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When she arrived at the public hospital in Texas, the woman was so sick she couldn't walk. About four months pregnant, she needed an abortion to save her life. A previous pregnancy had led to heart failure. This time she faced a higher risk of death from cardiac arrest that increased as the pregnancy advanced.

But the hospital's leadership denied her the abortion she needed.

"It was decided that she was not going to be dying at that moment," Dr. Ghazaleh Moayedi, who cared for the patient, told *Rewire.News*. "It really was almost a cruel joke: that she wasn't really dead enough to warrant intervention."

Many of the poorest and sickest patients end up at public hospitals when their pregnancies go wrong. But little-known laws in 11 states—Arizona, Kansas, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Ohio, Oklahoma, Pennsylvania, and Texas—prohibit abortion care in various kinds of public facilities, according to an analysis conducted by the Guttmacher Institute for *Rewire.News*. Louisiana, Mississippi, Ohio, Oklahoma, and Pennsylvania allow exceptions to the laws for victims of rape or incest, but the latter three states require the crime be reported to authorities. Only Mississippi and Texas make allowances in cases where the fetus can't survive. Although exceptions exist in all 11 states if a patient's life is in danger, hospital officials are free to interpret what that means and thereby deny abortion care to the sick and dying.

Such scenarios recall the days before abortion was legalized nationwide, when hospital panels approved cases on an individual basis if a patient's life was in danger. Even after the U.S. Supreme Court established the right to abortion in 1973, many hospitals have refused to provide the care for a range of financial, religious, or political reasons. While many of the laws targeting abortion in public facilities date back decades, the Guttmacher Institute, which monitors anti-choice legislation, did not have a list until *Rewire.News* requested one, nor does NARAL Pro-Choice America track these measures. Elizabeth Nash, senior state issues manager at Guttmacher, said the laws, often passed years apart, may have been overlooked because they were never part of an obvious trend—or because there are so many attacks on abortion, it's hard to highlight them all.

Abortion is among the safest medical procedures performed in the United States. In 2013, 89 percent of abortions took place in the first 12 weeks of pregnancy, and two-thirds were at or before eight weeks. Generally, these early abortions are easily handled by outpatient clinics, which tend to be far more affordable than hospitals. Major complications occur in less than half a percent of first-trimester abortions. Roughly 10 percent of abortions occur between 13 and 20 weeks, and while risks increase as pregnancies advance, most of these safely happen in clinics too. An extremely small percentage of abortions take place later in pregnancy; due to legal barriers, violent threats, and even the murder of physicians, there are few clinics left to provide such care.

But patients with medical conditions that make pregnancy and labor dangerous also need higher levels of care to manage risks such as hemorrhaging or cardiac arrest during an abortion. Outpatient clinics will often refer such patients to hospitals, where about 4 percent of abortions take place. Some states also require abortions after a certain point in pregnancy to be performed in a hospital.

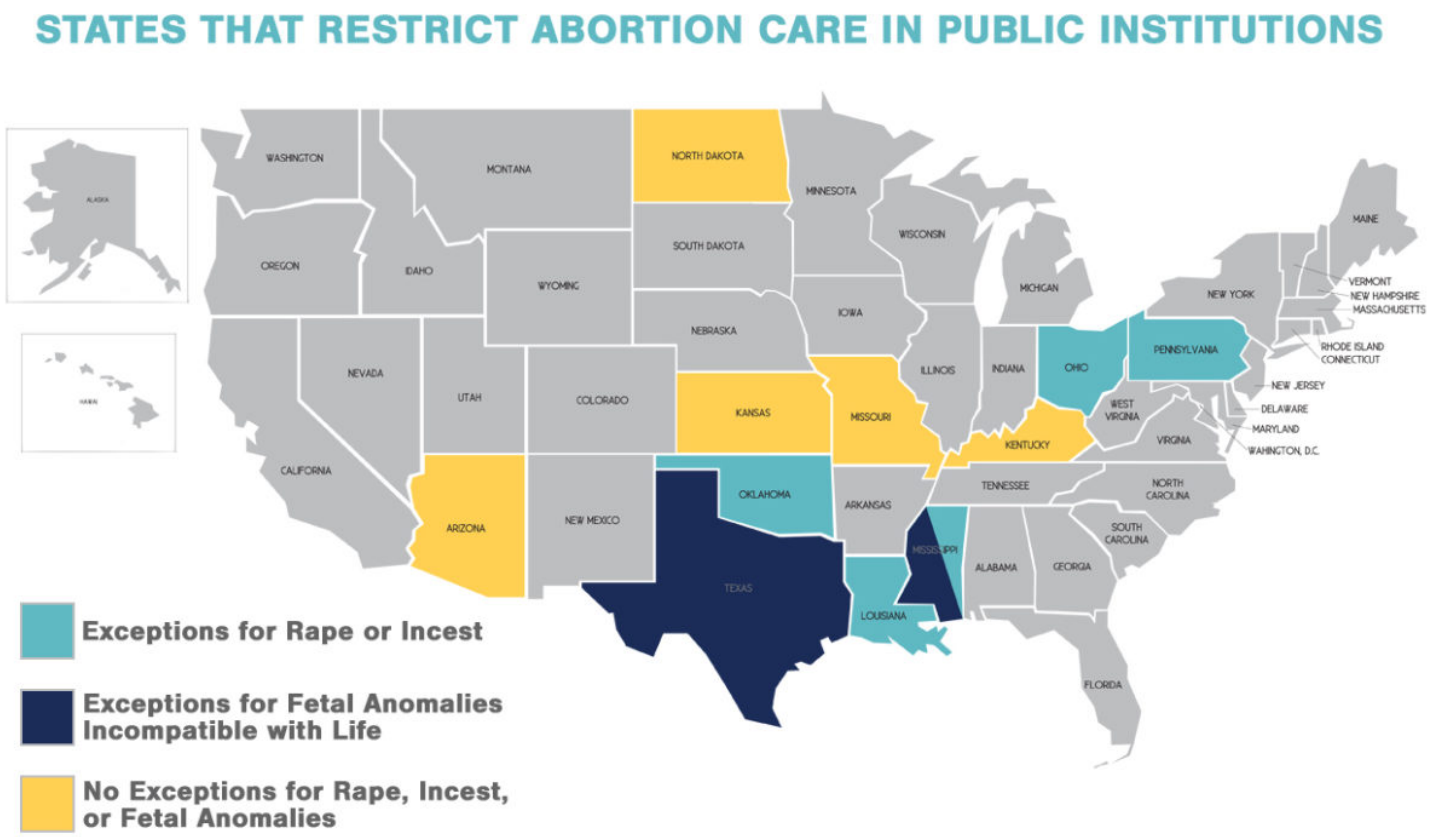
When hospitals in states with restrictive policies deny care to sick patients, providers may face a wrenching choice: Perform an abortion in an outpatient setting for someone who would most safely be seen in a hospital, or refuse care to a patient who might die without it.

In Texas, a 2011 law effectively bans abortion in "hospital districts": publicly funded entities that provide subsidized care to the poor. The only exceptions, at least for now, are cases where the fetus can't survive outside the womb or the patient's condition "necessitates the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of

substantial impairment of a major bodily function." (A Texas lawmaker just introduced legislation to repeal the first exception.) Access to abortion is so limited in Texas that it's difficult to pin denials of care like the one Moayedi described on any single measure. Some hospital districts refused to provide abortions except in cases of life endangerment even before legislators enshrined these restrictions in law.

When Moayedi broke the news, the patient was devastated. She was too ill to be seen in an outpatient clinic that lacked advanced resuscitation and heart monitoring equipment. Her options were to travel to New Mexico and pay thousands of dollars for a hospital abortion there—which she couldn't afford—or continue a pregnancy that might kill her. Like millions of people in Texas, she lacked health insurance.

Moayedi doesn't know what happened to the patient. She never saw her again.



Too Sick for a Clinic, Not Sick Enough for a Hospital

After she moved to another part of Texas, Moayedi appealed to a different public hospital for a patient with a pregnancy condition that put her at risk for complications including hysterectomy and hemorrhaging. The case seemed urgent to Moayedi, who had already watched one patient who carried a pregnancy to term with this condition require a 13-unit blood transfusion—more blood than a human body typically contains.

Again, hospital leadership said no to the abortion.

"The response was that it was not actually imminently life-threatening, that sometimes people lived from the condition and so they would not intervene," Moayedi said.

This time, Moayedi was able to refer the woman to a private hospital.

When such patients can't find a willing hospital where they can afford care, it puts outpatient abortion providers in an unsettling bind. Doctors in multiple states told *Rewire.News* they sometimes perform abortions in clinics that should ideally be done in a hospital, because the alternative is to force patients to continue a potentially fatal pregnancy.

Freestanding clinics generally lack the equipment to perform emergency hysterectomies or blood transfusions. (Anti-choice laws that require abortion providers to have hospital admitting privileges purport to address this concern. But such policies are intended to close clinics, not make patients safer; under existing federal law, hospitals must already accept patients in emergencies.)

Dr. Bhavik Kumar, an abortion provider at a stand-alone facility in Texas, said he recently safely performed an abortion for a patient whose placenta was in danger of growing into her cesarean-section scar. Another doctor had recommended the woman have her abortion in a hospital, but she said two hospitals—one that was part of a public hospital district, the other a faith-based nonprofit—refused to do the procedure. In New York, where he trained, Kumar said he "absolutely" would have referred this patient to a hospital. In Texas, he had no other option.

"For this patient, the safest thing is for her to be not pregnant as soon as possible," Kumar said.

Dr. Carley Zeal has seen this play out in Missouri, which has a ban that prevents providers in public facilities from even referring for abortion, as well as a 72-hour waiting period, restrictions on public and private insurance coverage of abortion, and targeted regulations that have shuttered all but one clinic in the state. "Because access is so restricted, and there are so few places for people to go, we practice at the brink of what we find safe," Zeal said. "We do as much as we can in an outpatient center [that] we consider possibly safe."

Zeal faced this same bind when she worked at an abortion clinic in neighboring Oklahoma, which has similar restrictions on insurance and public facilities and where—as in several states with similar laws—more than a quarter of hospital beds are in Catholic facilities that oppose abortion on religious grounds.

"There were definitely patients that were referred [to the clinic] for abortion services for a life-endangering pregnancy for medical co-morbidities that in other places would definitely warrant an in-hospital procedure," Zeal said. "But that just was not an option for them, because there was no way they could access a hospital that would provide the service."

The patients most affected by these laws are those too sick to be seen in outpatient clinics, but not sick enough for their hospital to allow an abortion. Patients with uncontrolled diabetes, for example, may end up having to travel hours for care, Dr. Meredith Pensak, an OB/GYN in Ohio, told *Rewire.News*.

"They are not sick enough that their life is at risk, but they're too sick to be safely done in a freestanding abortion clinic," Pensak said. "So we have to wind up sending them away to a hospital setting," in another city or out of state.

Compounding existing restrictions on public funding of abortion in the state, Ohio's 2011 law bans public facilities, including those at state universities, from providing abortion except when the pregnancy results from rape or incest that has been reported to the police, or when a pregnancy endangers a patient's life.

Chrisse France, executive director of the Cleveland abortion clinic Preterm, said it's not unusual for providers there to deem someone too sick for outpatient care. That patient may have nowhere else to go. Private hospitals may refuse to accept her if she is uninsured or using Medicaid, which in Ohio and most other states covers abortion only for rape, incest, or life endangerment. And the public hospital, typically a safety net for poor patients, is out of the question.

"She cannot be seen at our public hospital unless pretty much she's going to die today or maybe tomorrow," France said. "For example, if she has cancer and needs chemo—and going without chemo is obviously bad for her health—and she wants an abortion, they can't do it unless she's literally ready to die."

"Death by a Thousand Cuts"

In Ohio, as in most of the 11 states with laws targeting public facilities, there is no exception for fetal anomalies. In December 2018, Chelsea, who asked *Rewire.News* not to use her last name, was about 15 weeks into a planned pregnancy when a specialist at University of Cincinnati Medical Center told her that her fetus had triploidy, a condition where three sets of chromosomes develop in each cell instead of two. Babies with triploidy are stillborn or die shortly after birth.

The news devastated Chelsea, who had suffered a miscarriage months earlier. The condition also put her at higher risk for choriocarcinoma, a fast-growing cancer, and preeclampsia, a potentially deadly pregnancy complication characterized by high blood pressure. Chelsea's blood pressure had already been unusually high. Then the doctor

delivered the final blow: Affiliated with a public university, the hospital would end her pregnancy only once Chelsea was too sick to continue it.

"My head was spinning because of the information that I was being given, but I just felt like I was on an alien planet," Chelsea told *Rewire.News*. "There was no question in my mind: I'm not going to risk my organ function to carry a non-viable pregnancy to term."

The "best-case scenario [was] the baby would be stillborn, or the baby would suffocate to death, which to me was not something that I was willing to put my child through," she said.

University of Cincinnati Medical Center did not respond to requests for comment.

In greater Cincinnati, the last private hospital to perform abortions for fetal anomalies reportedly stopped doing so in late 2015. Deepening Chelsea's stress was the fact that Ohio was on the verge of eliminating the procedure she needed; the week of her diagnosis, state lawmakers approved a ban on the most common and safe method of second-trimester abortion, with no exception for fetal anomalies. The day after the doctor called to confirm her diagnosis, Chelsea wrote a letter to one of the bill's co-sponsors, Ohio Republican Sen. Louis Terhar.

"I cannot have a dilation & curettage (D&C) in a hospital like I did with my last loss, as this baby has a heartbeat," Chelsea wrote. "Instead I have to go to an abortion clinic with doctors and staff that I do not know. I have to go in with protesters screaming at me on the worst day of my life. I am praying for a miscarriage. I never thought I would say that after experiencing one before. But I thank God termination is an option for people like me."

Chelsea called Planned Parenthood, where she needed three visits to comply with Ohio's 24-hour waiting period: One for counseling and an ultrasound, one to sign a consent form after the doctor who would perform her procedure had signed it, and a third for the abortion. She was also forced by law to read a packet about how she could instead parent her child—something she desperately wanted to do—or put her baby up for adoption. Each barrier felt like another blow.

"It just feels like death by a thousand cuts," Chelsea said. "I kept saying, stick the knife in and keep twisting it, because it just made a bad situation horrific."

Fortunately, she was healthy enough to be seen in a clinic. Unlike the hospital, Planned Parenthood didn't offer general anesthesia, although Chelsea would have preferred to be asleep. Three days after her procedure, Ohio Gov. John Kasich signed the law banning the surgery she had undergone. (The law is not yet in effect; Ohio providers have filed a lawsuit challenging it.)

"My Hands Are Tied"

Many of the laws banning abortion in public facilities date back to the 1970s and 1980s, but some states, including Texas, passed measures in recent years to target specific programs for abortion care or training, Elizabeth Nash of the Guttmacher Institute told *Rewire.News*. This, in turn, has worsened a trend for would-be providers that was set in motion in the 1970s by the Hyde Amendment, which bans federal funding for most abortions.

"Once the Hyde Amendment was passed, and Medicaid stopped covering the costs of abortion for many states, hospitals stopped performing them because they weren't getting reimbursed for them," Jenifer Groves, who directs abortion clinics in New Jersey, Pennsylvania, and Connecticut, told *Rewire.News.* "And so that pushed the procedures out into the clinics, which meant that residents didn't have anybody to train on, unless there was a program in the clinic."

In 1989, the Supreme Court upheld a Missouri law that included a ban on abortion in public facilities, with an exception to save a patient's life. Since then, anti-choice activists have widened their assault.

"Over time, abortion opponents have been adding on to this idea of what is a publicly funded abortion," Nash told *Rewire.News.* State lawmakers have targeted abortion coverage in public employee health plans, transfer agreements between abortion clinics and public hospitals, and funds used by Planned Parenthood for non-abortion services.

Amid a national rise in maternal mortality, the patients most affected by restrictions on public hospitals are people with pregnancy complications often exacerbated by racism or poverty. They are also among those most at risk for dying from

the health issues they face; the leading causes of maternal death include cardiac conditions and preeclampsia, along with infection and hemorrhage.

There's no data on how many patients who die in childbirth were denied an abortion they sought for health reasons, but there is evidence linking state limits on abortion to worse outcomes for maternal health.

"People's inability to access the care that they need because of [anti-choice limits on] public insurance, religious restrictions, and anti-abortion politics may worsen a maternal health crisis, and all of this is preventable," Monica McLemore, assistant professor in the Family Health Care Nursing Department at the University of California at San Francisco, told *Rewire.News*.

Public hospitals, nationwide, see a higher percentage of poor patients than private hospitals. Low-income patients who are denied abortion care at these institutions are less likely to be able to get to another facility that can help them. Black women, who are three to four more times more likely to die from pregnancy-related causes than white women, are more likely to have public insurance and to give birth in Catholic hospitals, where care is restricted by religious rules.

Indeed, Catholic hospitals, which make up one in six acute-care beds nationwide, have sent miscarrying patients home while bleeding and in pain under religious directives that ban most abortions. A doctor at a Catholic hospital in Wisconsin told *Rewire.News* she had to wait overnight for a patient's temperature to soar—a sign of infection—before she could end the pregnancy the woman was losing at 18 weeks.

At some hospitals subject to the public facilities laws, there's a similar policy. A doctor in the Midwest, who requested anonymity, said that her institution waits for patients to run a fever if their water breaks long before fetal viability—a scenario where infection is all but inevitable.

"For a patient who has the means to leave the hospital, go to another hospital, and get better medical care, she can do that," the doctor said. "But for patients who don't have the means to travel, or maybe the medical savvy to know that that's an option, they stay until they have a fever and then we can induce them."

These situations present a moral dilemma for providers.

"I've had this conversation with my colleagues, you know: Do we tell a patient, 'We think you should leave against medical advice, and then we think you should just walk into this other hospital that can take care of you'?" the doctor said. "What are the legal and ethical ramifications of that?"

Because of her hospital's policies, the doctor in the Midwest said she has seen patients remain pregnant after they were unable to access an abortion to preserve their health. Discussions about whether to allow an abortion in each case can involve an ethics board, risk management officials, high-risk OB/GYNs, and other specialists. In one case, a patient who had suffered cardiac arrest shortly before getting pregnant did not meet the hospital's threshold for life endangerment and was unable to afford to travel and pay for an abortion at the nearest hospital that would see her, about four hours away. She ended up miscarrying in her second trimester. In another case, a patient who was dying from metastatic cancer needed abortion care. The hospital took so long to deliberate, she miscarried too.

"Our conversation should have been like, 'How can we help you heal and meet whatever your goals are in this terrible situation', and not about this stupid law," the doctor said.

"My hands are tied," she continued. "I can't do what's right for the patient."

Brie Shea contributed to this report. For a more detailed look at these laws, see our companion chart here.

Tell us your story. Have anti-choice or religious restrictions affected your ability to access health care? Email stories@rewire.news

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