic pregnancy with detectable fetal cardiac activity. And let me be 100% clear, an ectopic pregnancy is not viable (regardless of any detectable fetal cardiac activity). This patient was admitted to the hospital for three days waiting until there was no fetal cardiac activity, so the obstetrician felt legally safe to perform the necessary procedure to remove the nonviable ectopic pregnancy. You are talking about up to $15,000 per day for these hospital stays that expose a woman to unnecessary dangers—infection, septic shock, future infertility, mental trauma, and other complications. We have already seen patients die this way in Texas."*

Doctors requested anonymity, citing fears of professional—and in some cases—personal retribution from speaking out, which further emphases the important theme of a culture of fear overlaying the practice environment for these physicians.

Interview Narrative Summaries

Interview #1

Practice	Gender/Race	Location
■ Neonatologist ■ Urban hospital ■ 4 years in practice	■ Male/White	■ Harris County

"Your baby has a fatal fetal anomaly and cannot survive. But you will have to carry to term…"

Interview Summary

The number of Texas women delivering babies with fatal anomalies is going up as a direct result of the abortion ban. For the women, this means continuing their pregnancies for nine months with all the risks attendant to pregnancy and none of the joy. **The dynamics between doctors and patients are fundamentally different**; we can no longer give them the choice to terminate the pregnancy after we diagnose a fatal fetal anomaly. There used to be a kind of peace that came from empowering the parents to make that choice. Now, we know their baby does not have a future, but the mother must continue her pregnancy, answering well-meaning questions about her baby's sex and due date and her future plans. **She then goes through the risks and pains of delivery knowing that we can do nothing to save her baby**.

One of the most striking circumstances occurs when the fetus is diagnosed with anencephaly, where the skull and brain are not fully formed. There is nothing you can do to save the fetus. All I can do is offer comfort care. In one case, I was delivering a fetus diagnosed with anencephaly when the brain ruptured, and the fluid spilled out on to the nurse practitioner and me. We quickly worked to clean ourselves and wrap the baby to give to the mother. In other cases, babies are born with misshaped heads and distorted facial features, triggering even greater trauma for the mother. "This creates a difficult ethical situation for our patients [the lack of exception for fetal anomalies]; if

you think about this for more than ten seconds, it's easy to say 'it is God's will' without thinking about the logistics of someone who is visibly pregnant having to answer the question 'is it a boy or girl,' then go through the pain of delivering knowing the baby is going to die."

Requiring women whose babies have been diagnosed with fatal fetal anomalies to carry to term imposes a considerable emotional burden on the mother, over and above the attendant risks of pregnancy. It also puts increased demands on the social workers, nurses, and doctors who are supporting her during her pregnancy and after delivery—and with more costs.

Interview #2

Practice	Gender/Race	Location
■ OB/GYN ■ Private practice ■ 5 years in practice	■ Female/White	■ Redacted

"She would go to work, and people would consistently say to her, 'Oh, my gosh! You look like you're about to pop! What are you having?' and make comments all while she knew that she wouldn't get to take this baby home."

Interview Summary

I had a young patient, and it was her first pregnancy. She elected not to do genetic screening early in pregnancy because her risks were low. When we did her anatomy scan, unfortunately, she had a baby with significant fetal anomalies not compatible with life. The baby did not have a functional mouth, prohibiting the ability to receive food or medication orally and significant cardiac defects incompatible with life. The high-risk doctor I referred her to agreed that this baby was not compatible with life and offered her an amnio to get a definitive diagnosis. In the past, how I was trained to handle this was to offer her options: either to be admitted and induced and deliver her baby, who would ultimately not survive, or to continue the pregnancy, knowing that she would likely develop complications—and the baby still would not survive. Because of the restrictions in place, she only had the option to continue the pregnancy. She developed polyhydramnios, a condition where there is an excessive amount of amniotic fluid in the uterus during pregnancy, to the point that she was having difficulty breathing. The high-risk OB/GYN at that time offered to perform an amnio reduction, where we would put a needle in and drain off fluid to ease her effort of breathing, or to proceed with an induction. And she elected to move forward with delivery. During labor, the baby demised, as we expected.

Throughout this pregnancy she was given no option but to continue, knowing that she would develop complications. She experienced significant financial impact because they proceeded with routine monitoring with the high-risk OB, knowing that the outcome would not change. The patient also faced significant emotional impact. She would go to work, and people would consistently say to her things like, "Oh, my gosh! You look like you're about to pop! What are you having?" and make **comments, while she knew that she wouldn't get to take this baby home**.

In rural hospital settings, cases like these are more challenging. There was a patient who came into a rural facility that didn't have access to ultrasound, due to what appeared to be an ectopic; the gynecologist called the person on call from our facility to conduct an ultrasound.

My colleague accepted her as a transfer to get an ultrasound and potentially give Methotrexate. The ultrasound confirmed the ectopic pregnancy at our facility, and she got Methotrexate and was told to follow up with her gynecologist. She presented back to the rural hospital with pain. I got called for a request to transfer her again for another ultrasound. She did not need an ultrasound. **This woman has blood in her belly, she's rupturing**. I told them she needed to be taken to the OR, and they pushed back and said that that doctor did not feel comfortable intervening without further imaging to verify that this was an ectopic, and not an intrauterine, pregnancy. I called the admin on call and told them that I was highly concerned that this patient was going to rupture en route, and so they agreed to decline the transfer. They delayed her care to get a CT scan, since they didn't have ultrasound availability. The facility also did not have Methotrexate. The CT confirmed at least that she had a belly full of blood, and so they took her to the OR, and she had a ruptured ectopic with blood in her belly. Even though there's a carve out for ectopics, there are still hospitals that are not managing them for fear of retaliation or litigation, or they just truly misunderstand the law. **But women are being harmed by that**.

I always thought I'd stay in Texas forever. I married a Texan. They hate leaving Texas. If Cytotec becomes a controlled substance, then I would leave the state. Cytotec is used to help manage pregnancy loss. If they made Cytotec a controlled substance then we would have to take it out of the hospital hemorrhage kit, and then when we needed it, the nurse would have to stop caring for the patient, leave the room and go to the Pyxis, sign in and verify with the machine that there's the right number in there before you can then dispense the number that you need. **This is an extremely time-consuming process that delays urgent medical care in the case of maternal hemorrhaging**.

I am speaking up about these things because I can't fear retaliation too much, because what if something happens to one of my daughters someday? How am I supposed to be like, "Yeah. Your mom was an OB/GYN, but she did nothing to try to fight this battle." I would feel responsible for them too.

Interview #3

Practice	Gender/Race	Location
■ OB/GYN ■ Private practice and hospitalist in rural and urban settings ■ 20 years in practice	■ Female/White	■ Redacted

"Am I even allowed to tell her any options that she has? Is it my job as a physician to say, 'You must continue on with this pregnancy, whether you like it or not'?"

Interview Summary

When Dobbs was first overturned, I was fortunate to be in an urban facility where we worked with the hospital legal department. I also had support from my employer, despite the confusion with the legal landscape; however I know this was not the case for the majority of OB/GYNs across the state.

I fully realized the impact of the Texas abortion ban when I was doing locums [occasional shifts working at a different hospital]. There was a 17- or 18-year-old young girl who presented with irregular bleeding. It turned out that she was six weeks and one day pregnant, and it was my first time trying to counsel in that situation. It was an unexpected pregnancy. I was walking on eggshells, thinking, "Do I want the nurse in here when I have a conversation with this patient? She'd come to the hospital by herself. But does she want to call a family member? Do I include them in the conversation?" This was the first time where I had to pause and think. **"Am I even allowed to tell her any options that she has? Is it my job as a physician to say, 'You must continue on with this pregnancy, whether you like it or not'?"** That was the first time where all of a sudden, as a physician with many years of training, I felt like I was doing something illegal or inappropriate. I kept thinking, **"Am I breaking a law? Is this criminal?"**

As time went on after Dobbs was overturned, the initial support from the hospital system became more blurred. During our final meeting with the hospital lawyer, she encouraged us to get a retainer for our own lawyer in case we needed one during our routine practice of medicine. This is when I was like, "I'm working very hard taking care of patients, and I am providing the best care that I can for people. And then in the middle of this, I'm also supposed to find a lawyer to protect me from the same patients that I am caring for or their families or the hospital staff in case someone reports when I provide or discuss medical options?"

I love taking care of patients. It is hard on family and trying to maintain work-life balance, and now, all of a sudden in this post-Dobbs environment, there is a negative vibe around providing standard care. It feels like you are trying to get away with something.

It really impacted how I felt showing up for work each day. I ask myself, "Is this going to be the day where something happens where I'm the test case?"

Another incident that drove this point home is when I did a PRN shift at an urban hospital. During one shift, we only had around eight-ten antepartums, which was routine. But on this shift, there were three antepartums that were admitted to the hospital with congenital anomalies, two of which were not compatible with life; for the other, it was uncertain what the outcome would be. And I just remember rounding and thinking, "Gosh, that's weird. I just don't remember us ever having this many patients sitting here with prolonged admission with non-viable fetuses." The midwife I was working with and I were talking when we both realized that this was a consequence of the law—these patients were not given an option of whether to continue their pregnancy or not."

I have enough life and professional experience to know that, when given the choice, we never know what a patient will decide. I just wish that people who were making these laws had the experience of being wrong about guessing how someone would choose. There were times where people would get an unexpected diagnoses like Trisomy 18, not compatible with life beyond a year, and I would discuss this with them and in my mind say, **"I know this person. This person's going to 100% choose termination," and they wouldn't, and vice versa**. I learned very early in my practice that as a provider, I am out of the equation. My job is information provider, to answer questions and to provide support no matter what the patient chose.

In terms of my practice plans, I am actually not practicing anymore. I stepped away at the end of December. I'm trying out a sabbatical and I'm doing fine not practicing. I don't miss it and, at this point, it is clear that I will not return. I do not miss the stress of practicing medicine and obstetrics these days. I do not miss the fear of not knowing if I'm going to lose my license because I'm practicing standard of care or if I am going to have to pay a huge penalty or be incarcerated. That's just not worth it. My family members know I have a lot of integrity, and so if I am going to practice, I will always do the right thing—which is educating patients according to standard of care and **letting them make their own decisions**.

Interview #4

Practice	Gender/Race	Location
■ OB/GYN and MFM ■ Urban hospital ■ 9 years in practice	■ Female/White	■ Dallas County

"I feel like I have a target on my back when I fill out these forms and provide comprehensive and evidence-based obstetric care to patients in crisis."

Interview Summary

Prior to the passage of SB8 and the Texas abortion ban, we offered termination when the mother's life or health was at substantial risk or when the fetus had been diagnosed with a lethal fetal anomaly. After the abortion bans went into effect in Texas, we held an urgent meeting to review the circumstances under which we could still offer abortions. Ultimately, it was determined that only faculty could perform abortions in cases when the mother's life or health was at risk; trainees could perform an initial assessment of the patient but could not participate actively in the induction procedure or delivery to mitigate risk of involvement in litigation. **This is a disservice to our trainees who will be the next generation of physicians**.

We have always ensured thorough counseling of any patient is documented following a diagnosis of a previable premature rupture of membranes, which has not changed. However, we ensure the documentation in the medical record now reflects agreement on the clinical assessment and management plan by two separate physicians, not just one. We have always completed the required documentation for the state following termination of pregnancy, but now I feel like I have a target on my back when I fill out these forms and provide comprehensive and evidence-based obstetric care to patients in crisis.

We can no longer offer termination for lethal fetal anomalies unless the fetus has died or there are additional life-threatening maternal complications. In the case where a patient asks about interruption of pregnancy, I discuss the legal restrictions on abortion practices in different states, and some women choose to go out of state for an abortion. I do not withhold this information if a patient asks about resources, but this is part of the medical discussion and confidential conversation with my patient. Some women decide to continue their pregnancy, and we continue to provide comprehensive prenatal care and work with them to develop neonatal palliative care plans. **The reality is that these women are at increased risk of complications as they continue the pregnancy. Labor and delivery complications at full term are more complex to manage and result in greater maternal morbidity and mortality. That's the evidence**.

Interview #5

Practice	Gender/Race	Location
■ Emergency Medicine ■ Urban hospital ■ 3 years in practice	■ Female/Asian	■ Redacted

"While Dobbs has not directly impacted my clinical work, it has had significant impacts on the comprehensive academic training of our emergency medicine residents."

Interview Summary

The way that our ED is designed, we have a separate OB/GYN emergency department. **While Dobbs has not directly impacted my clinical work, it has significantly impacted the academic training of our emergency medicine residents**. I am very involved in our medical training didactics, and we recently had a simulation training (SIM) with our residents on navigating a first trimester loss that was largely focused on how to navigate the conversation with the patient. This SIM was challenging because there is a lot of uncertainty not just amongst the residents and students, but also amongst the faculty on what is okay and safe to say or prescribe to a patient. This uncertainty makes people lean towards a more conservative, watchful, waiting approach, and that's not necessarily the best thing for the patient. Even in this simulation environment, because of all the confusion, I saw the conversation skew towards a more conservative and watchful approach. **Even in cases of a confirmed loss of the fetus**, we have not gotten much guidance on how to approach these situations; maybe our OB colleagues have, but I would say in the ED we have not gotten any. **The laws are impacting medical training**, and I think that residents who might go on to practice in other places may not have the best knowledge about how to approach these types of cases.

These new laws have also affected our ability to recruit residents we are really excited about. Every year we send out surveys to residents that we ranked higher and did not come to our institution for whatever reason and we ask them why. One of the questions asks them about the negatives they saw in the program. A few years ago, we got an answer that said Texas political leaders and their health policies. We as an institution do not have power to change this.

I have a friend who was planning to move to Texas after residency but changed her mind after some of the legislative decisions. If I wasn't here at the point that the laws started changing, I do not know if I would have chosen to come. Ultimately, these laws will influence my decision to stay in Texas or leave the state.

Interview #6

Practice	Gender/Race	Location
■ OB/GYN and MFM ■ Suburban hospital ■ 10 years in practice	■ Female/White	■ Redacted

"The laws put a wedge between the patient and the doctor, injecting third parties—with no first-hand knowledge of the patient or medical training—into clinical decisions."

Interview Summary

When a pregnant woman presents with previable PPROM, we must decide whether her condition meets the legal definition of an emergency. We must make our decision against a background of fear and through the lens of the law as interpreted by the hospital's legal department. **We are asked to take a "check the box approach," but medicine, like life, does not fit into prescribed boxes**. Forcing the woman to carry a pregnancy that, in many cases, has a very low or no chance of fetal survival but up to almost a 60% chance of maternal morbidity is counter to the oath we all took when we entered this profession. Before Dobbs, I was able to counsel the patient about all management options in the setting of previable PPROM and the choice was theirs. Now if a patient presents with previable PPROM but does not show signs of infection, I have found myself too many times forced to say, "I'm sorry, the law does not allow me to induce labor."

Termination of pregnancy is sometimes the safest plan of care. The reasons that a women chooses termination of pregnancy are complex. **It is often a mother making one of the hardest decisions of her life regarding a pregnancy she desperately wanted** but, due to a serious medical complication, an abortion may be the safest and best course. It will allow her to be present to see her other children grow up or to have more children in the future. We grieve the loss of the pregnancy with each patient. But it is our job to help the patient have a safe pregnancy, which sometimes includes making those hard decisions. This is what we have been trained to do. We want to do our job safely, without interference or fear of prosecution. That is all we ask.

Since these laws have gone into effect, the medicine we practice is no longer ours and is more of a legal construct. Instead of worrying about whether or not the patient is sick (based upon on our clinical judgement and medical training), we now have to worry about whether or not the patient is sick according to the legal definition, which is defined per institution.

Interview #7

Practice	Gender/Race	Location
■ OB/GYN ■ Suburban hospital ■ 2 years in practice	■ Male/White	■ Redacted

"I was advised to tell pregnant women to Google their options if they request an abortion…"

Interview Summary

I did my training in states where abortion remains legal. I could offer the option of pregnancy termination to my patients where an ultrasound showed a congenital anomaly inconsistent with life. The first time I had a Texas patient with a similar diagnosis, I froze up. She immediately asked if she could have an abortion. **I was in an awkward position—how much was I allowed to say?** I responded simply that abortion is not legal in Texas. Feeling like I had really messed up, I later asked a more senior colleague who explained that they tell patients who ask about options that they need to Google that information. There is no standard on how to help patients navigate these tragedies. I now am more comfortable and will explain more to my patients, stopping short of a referral.

Several months ago, a pregnant woman who had had multiple prior C-sections came to our hospital with previable rupture of membranes. The doctor on site offered her an abortion and then the nurses and doctors disagreed about what was the proper medication to use. While they were debating the right way to proceed, the woman became septic. I then got an emergency call while I'm at home asking me to come in and do an emergency dilation and curettage procedure (D&C). In states where abortion is legal, the doctors and the nurses would be familiar with the proper medical or surgical options for terminating a pregnancy for a woman who had already had multiple C-sections. And, if they were not, they would have followed national and international guidelines. In Texas, care teams get much less exposure to women requiring abortions in special circumstances like this, and avoidable harms can occur.

Residents who train at our hospital get even less exposure to women requiring pregnancy termination. The residents do the initial evaluation, an attending physician confirms the diagnosis, and the resident is excused from the room to ensure they do not face litigation. They cannot hear how I counsel the patient and the options we discuss, nor do they participate in the induction. Our residents are not learning about abortion procedures, and many of our doctors and nurses are not abreast of best practices. These laws are compromising clinical education and care.

Interview #8

Practice	Gender/Race	Location
■ OB/GYN ■ Urban facility ■ 35 years in practice	■ Male/White	■ Urban

"…So the law is very effective in ensuring people err on the side of not doing things or referring them out or delaying care."

Interview Summary

Prior to SB8, I was in practice down in the Rio Grande Valley area of Texas. During this time, I was caring for a number of patients who were experiencing first trimester loss, PPROM, and complicated medical issues such as renal failure or severe preeclampsia, as well as lethal fetal anomalies. This abruptly changed after the passage of SB8. I could no longer provide much of this critical, evidence-based care. This significantly changed my practice. In addition to changing my practice, SB8 affected clinical relationships within a facility. There was a lot of mistrust at this point among staff at the hospital. This included MAs, PAs, and nursing staff. You could no longer counsel patients without fear that someone might have a problem with it and sue you. **This created a hostile environment, an environment of fear**. So, we defaulted to communicating directly with patients with no other parties present.

Then we faced the overturning of Dobbs, and this increased the delay in care. People became more reluctant to diagnose a miscarriage. **People were fearful of making any mistakes because of the new laws**. I've received a call in the last month where someone had an ectopic that had a heartbeat, and the provider wanted to clarify if they could treat the ectopic. They hadn't had a case like this since the law went into effect, and they wanted to make sure that they were following the laws. They were uncertain. For someone who had just diagnosed a dangerous ectopic [requiring immediate treatment] to take the time to call an "expert opinion" is absurd.

This also had significant impacts on our residents. We took a lot of responsibility away from our learners and instead had our faculty take over to mitigate any risk to the learners. I would still include my residents in the room as I counseled patients post-Dobbs overturning, but I significantly reduced the number of other learners that would have previously been in the room [e.g., PA or NPs and residents from other programs].

You know one of the things that might help make things easier and less stressful for providers, particularly in community hospitals, is clarification of the laws and what is allowed. I think it is one of the intentional aspects of both laws. The Supreme Court of

Texas, the Legislature, the Governor's office, and the Attorney General's office like to say that the laws are clear.

In my experience, many physicians feel the law is vague. I think it's intentionally vague. I have discussed this many times with other physicians—if you're faced with a situation where there's ambiguity, and you decide incorrectly and you could end up with a $100,000 fine and in prison for five years or losing your medical license, you're going to err on the side of that not happening. So the law is very effective in ensuring people err on the side of not doing things [for patients] or referring patient out or delaying care to make certain that they will not be charged.

I think that it would be very helpful if those could be clarified. The law allowing affirmative defense in the case of PPROM and an ectopic, it's still only a defense. I've been reassured by many people, "Oh, no District Attorney would go after anybody in that situation now, because you could use this affirmative defense". You could still get charged under the law if somebody had a different interpretation of what actually happened. "Well, was she really PPROM?" or "Did she really have an ectopic?" It is often not black and white. So I think that clarifying that would be very helpful. Or better yet, get rid of the law for those issues and the need for an affirmative defense. If we are going to have these laws, we also need to charge hospitals to have policies so it is clear what physicians can and cannot do.

In the cases where I see patients with fetal anomalies, I have done extensive research and spoken with legal counsel and still believe I am allowed to talk to patients about their options. **The Texas laws have made me think more about my future practice plans in Texas**. I have remained in Texas due to family reasons which will likely change in the next two–three years. When this changes, I will likely leave Texas to practice so I can provide comprehensive health care to all of my patients.

Interview #9

Practice	Gender/Race	Location
■ Family Medicine ■ Private practice ■ 15 years in practice	■ Female/White	■ Small city

"We are asking women to risk their future fertility and health to continue a pregnancy where the fetus has a fatal condition."

Interview Summary

If you spend one week in my practice, you will find plenty of examples of how much Texas' abortion ban has impacted it. In one instance, there was a patient present with

a fetal contracture, and it was anticipated that the patient would not be able to have a successful vaginal delivery or C-section with the fetus born alive, with the C-section further impacting the mother's future fertility.

Women who have the means may choose to go out of state for an abortion. They do so in secret and are lost to us for follow up care. They do not want to put their care team at risk of prosecution.

I recently had a family facing a pregnancy that they had not planned—she was using contraceptives. They could not afford another child; they have other children and are even now struggling to make ends meet. When I counseled her that her pregnancy test was positive, **I could see and hear suicidal ideation in our conversation**. She asked me what her options were, and I told her I cannot have this conversation because this would be considered aiding and abetting an abortion. **I have known this patient for almost 15 years, and I can't have that conversation with her in the most meaningful time of her life**. I am not able to give my patients all the information they need to make an informed decision.

The complicated legal nature of providing obstetric care in Texas has pushed several of my FM colleagues to quit providing OB care or leave the state. We already have maternity care deserts in this state. As family medicine physicians, we help to bridge the gap in reproductive care, especially in the wake of the OB/GYN shortage. I love delivering babies, and I can't imagine not, but I'm also navigating this world where I cannot walk with patients down that terrible road of navigating a challenging pregnancy diagnosis. **We are forced to stop halfway down the road and say, "Okay, you go on ahead, but I can't come with you or help you figure out which direction to go in."**

While this is a difficult position to be in as a clinician, I do not plan to leave Texas. As providers, we are in the trenches for a reason. We consider our community members to be our family, and we are staying by their side, doing whatever we can to benefit them and to give them information and resources as much as the law allows.

Interview #10

Practice	**Gender/Race**	**Location**
■ Emergency Medicine ■ Urban facility ■ 13 years in practice	■ Female/White	■ Dallas

"We see so many women experiencing bleeding in early pregnancy—as the safety net, we care for the women who don't have access to OB/GYN care."

Interview Summary

One of the bread-and-butter things that we do in emergency medicine is early pregnancy care. There's published research that outlines how, based on national data, emergency departments see about 900,000 visits annually for early pregnancy loss-related care. Not all of those cases are confirmed losses; a lot of times, we see bleeding that can be normal in pregnancy in the first trimester. A lot of what we have to do is make a diagnosis of whether a pregnancy is potentially ectopic or likely to end in miscarriage in early pregnancy. There are very specific ultrasound criteria for the diagnosis of pregnancy loss. A lot of times, we do not have access to all of the outpatient imaging for patients when they come to us.

We took care of a patient who, if you looked at her medical history and listened to what she was telling you, clearly needed a D&C. But instead of listening to the patient, there was an esoteric conversation about whether she was really sick enough. She got sent home and two weeks later she came back even sicker and got a D&C. This is a case where we were not able to trust the patient.

I really do think there is a significant amount of fear and uncertainty on the part of ER physicians; we have to operate really quickly and make decisions really fast, and there is no time for long, thoughtful discussion. The fear aspect has made everyone want to step back from complicated cases and not deal with them.

Interview #11

Practice	Gender/Race	Location
■ OB/GYN and complex family planning ■ Urban hospital ■ 5 years in practice	■ Female/White	■ Dallas County

"Practicing in Texas is a decision that me and my family have to re-affirm daily..."

Interview Summary

Since the passage of SB8 and ultimately the trigger ban post-Dobbs, my practice has changed quite a bit. I am now practicing as a generalist, with only a small portion of my job involving my subspecialty training in complex family planning. While I want to fully utilize my subspeciality training to care for patients, the stresses of travel and the inability to provide abortion care locally to the vast majority of those who need it has led me to my current role.

There are thousands of patients I cannot care for due to the Texas abortion laws. **The closure of clinics has led to my hospital's ED seeing an uptick in cases of second trimester demise and PPROM cases**. In our facility, we are fortunate to have support from clinical and administrative [legal] leadership to navigate the laws and provide good care, but I know this is not universally the case across the state, particularly for smaller facilities.

As a result, we are managing more complex cases. I feel fortunate that I am supported by my institution and can use my subspecialty training to help in treating these patients, **but this is still only a small portion of the patients who need care in our state**. I know that my situation is the exception, not the rule, with respect to the support and protections I feel I have.

Since SB8, the practice environment has felt extremely tenuous. **People are still walking on eggshells more than three years later**. We have come a long way as a professional community navigating the laws and providing care, but we have SO much further to go.

Interview #12

Practice	Gender/Race	Location
■ Emergency Medicine ■ Suburban hospital ■ 20 years in practice	■ Female/White	■ Did not share

"It's not coming as a rainstorm. It is coming as a drip…drip…drip."

Interview Summary

While we still consult regularly with our OB colleagues for pregnancy cases, emergency medicine doctors are feeling more exposed than ever. **A D&C used to be common for miscarriage management, but fewer are being done now due to the environment being so litigious**. Now, patients won't get a D&C [from an OB] unless they are septic or there is [significant] blood loss, and the patient's life is at an unnecessarily high risk. Similarly in the past, if you were experiencing an ectopic pregnancy, you could be prescribed medicine; but now surgery is the only option. There used to be mifepristone [available], but now the pharmacy does not even stock that anymore, standard of care be damned. **These laws have directly impacted the standard of care**.

I worked at a health facility where a pregnant patient died from a hypertension complication, after bouncing back and forth from our facility to another, both places and teams confused by and in fear of the new laws and what that meant for us in

treating her. As our team and hospital came together in the aftermath of this case, it was clear that nobody knew the world we were entering and what to do to protect us as physicians. The initial response from our hospital was….just a lot of preeclampsia training.

I have spent 20 years in the south and never worked anywhere else, and I am watching the laws get worse and worse and worse. **"I do not know – 'Am I going to get in trouble because I did not give my patients options or because I did'?"**

Interview #13

Practice	Gender/Race	Location
■ Emergency Medicine ■ Suburban and rural hospital ■ 10 years in practice	■ Male/White	■ Amarillo

"I recently signed a contract for a job in California's SF area. I start part-time in April. Part of this decision is due to the Texas anti-choice laws."

Interview Summary

Prior to SB8 and Dobbs, when a pregnant patient came into the ED for vaginal bleeding, you would perform an ultrasound and find out they are in the process of a miscarriage. Regardless of cardiac activity, if the fetus was below the age of viability, had congenital defects, or it was in the woman's best interest, you could manage the case.

After SB8 and Dobbs, the conversation is so much more complicated.

Now, if we determine their last menstrual period is over six weeks, and they have abdominal cramping or pain with vaginal bleeding, standard of care is to still get an ultrasound to rule out an ectopic pregnancy or other life-threatening complications. If fetal cardiac activity is detected, this completely changes how we can discuss options with our patients—regardless of if the fetus is non-viable, ectopic, has congenital defects, or it is simply in the best interest of the woman or her choice to get an abortion. I work in Amarillo, Texas and several of the small towns around the Texas Panhandle. We are **classified as a maternity health care desert, and you can imagine that access to comprehensive women's care and options is extremely limited**. Thus, patients are often left on their own to navigate the legal complexities of women's health care in Texas. Even if the patient point-blank asks, "Where can I go to get help?" **I am not allowed to provide any resources for her for fear of facing jail-time**, fees, lawsuits, and loss of my medical license to continue practicing medicine.

I was recently in a situation in a local ED where I diagnosed a patient with an ectopic pregnancy with detectable fetal cardiac activity. And let me be 100% clear, an ectopic pregnancy is not viable (regardless of any detectable fetal cardiac activity). This patient was admitted to the hospital for three days waiting until there was no fetal cardiac activity, so the obstetrician felt legally safe to perform the necessary procedure to remove the non-viable ectopic pregnancy. **You are talking about up to $15,000 per day for these hospital stays that expose a woman to unnecessary dangers—infection, septic shock, future infertility, mental trauma, and other complications**. We have already seen patients die this way in Texas.

Interview #14

Practice

- Emergency Medicine and fellowship trained in ultrasound
- 7 years in practice

Gender/Race

- Female/Mixed

Location

- Suburban area of large city

"While I mostly refer my patients who need obstetric care to any local OB with availability, now I am going to specifically ask the OBs what they are going to do for the patient before I even consider referring them to their care, because I've lost quite a bit of faith."

Interview Summary

I have my own personal story. I had severe abdominal pain and didn't know I was pregnant. I did a home pregnancy test after my shift in the ER, and it was positive. I immediately went to the ER because I figured it was ectopic, as I was in severe pain, and they confirmed that my hCG quant was 4,800—with that result, you would expect to see a pregnancy within the uterus on the ultrasound if one was growing there. You can see an intrauterine pregnancy on ultrasound at a hCG quant level above 1500. They saw a left adnexal mass, which they said could be an ectopic pregnancy or an exophytic corpus luteal cyst, and did not see an intrauterine pregnancy. The doctor explained to me that they were not certain it was an ectopic pregnancy but from my medical knowledge, I knew that it was most likely ectopic. I asked, "What else could the diagnosis be? I am a physician; what am I missing?" And they said that they didn't think I was missing anything, but they needed to be certain before they would treat me. **We waited two days to do a repeat ultrasound and hCG quant**.

The repeat ultrasound found the pregnancy continuing to progress in the tube and my hCG quant went up—indicating a higher risk of treatment failure. My doctors offered

to use Methotrexate despite the elevated risk of treatment failure at that point. **But they said they were busy that day, and so they told me to come back the next day for treatment**. I came back the next day—by now it's Thursday, and all this started on Sunday night. I got the Methotrexate treatment, but the next day the ectopic pregnancy ruptured my fallopian tube. **I went to the OR, and I lost my tube**. **This was devastating for me**.

I have a good relationship with my OB/GYN, so this is someone that I trust to tell me what to do. Before my own personal experience, I was naïve to the full scope of issues in reproductive health landscape post-Dobbs. While I mostly refer my patients who need obstetric care to any local OB with availability, now I am going to specifically ask the OBs what they are going to do for the patient before I even consider referring them to their care, **because I've lost quite a bit of faith**.

Appendix

Term	Definition
Adnexal mass	A growth found in the adnexa of the uterus, which includes the ovaries, fallopian tubes, and surrounding tissues.
Anencephaly	A severe birth defect where a significant portion of the brain and skull is missing.
Antepartum	Refers to the period of time before childbirth, specifically from the conception of a fetus until the onset of labor.
Congenital Anomalies	Are structural (how the body is built) or functional (how the body works) anomalies present at birth that can cause physical disability, intellectual and developmental disorders, and other health problems.
C-Section	Also known as a cesarean section, a surgical procedure to deliver a baby through incisions in the mother's abdomen and uterus. It's performed when a vaginal birth is not safe for mother, baby, or both.
Cytotec	A medication used to help pass a pregnancy after a miscarriage. It can be used to treat a missed miscarriage.
D&C	Dilation and curettage (D&C) is a surgical procedure that involves dilating (opening) the cervix and removing tissue from the inside of the uterus.
Ectopic Pregnancy	An ectopic pregnancy occurs when a fertilized egg implants outside of the uterus, typically in one of the fallopian tubes. Ectopic pregnancies are never viable and can cause life-threatening internal bleeding if they cause a fallopian tube to rupture. This is a serious medical condition that requires immediate attention.
ED/ER	Emergency Department/Emergency Room
EM	Emergency Medicine Physician
Exophytic corpus luteal cyst	A fluid-filled sac that grows on the ovary and can be seen on an ultrasound, usually benign.

Term	Definition
Fetal Contracture	A condition where a fetus develops a joint stiffness or limitation in movement due to tightened muscles, tendons, or skin around a joint, often caused by restricted fetal movement during pregnancy, resulting in a baby born with limited range of motion in affected areas.
FM	Family Medicine Physician
Maternal Hemorrhaging	Refers to excessive blood loss occurring in a woman during or shortly after pregnancy, most commonly known as "postpartum hemorrhage (PPH)," which is a serious complication where a new mother experiences significant bleeding following childbirth; it is considered a leading cause of maternal mortality worldwide.
Methotrexate	A type of medicine that stops cells from dividing. It can be used as a way (other than surgery) to treat a pregnancy that's implanted outside the uterus (ectopic pregnancy). It's given by injection with a needle.
Miscarriage	Is the loss of a pregnancy before 20 weeks of gestation. It occurs when the fetus stops growing and develops abnormally, resulting in its expulsion from the uterus.
Missed Miscarriage	A missed miscarriage, also known as a missed abortion or a silent miscarriage, occurs when a fetus is no longer alive, but the body does not recognize the pregnancy loss or expel the pregnancy tissue. As a result, the placenta may continue to release hormones, so you may continue to experience signs of pregnancy. A doctor will usually diagnose this condition during a routine checkup, when a fetal heartbeat is absent. A subsequent ultrasound will show an underdeveloped fetus.
PPROM	Previable premature rupture of membranes is a pregnancy complication that occurs when the amniotic sac breaks before 20–22 weeks of pregnancy. It's a serious health risk to both the mother and baby.
PRN	Stands for the Latin phrase "pro re nata," which means "as needed" or "as the situation demands."
Pyxis	An automated medication dispensing system, essentially a locked cabinet with compartments containing various medications that can only be accessed by authorized health care staff using their credentials, ensuring secure and tracked medication administration to patients.
OB/GYN	Obstetrics and gynecology physician
OR	Operating Room
Resident	A physician who has completed medical school and is undergoing postgraduate training in a specific specialty, such as OB/GYN, emergency medicine, or family medicine.
SIM	Stands for simulation, which is a training method that uses artificial scenarios to help medical students learn and practice clinical skills. SIM can help students develop skills like teamwork, stress management, and communication.

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