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CAUGHT IN THE MIDDLE: PROVIDING OBSTETRIC CARE WHEN PREGNANT WOMEN HAVE COMPlications

Ellen Wright Clayton, MD, JD* & Luke A. Gatta, MD**

INTRODUCTION

Pregnancy is a unique condition in human health in which a woman undergoes major physiological changes at some risk to her health to provide essential nurturance to the fetus.\(^1\) Thankfully, while many women\(^2\) do well with pregnancy, some women who were apparently healthy prior to conception, nonetheless develop serious health problems, either related or unrelated to the pregnancy itself such as preeclampsia or placenta accreta spectrum. Preexisting conditions such as autoimmune conditions, hypertension and other heart conditions, and organ transplantations, may worsen with pregnancy. At times, the health threat to the woman can be managed pharmacologically or by close monitoring, but sometimes, the best and even only course of action to protect the woman’s health is an intervention that would terminate the pregnancy. Depending on the gestational age this may be preterm delivery or previable termination.

Prior to the U.S. Supreme Court’s decision in Dobbs v. Jackson Women’s Health Organization,\(^3\) these often emotionally charged and ethically challenging decisions about how to proceed with the pregnancy were made in private by the clinician and the pregnant woman. Clinicians were guided by professional guidelines that set forth factors to help them decide whether offering termination would be in the best interest of the pregnant woman when continuing pregnancy

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\(^2\) We use the term pregnant “woman” to describe pregnant individuals but recognize that intersex people and people of various gender identities, including transgender, nonbinary, and cisgender individuals, give birth and receive maternity care.

\(^3\) 597 U.S. 215 (2022).
would place their health at risk. The woman may have also been consulting with her partner or those supporting her. Both the pregnant woman and the clinician would have been informed by their own ethical commitments. The world, however, has changed. In many states, obstetricians who seek to honor the choices of their patients who desire to terminate their pregnancies in order to protect their health may be caught between penalties from highly restrictive abortion laws and lawsuits from their patients. Both of these legal actions would expose previously confidential care and difficult decisions to public scrutiny.

The discussion that follows begins with the extent to which information about a woman’s abortion is protected (or not) by the Privacy Rule of the Health Information Portability and Accountability Act (“HIPAA”), since such information is typically essential for imposing criminal and civil penalties on clinicians. The next section addresses existing state statutory provisions in abortion-restrictive states that permit abortion when necessary to save the life or health of the pregnant women. These exceptions are vague, which can not only lead to delay in care and even for the need for the pregnant woman to travel to a more permissive jurisdiction but also for state agencies to access the details of care. We then turn to the possibility that women who suffer harm from delayed access to abortion will sue their physicians, which would also open the details of their care to public scrutiny.

I. PATIENT INFORMATION ABOUT ABORTION IS POORLY PROTECTED

Sometimes, pregnant women, their partners, or friends discuss their experiences on social media. Increasingly, pregnant women are bringing suits to

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5 Notably, clinicians who have conscientious objections to abortions are protected from any legal consequences for refusing to provide them. See 42 U.S.C. § 300a-7; R. Alta Charo, The Celestial Fire of Conscience—Refusing to Deliver Medical Care, 352 NEW ENGLAND J. MED. 2471 (2005) (discussing conscience clauses that provide exemptions for doctors who object to performing various forms of medical care including abortion). As a result, only clinicians who wish to honor their patients’ decisions face legal risk.

6 45 C.F.R. §§ 160, 164(A), 164(E) (establishing various federal regulatory requirements for the protection of patient health information).

challenge abortion-restrictive laws, which frequently makes public the actions of their health care providers.\(^8\) And on occasion, third parties report information about an abortion to law enforcement,\(^9\) due either to conflict with their own beliefs or to confusion about whether the laws regulating abortion require reporting.

The Biden administration has sought to foreclose criminal prosecutions by limiting access to clinical information about reproductive health care, including abortion, but its efforts have fallen short. Shortly after *Dobbs* was decided, the Department of Health and Human Services (“HHS”) issued non-binding guidance declaring that HIPAA allows covered entities not to provide access to protected health information (“PHI”) under certain circumstances.\(^10\) It also stated that


\[^10\] The guidance provides, in part that

> [t]he Privacy Rule permits but does not require covered entities to disclose PHI about an individual, without the individual’s authorization, when such disclosure is required by another law and the disclosure complies with the requirements of the other law. This permission to disclose PHI as “required by law” is limited to “a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law.”


An individual goes to a hospital emergency department while experiencing complications related to a miscarriage during the tenth week of pregnancy. A hospital workforce member suspects the individual of having taken medication to end their pregnancy. State or other law prohibits abortion after six weeks of pregnancy but does not require the hospital to report individuals to law enforcement. Where state law does not **expressly require such reporting**, . . .
individuals who work at covered entities but who are not involved in the patient’s care are specifically forbidden to release such information.\textsuperscript{11}

The Office of Civil Rights of the Department of Health and Human Services then issued a notice of proposed rulemaking to amend HIPAA\textsuperscript{12} to prohibit

the use or disclosure of PHI by a regulated entity . . . [for a] criminal, civil, or administrative investigation into or proceeding against any person in connection with seeking, obtaining, providing, or facilitating reproductive health care, where such health care is \textit{lawful} under the circumstances in which it is provided.\textsuperscript{13}

They illustrate this provision in abortion-restrictive states by saying: “For example, if a resident of a state receives reproductive health care, such as a pregnancy test or treatment for an ectopic pregnancy, in the state where they reside, and that reproductive health care is lawful in that state.”\textsuperscript{14} Notably, the notice of proposed rulemaking provides no protection for clinicians where the legal question is whether the risks to the woman’s health were serious enough to be covered by medical exceptions to be lawful, which is exactly what is at stake in many of these laws.

such a disclosure would be impermissible and constitute a breach of unsecured PHI requiring notification to HHS and the individual affected.

\textit{Id.} The guidance also limits disclosure for law enforcement, stating,

[i]n the absence of a mandate enforceable in a court of law, the Privacy Rule’s permission to disclose PHI for law enforcement purposes does not permit a disclosure to law enforcement where a hospital or other health care provider’s workforce member chose to report an individual’s abortion or other reproductive health care. That is true whether the workforce member initiated the disclosure to law enforcement or others or the workforce member disclosed PHI at the request of law enforcement [because such reports are not legally required].

\textit{Id.}

\textsuperscript{11} See id.
\textsuperscript{13} Id. at 23,510 (emphasis added).
II. THE THREAT FROM STATE CRIMINAL LAW FOR WOMEN WHOSE HEALTH IS AT RISK

By the end of 2023, twenty states had passed laws that permit abortion only to prevent the death or serious physical harm to the women. For example, Texas permits abortion only when

in the exercise of reasonable medical judgment, the pregnant female on whom the abortion is performed, induced, or attempted has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced.

Yet, how are physicians are supposed to know what risk is serious enough to make abortion permissible? These thresholds are not clear on their face to either physicians or their patients, or for that matter, to anyone else. In particular, pregnant women may differ in what level risk is acceptable to them, an issue critical

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15 See, e.g., ALA CODE § 26-23H-4; ARIZ. REV. STAT. § 36-2159 (not clear); ARK. CODE §5-61-304(a); FLA. STAT. § 390.0111(1)(a); GA. CODE § 16-12-141(3); KY. REV. STAT. § 311.723(2)(c); IND. CODE § 16-34-2-1(1)(A)(i); LA. STAT. § 40:1061.10(D)(4)(a); MISS. CODE § 97-3-3(1)(a); MO. REV. STAT. § 188.017(2)–(3); NEB. REV. STAT. § 28-3,106; N.C. GEN. STAT. § 90-21.81(5); N.D. CENT. CODE §12-1-19.1-03.1; OKLA. STAT. tit. 21, § 861; H.R. 3774, 125th Gen. Assemb., 1st Sess. (S.C. 2023); S.D. CODIFIED LAWS § 22-17-5.1; TENN. CODE § 39-15-217(a)(3) & (e); TEX. HEALTH & SAFETY CODE § 171.205; TEX. HEALTH & SAFETY CODE § 170A.002(b)(2); W. VA. CODE § 16-2R-2, -3(a)(3).

16 See, e.g., ALA CODE § 26-23H-4; ARIZ. REV. STAT. § 36-2159; FLA. STAT. § 390.0111(1)(a); GA. CODE § 16-12-141(3); IND. CODE § 16-34-2-1(1)(A)(i); KY. REV. STAT. § 311.723(2)(c); LA. STAT. § 40:1061.10(D)(4)(a); MO. REV. STAT. § 188.017(2)–(3); NEB. REV. STAT. § 28-3,106; N.D. CENT. CODE §12-1-19.1-03.1; N.C. GEN. STAT. § 90-21.81(5); H.R. 3774, 125th Gen. Assemb., 1st Sess. (S.C. 2023); TENN. CODE § 39-15-217(a)(3) & (e); TEX. HEALTH & SAFETY CODE § 171.205; TEX. HEALTH & SAFETY CODE § 170A.002(b)(2); W. VA. CODE § 16-2R-2, -3(a)(3).

17 This law specifically forbids abortion when needed to prevent the woman from harming herself, a provision found in many of the emergency exceptions.

18 TEX. HEALTH & SAFETY CODE § 170A.002(b)(2). Other states vary in their definitions of when abortion to protect the health of the pregnant woman is not a crime.

to providing care. For example, a 7% risk of a heart attack may seem high to some patients but not to others. Women in several states are filing lawsuits against these laws, often citing the harm they suffered from delay due to uncertainty about what the law permits.20

Three justices of the Texas Supreme Court In re State of Texas21 recently provided little help to clinicians despite purporting to provide clarification of the statutory requirements when they stated in dicta22

Under the law, it is a doctor who must decide that a woman is suffering from a life-threatening condition during a pregnancy, raising the necessity for an abortion to save her life or to prevent impairment of a major bodily function. The law leaves to physicians—not judges—both the discretion and the responsibility to exercise their reasonable medical judgment, given the unique facts and circumstances of each patient . . . [reasoning that] the exception is predicated on a doctor’s acting within the zone of reasonable medical judgment, which is what doctors do every day.

These justices suggested that the Texas Medical Board could provide more guidance about medical judgment, failing to recognize that the Board rarely seeks to determine the standard of care.23 The justices refused to say more themselves about how to define “reasonable medical judgment.”24 They did, however, state that “reasonable medical judgment does not mean that every doctor would reach the same conclusion,”25 so that conflicting testimony at trial would be resolved by the finder of fact.

Perhaps the Texas Supreme Court will provide more definition in its forthcoming opinion in Zurawski v. Texas,26 in which plaintiffs directly challenged the constitutionality of what the trial court characterized as “the widespread uncertainty regarding physicians’ level of discretion under the medical exception to Texas’s abortion bans.”27 Although the trial court enjoined the medical exception

20 See supra note 8 and accompanying text.
22 Id. at *4. Kate Cox, whose fetus had Trisomy 18, and her physician sought a writ of mandamus permitting her abortion to be performed in Texas. Three justices of the Texas Supreme Court denied the petition. The remainder of the opinion was dictum.
23 See, e.g., 22 TEX. ADMIN. CODE § 170.3 (establishing guidelines for prescription of controlled substances, a topic of major concern to the Board, stating that “[a] physician’s treatment of a patient’s pain will be evaluated by considering whether it meets the generally accepted standard of care and whether the following minimum [procedural] requirements have been met . . . .”).
24 In re State, No. 23-0994 at *6.
25 Id.
provision, the injunction never went into effect because its ruling was appealed by the state the same day. Beth Klusmann of the Texas Attorney General’s office in her oral argument before the Texas Supreme Court in Zurawski reportedly asserted that physicians were needlessly concerned about criminal penalties. She argued that physicians who exercise reasonable judgment in performing an abortion “should be fine under this law.”

28 She, however, refused to clarify in response to questions from the court what level of risk would qualify for exemption, saying only that “[i]f . . . a woman is bleeding or has amniotic fluid running down her legs, then the problem is not with the law. That is with the doctors. I mean, that woman clearly would qualify for medical emergency exception.”

Yet, the residual ambiguity about how sick a pregnant woman must be before abortion to protect her health is permissible looms large for physicians. Health care institutions often have new administrative requirements in response to these statutes, which can delay care. Failure to meet the terms of these legal exceptions can make physicians subject to criminal prosecution, which will be judged after the fact by a jury and in the press. If convicted, they could incur large fines, long prison terms, and lose their licenses.

III. THE NEW THREAT FROM MEDICAL MALPRACTICE SUITS IN ABORTION-RESTRICTIVE STATES

Women in restrictive states are challenging these statutes, reporting that they have not been able to obtain abortions in a timely fashion when needed to prevent harm to them. 30 Like the variability that characterizes pregnancies in trouble, the claims that have already emerged are protean, for example, that women have become septic from a doomed pregnancy or that they were not given care in the case of a miscarriage until the fetus was in the birth canal. 31 In Zurawski v. Texas, a case that has received much media attention, Beth Klusmann of the Texas Attorney General’s office reportedly urged that instead of challenging the statutes, women who suffer


31 Id.
harm from delays in abortion should sue their doctors instead, a view endorsed from the bench by Justice Brett Busby.33

A growing number of commentators are already raising concerns about liability for malpractice for harm resulting from delay in abortion, and some have argued that bringing malpractice suits might be an effective strategy to change the statutes and how they are enforced. Some law firms are already advertising that they are willing to pursue such claims. Others discuss physicians’ need for liability insurance. These lawsuits should they come to pass will necessarily subject to physicians’ actions to public scrutiny.

CONCLUSION

Physicians in abortion-restrictive states who care for pregnant women who become ill are facing new challenges as they try to meet their patients’ needs while avoiding criminal prosecution on the one hand or civil litigation if there is a bad outcome, especially when care is affected by the threat of vague statutes, on the other. All these legal actions will occur in the public eye. Unfortunately, the


33 Autullo, supra note 28.


proposed changes to HIPAA do not protect against criminal prosecution when the medical exception for the woman’s health is at issue.

Two changes are needed. The first is amending the state statutes to permit physicians to meet the needs of their pregnant patients within the privacy of the physician-patient relationship. Particularly when caring for pregnant women who are ill, physicians should be presumed to be acting in good faith and in accordance with the standard of care. If and when abortion is warranted to protect the woman’s health, the presence of a fetal heartbeat should not be cause for delay. The second is amending the proposed changes to the HIPAA Privacy Rule to prevent access by law enforcement throughout the United States to information about abortion without the woman’s authorization.