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Democracy Dies in Darkness

New abortion laws are especially cruel to my patients with high-risk pregnancies

What happens when a pregnancy goes wrong at 18 or 20 weeks.

By **Chavi Eve Karkowsky**
Chavi Eve Karkowsky, MD is a Maternal-Fetal Medicine physician (also known as a high-risk obstetrician). She has a book, "High Risk: A Doctor's Notes on Pregnancy, Birth, and the Unexpected" coming out March 2020 from Liveright/W.W. Norton.

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When I walk into a room of a woman whose water has broken at 16 weeks or 18 weeks or 20 weeks of pregnancy, I introduce myself as her high-risk pregnancy doctor. Then I tell her, “You’re the most important one in this room.”

I say this because I was taught to say this; I say this because it’s true. But most of all, I say this because it’s so easy to forget. Women forget, so focused on their baby, how important they are; all too often, doctors forget. The eight states — including Missouri, Alabama, Ohio, and Georgia — that have passed abortion bans have also forgotten, though perhaps it would be more precise to say that they just don’t think that it’s true. But the legislation they’ve passed will also make it hard for anyone else to remember.

When a woman’s water breaks prematurely -- the rupture of membranes at very early gestational age -- it most often ends in tragedy. Twenty weeks is much too early for a newborn to live outside the uterus. Technology has brought the age of viability, when a fetus can survive outside a woman’s body, to somewhere around 23 weeks. Even then, survival rates are low, and complications are high.

In the majority of these cases, women go into labor right away and deliver quickly. For those who don't, the odds are still very low. Those women usually develop an infection or go into labor within a week or two — long before viability, long before any hope of a baby they could take home. Even if the fetus gets to a viable gestational age, there are complications from growing without fluid: lungs that don't develop or facial deformities or limb contractures. And there are the risks to the woman herself from the ongoing pregnancy: infection, bleeding, sepsis and worse.

Because of that, the American College of Obstetrics and Gynecology recommends that "immediate delivery should be offered." This language is opaque, but here is what it means: Delivery at this gestational age is a termination of pregnancy and should be an option for any woman in this situation.

When I walk into that room and tell a woman that she is the most important one in the room, here is what I am saying: This is a tragedy, but unfortunately, it can get worse. Then in concordance with my clinical judgment and professional guidelines, I offer her an abortion.

I offer this option with the gravity it is due in a desired and beloved pregnancy. It is a terrible discussion to have, full of grief, mourning and fear. In my experience, about half of women choose the termination of pregnancy after our discussion. For those who don't, we continue to care for them; to hope, pray and provide the medical care we have, for as long as we get. Sometimes we get a lot of time; mostly, we don't.

Some patients wait and then will accept a termination when they start to get sick: a fever or bleeding. Some women wait and get sick enough to need the ICU; I've delivered several of them there. Some of these patients bleed enough to need transfusions or surgery. In my experience, I've had more than one patient in this situation require a hysterectomy for bleeding that wouldn't stop, because her uterus was too infected to clamp down. And once, long ago, I had one patient in this situation die.

Offering that termination, then, is the safest thing to do. It is standard of care. It is, arguably, malpractice not to offer it to that woman.

Yet, in that moment, when I walk into the room and tell her how important she is, often that woman is stable. She is not actively ill, not yet; she is not at that moment in immediate danger. And so I wonder: Is offering her that termination of pregnancy, then, a crime under some of these new laws?

Will I have to wait until she gets a fever, so I can check off that box, that she's in danger? Is that sufficient or will it require her heart rate to go up or her blood pressure to go down? Will she have to wait until she's unstable to have this option offered to her? At what point, exactly, will I be risking jail for helping my patient through this, unharmed?

You may say that no doctor in this situation would be prosecuted; regardless, those laws have an effect, because they exist. Laws such as those passed in Alabama, Missouri and Georgia create an incentive that divides us: I can take the best care of her or protect myself, but I can't do both. This divergence of interests creates hesitation, and that hesitation creates delay; for some women, that delay will mean danger. It's one thing to accompany a woman who chooses this narrow and dangerous path in accordance with her beliefs and hopes; it's quite another to have forced her down it.

I don't work in one of those states. But I can see from here how little those who have made those laws understand about a woman's body, her experience or her life. They don't seem to have compassion or even curiosity about all the different ways a pregnancy — even a desired pregnancy — can go wrong. They don't understand what we sometimes need to ask to do, because all the alternatives are bad.

These laws don't remember who is the most important one in that room. Those laws are working to make sure I have trouble remembering, too. And sometime soon, women will be harmed because of it.

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