



Perspective

A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8

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When the U.S. Supreme Court issues its decision in *Dobbs v. Jackson Women's Health Organization*, the abortion care landscape will most likely be changed for at least a generation.

Even before a draft opinion was leaked, many experts anticipated that the Court would overturn *Roe v. Wade*, and nearly half the states are poised to ban or dramatically limit abortion care when that occurs.¹ These state laws criminalizing abortion may allow for very narrow exemptions, and anyone who violates the law could be subject to civil penalties, criminal fines, or imprisonment.²

Health systems and clinicians planning their responses³ can look to Texas, where we have already witnessed the impact of strict abortion bans on the provision of evidence-based, essential health care for pregnant people. Since September 1, 2021, Texas Senate Bill 8 (SB8) has prohibited abor-

tions after the detection of embryonic cardiac activity, which occurs around 6 weeks after a person's last menstrual period. After that point, SB8 allows abortions only in physician-documented medical emergencies. Anyone suspected of violating the law or aiding and abetting a prohibited abortion can face a civil lawsuit with monetary penalties of at least \$10,000.

We interviewed 25 clinicians from across Texas about how SB8 has affected their practice in general obstetrics and gynecology, maternal and fetal medicine (MFM), or genetic counseling. We concurrently interviewed 20 Texans who had medically complex pregnancies and sought care either in Texas or out of state after

September 1, 2021. Although aimed at clinicians who provide abortion care, SB8 has had a chilling effect on a broad range of health care professionals, adversely affecting patient care and endangering people's lives.

Some Texas clinicians still provide abortion counseling and referrals, believing that the law does not limit their free speech, while also noting that such freedom depends on a clinician's willingness to assume possible legal risk. On the basis of legal guidance, other Texas clinicians believe they are not even allowed to counsel patients regarding the availability of abortion in cases of increased maternal risks or poor fetal prognosis, although before SB8 they would have done so. Many clinicians have also been advised that they cannot provide information about out-of-state abortion facilities or directly contact out-of-state clinicians to trans-

fer patient information. These fears have disrupted continuity of care and left patients to find services on their own.

Many patients we interviewed described feeling hurt and confused when they learned their condition was not exempt from SB8 and they could not receive care in their home state. After receiving fetal diagnoses of spina bifida and trisomy 18, a 39-year-old woman was shocked that her physician would not even inform her about termination options. She said, “When you already have received news like that and can barely function, the thought of then having to do your own investigating to determine where to get this medical care and to arrange going out of state feels additionally overwhelming.”

Clinicians we interviewed recounted a variety of circumstances in which a patient could have received hospital-based abortion care before SB8 but was now denied that care. Patients with a life-limiting fetal diagnosis, such as anencephaly or bilateral renal agenesis, are only being counseled to continue their pregnancy and offered neonatal comfort care options after delivery. All hospitals where our respondents practiced have prohibited multifetal reduction, even though in some cases (e.g., complications of mono-chorionic twins) failure to perform the procedure could result in the loss of both twins.

Patients with pregnancy complications or preexisting medical conditions that may be exacerbated by pregnancy are being forced to delay an abortion until their conditions become life-threatening and qualify as medical emergencies, or until fetal cardiac activity is no longer detectable. An

MFM specialist reported that their hospital no longer offers treatment for ectopic pregnancies implanted in cesarean scars, despite strong recommendations from the Society for Maternal–Fetal Medicine that these life-threatening pregnancies be definitively managed with surgical or medical treatment.⁴ Some clinicians believe that patients with rupture of membranes before fetal viability are eligible for a medical exemption under SB8, while others believe these patients cannot receive an abortion so long as there is fetal cardiac activity. In multiple cases, the treating clinicians — believing, on the basis of their own or their hospital’s interpretation of the law, that they could not provide early intervention — sent patients home, only to see them return with signs of sepsis. An obstetrician–gynecologist recalled only one patient who was able to obtain an abortion at their hospital under SB8’s maternal health exemption, because her severe cardiac condition had progressed to the point that she was admitted to the intensive care unit. As an MFM specialist summarized, “People have to be on death’s door to qualify for maternal exemptions to SB8.”

Clinicians repeatedly noted that only Texans with financial resources and social support can obtain an abortion outside the state. Moreover, patients who travel for such care can have further complications while on the road or in the air. A patient with rupture of membranes before fetal viability said she was angry and sad to learn she could not get care in Texas because of SB8. She weighed her risks and decided to travel. “I knew how dangerous it was for me to get on a plane and go

get an abortion,” she told us, “but I knew that it was still the safer option for me than sitting in Texas and waiting, and I could potentially get sicker.” She reported that her obstetrician advised her, “If you labor on the plane, leave the placenta inside of you. You’re going to have to deal with a 19-week fetus outside of your body until you land.”

The climate of fear created by SB8 has resulted in patients receiving medically inappropriate care. Some physicians with training in dilation and evacuation (D&E), the standard procedure for abortion after 15 weeks of gestation, have been unable to offer this method even for abortions allowed by SB8 because nurses and anesthesiologists, concerned about being seen as “aiding and abetting,” have declined to participate. Some physicians described relying on induction methods to get patients care more quickly; others reported that their colleagues have resorted to using hysterotomy, a surgical incision into the uterus, because it might not be construed as an abortion. Although induction may be appropriate in some circumstances, hysterotomy increases a patient’s immediate risks for complications as compared with D&E or labor induction and has negative implications for all future pregnancies. One obstetrician–gynecologist described this practice as going “back to doing what they used to do before there was a D&E provider in town.”

The constraints on physicians’ autonomy to practice evidence-based medicine have created concern about the law’s long-term consequences for the medical field.⁵ SB8 has taken a toll on clinicians’ mental health; some phy-



An audio interview with Dr. Lauren Thaxton is available at NEJM.org

sicians report feeling like “worse doctors,” and some are leaving the state. As a result, clinicians worry that pregnant Texans are being left without options for care and without doctors capable of providing it.

Texas offers a preview of what we can expect if the Supreme Court overturns *Roe* and states are allowed to enact abortion bans and penalize people who violate the law. Health systems and clinicians caring for patients with complex pregnancies will have diverse interpretations of the laws’ narrow exemptions, which will result in unequal access to care. Patients without the resources to travel will assume the risks of continuing their pregnancy and term delivery, until they are

deemed “sick enough” to receive care. In states where abortion remains legal, clinicians will need to care for people who can travel but have had to assume other health risks, such as sepsis, hemorrhage, or delivery en route. As Texas has shown, allowing politicians and fear to determine what care can be provided is dangerous for patients and clinicians alike.

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