Admitting privileges and their relationship to hospital-based care after abortion: a retrospective case series

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Background

- In June 2016, the US Supreme Court ruled in *Whole Woman's Health v. Hellerstedt* that Texas' admitting privileges law was unconstitutional.[1]
- As of early 2017, 4 states continue to have admitting privileges laws in effect.[2]
- Admitting privileges laws are often justified with arguments related to patient safety and "continuity of care."
- Texas claimed that admitting privileges were needed to "reduce the delay in treatment and decrease the health risk for patients with critical complications."[3]

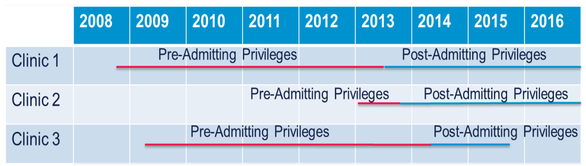
Study Aims

- To explore whether obtaining admitting privileges had any impact on how patient care was managed between abortion facilities and hospitals.
- To describe the pathways of care when an abortion patient was transferred or referred to an emergency department (ED) or hospital.

Methods

- Retrospective detailed chart data was abstracted from 3 abortion facilities in states where admitting privilege laws were passed within the last 5 years.
- Inclusion criteria:
  - Cases that had any contact with a hospital or ED following an abortion (and the contact was known to the abortion-providing facility).
  - Cases up to 5 years before and 5 years after abortion-providing physicians obtained admitting privileges. (Table 1)
- Hospital data were abstracted only when included in the patient chart at the abortion facility.

Table 1: Timeframe for eligible data collection



Note: Clinic 2 did not open until early 2013; Clinic 3 closed for reasons unrelated to admitting privileges in late 2015

Results

- 46 cases met inclusion criteria. We grouped cases into 4 pathways to hospital-based care. (Table 2)
- Both before and after obtaining admitting privileges, the majority of cases were immediately referred to an ED/hospital and were due to suspected ectopic pregnancies.

Table 2. Characteristics of transfers and referrals to ED/Hospital

Reason for hospital care	Pre-admitting privileges (N=22)	Post-admitting privileges (N=24)
1) Facility transferred care by ambulance		
Hemorrhage	1	1
Severe vasovagal response	1	--
Incomplete abortion	--	1
2) Facility directly referred patient by phone or referral form		
Ectopic/suspected ectopic	8	7
Missed abortion	1	1
Accreta/suspected accreta	--	3
Complications of diabetes/hyperemesis	--	1
Transfer of care for second tri abortion	--	1
3) Facility referred patient when patient called facility after the abortion		
Suspected ectopic/ectopic	3	1
Hemorrhage/bleeding	1	1
Incomplete abortion	--	1
Chest pain/GERD	--	1
4) Patient self-referred with subsequent patient-facility or facility-hospital communication		
Ectopic/ruptured ectopic	3	--
Hemorrhage/bleeding	1	1
Incomplete abortion	3	2
Pain	--	1
Follow-up	--	1

- The processes by which care was referred or transferred (e.g. phone call to ED; ambulance transfer) were similar both before having and after obtaining privileges.
- A provider with admitting privileges admitted 1 patient who had been experiencing complications of diabetes and hyperemesis. (Case 2)

Key themes

- When care needed to be urgently managed in a higher level setting, an ambulance was called to transfer care to a hospital, both before and after obtaining privileges.

Case study 1 (post AP):
Patient received 1st trimester aspiration under IV sedation. During the procedure, patient began bleeding which required massage, compression, methergine, and misoprostol, after which the bleeding stopped. After going to recovery, the patient felt a rush of blood and hospital transfer was arranged by the facility. Physician resumed pressure on the uterine arteries; bleeding slowed and eventually stopped. By the time of paramedic arrival, bleeding had stopped and the patient's BP had recovered. Vagina was packed with gauze and patient was judged stable for transport by ambulance. At ED, ultrasound found no retained fetal or placental parts and no active bleeding within the uterus or in the pelvis. Patient was admitted to hospital for observation. Abortion facility physician suspected possible cause of bleeding as arteriovenous malformation at site of previous C-section scar x 3.
Category 1 (Transferred by ambulance), hemorrhage

- For several cases, care was directly transferred or referred when the care the patient required was outside the scope of practice of the abortion provider or they determined that the case could best be managed in a hospital setting.
- These cases included suspected ectopic pregnancies, accreta, chest pain, and complications of diabetes and hyperemesis.
- When a hospital and abortion facility had continuous communication and coordination, the patient received care tailored to her specific case.

Case Study 2 (post AP):
Patient had been hospitalized for 2 weeks due to gastroparesis, Type 1 diabetes, and hyperemesis and desired abortion. She was released to go to abortion facility nearby for procedure. She successfully received 1st trimester aspiration abortion and then was re-admitted to nearby hospital by abortion-providing physician. She received continued treatment for gastroparesis and diabetes and discharged the next day. No abortion complications reported.

Category 2 (Direct referral of patient), complications of diabetes and hyperemesis

- Hospitals did not always provide post-abortion care in line with best practices. (Case 3)
- For delayed symptoms, patients often sought follow-up care at their closest hospital, not the hospital where the provider had admitting privileges.

Case Study 3 (post AP):
Medication abortion patient called the facility 14 days after mifepristone visit to say she could not get an ultrasound at the ED but had a positive pregnancy test. The facility advised the patient to follow-up at the facility for the ultrasound. The patient called again the same day from an ED stating they would only do blood and urine tests. The hospital physician called back to say he was going to do an hCG and the facility reiterated that an ultrasound is standard procedure after medication abortion. The physician at the hospital said he was upset that the patient reported that the facility had told her to go to the ED. The facility replied that they never tell patients to go to the ED for an ultrasound, but to follow-up at their facility or at the patient's primary care provider. Hospital notes in the patient file state that when patient presented at hospital, she had no vaginal bleeding but said "I want to make sure I miscarried". Patient lives 230+ miles from abortion facility.

Category 4 (Self-referred), follow-up for medication abortion

Conclusions

- Obtaining admitting privileges does not appear to change the communication and ways in which patients are transferred or referred to EDs/hospitals.
- Provider admitting privileges would not have any impact on the care patients receive when they self-refer or when they present for care at a hospital far from the abortion facility.
- Hospitals should have the capability of providing high-quality post-abortion care, particularly for patients who seek follow-up care far from the abortion facility.

1. *Whole Woman's Health v. Hellerstedt*, 579 U.S. ___ (2016).
2. Guttmacher Institute, State Policies in Brief: Targeted Regulation of Abortion Providers, April 2017.
3. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F. 3d 583, 592 (2014).