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Understanding U.S. non-religious hospital inpatient approval mechanisms for induced abortion☆,☆☆

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ABSTRACT

Objectives: To evaluate whether inpatient abortion approval mechanisms are used in U.S. non-religious obstetric tertiary care hospitals and describe the scope of use and perceived role of these mechanisms from the perspective of Labor and Delivery Medical Directors.

Study design: We conducted an exploratory cross-sectional, web-based survey in the Spring, 2024. Using purposeful distribution based on the January 2024 Guttmacher Institute's state abortion policy map, we recruited a convenience sample of Labor and Delivery Medical Directors divided between restricted, intermediate, and protective states with a goal of nine responses each. We included those that accepted high-risk maternal inpatient referrals, had a level II or III neonatal intensive care unit, and had ever provided inpatient induced abortions. The survey collected information on ability to provide abortion care, existing approval mechanisms, and reasons for use of these mechanisms in non-emergency and emergency situations.

Results: Of 45 invited directors, we received 37 (82.2%) responses of which 29 met inclusion criteria (11 restricted, nine intermediate, nine protective). Most respondents indicated ability to provide inpatient induced abortions in non-emergent (25 [86.2%]) and emergent (29 [100%]) situations. Among restrictive and intermediate settings, all reported having abortion-specific approval mechanisms in non-emergent situations. Primary reasons for approval mechanisms were avoiding potential legal risk (52.0%) and controversy among team members (32.0%).

Conclusions: Medical Directors of Labor and Delivery Units in our sample indicate that contemporary U.S. non-religious obstetric tertiary care hospitals, especially in politically restrictive settings, are utilizing approval mechanisms for inpatient induced abortion care. These mechanisms are perceived to be in place to avoid controversy, both legal and among hospital team members.

Implications: Our exploratory sample suggests U.S. non-religious tertiary care hospitals commonly apply approval mechanisms for inpatient abortion care to navigate vague legal standards and institutional risk. These approval mechanisms require additional steps, such as multiple physician approval, and focus on the perceived needs of hospitals and physicians rather than the patient.

1. Introduction

The U.S. medical system has long grappled with regulating abortion care. Contemporary state-based policies range from functionally complete abortion bans to abortion protections enshrined in state constitutions. Over the last few decades, U.S. health systems have been asked to comply with an increasing number of laws that permit abortion only in specific, often vaguely defined, circumstances [1]. While most U.S. abortion care is provided in outpatient settings, there are multiple health systems and patient factors that necessitate abortion provision in a hospital [2]. Operationalizing these laws for hospitalized patients or patients requiring procedures in a hospital setting is complex and burdensome for both patients and clinical teams.

Amidst increasing state level restrictions, many patients, clinicians and administrators in the U.S. healthcare community face

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uncertainty over who can be legally provided with induced abortion care [3]. In response, health systems have enacted approval processes to address the need for abortion care. These processes range from single-person approval to the use of multi-person review committees assigned with the power to make decisions [4]. A description of contemporary U.S. non-religious obstetric tertiary care hospital inpatient abortion approval mechanisms, and rationale for use will help guide a nuanced discussion about ethical ways U.S. health systems can continue to provide inpatient abortion care in a rapidly changing medico-legal landscape. The specific aim of this work is to evaluate whether inpatient abortion approval mechanisms are being used in U.S. non-religious obstetric tertiary care hospitals and to describe the scope of use and perceived role of these mechanisms from the perspective of Medical Directors of Labor and Delivery units.

2. Materials and methods

We conducted a cross-sectional, web-based survey of Medical Directors of Labor and Delivery units of non-religious tertiary level obstetric hospitals. The study was considered exempt after review by the University of California Davis Institutional Review Board. We grouped hospitals based on location, using the state of practice to define abortion policy categories as described in the Guttmacher Institute's January 24, 2024, U.S. policy map (Appendix A) [5]. We defined the Guttmacher's "most restrictive" and "very restrictive" states as restricted settings, "restricted" and "some restrictions" states as intermediate settings, and "protective," "very protective," and "most protective" states as protective settings.

We created the survey in REDCap (secure web-based platform) to assess eligibility, obtain demographic information, and collect data on respondents' understanding of the ability to provide inpatient induced abortion, existing approval mechanisms, and reasons for the creation and use of inpatient approval mechanisms. We assessed participants' abortion attitudes using adapted 2018 and 2020 national Gallup survey questions [6]. The survey included requests for inpatient labor induction termination and procedural abortion (dilation and curettage [D&C] and dilation and evacuation [D&E]) in both non-emergency and emergency situations. Two Labor and Delivery Unit Medical Directors, one from a protective and one from a restrictive setting, pilot-tested the survey, and we incorporated their feedback to finalize the survey (Appendix B).

Prior to survey distribution, we identified non-religious obstetric tertiary care hospitals with a Neonatal Intensive Care Unit (NICU) at level II or higher in each of the previously described grouped state policy categories and contacted Labor and Delivery Unit Medical Directors about the planned future research study. As an exploratory evaluation, we set an arbitrary convenience sample goal of receiving nine completed surveys from each geographic setting. Assuming a 60% response rate, we invited 45 Medical Directors (divided between the three grouped state setting categories) who had responded to our initial invitation to participate. In the Spring of 2024, we electronically invited these Directors to complete the closed-link survey through a one-time-use survey code. The initial survey page informed potential participants of the study's purpose, data anonymity, expected time to complete, and the investigator's contact information. The first three survey questions addressed eligibility; respondents who self-identified as currently working as the Medical Director of a Labor and Delivery of a hospital that accepted high-risk maternal inpatient referrals, had at least a level II NICU, and provided inpatient induced abortions (even if rarely) could continue the survey.

Before the survey asked further questions, survey terms were defined, specifically "*inpatient*" as hospital admission status with admission to a hospital bed/room or for procedural care in a hospital setting, "*induced abortion*" as voluntarily ending an ongoing pregnancy using procedures or medications with the knowledge that the pregnancy will not survive or result in live birth, and "*medical emergency*" as a condition of sufficient severity that the absence of immediate medical treatment could reasonably result in serious physical or mental disability or death. The survey included open- and closed-ended questions with space for free response and, on average, took 20 min to complete. Respondents were allowed to review and change answers throughout the survey. Respondents were offered the option to anonymously link to a separate website to receive a $100 gift card as compensation.

We closed the survey when we received at least nine completed surveys (more than 75% of questions completed) from eligible respondents within each setting category. Two authors (HR and MJC), both with previous qualitative research experience, used inductive content analysis with identification of thematic patterns to analyze open-ended responses to the question of why directors believe institutional approval mechanisms exist for the provision of inpatient induced abortion [7].

3. Results

We invited 15, 14, and 16 participants from restricted, intermediate, and protective settings, respectively. We received responses from 12 (80.0%), 12 (85.7%), and 13 (81.3%) respondents per category, respectively, for a participation rate of 37/45 (82.2%). Eight surveys did not meet eligibility criteria and eight did not meet survey completion criteria, leaving 29 surveys in the analysis (11 restricted, nine intermediate, and nine protective settings). Respondent characteristics are presented in Table 1; most self-identified as female, agnostic or non-Catholic Christian, aged mid-40s, white, with less than 5 years of experience as a Labor and Delivery Medical Director. Participants represented 26 unique states and all practiced in non-religiously affiliated settings, with 28 (96.6%) self-identifying as a regional obstetric referral hospital.

Respondents' abortion attitudes are presented in Table 2. All respondents identified as pro-choice and none identified with the personal belief that abortion is morally wrong, should be illegal in all circumstances, or should be illegal in the second three months of pregnancy.

3.1. Inpatient induced abortion provision

Respondents' ability to provide inpatient induced abortions in non-emergency and emergency situations are presented in Table 3. All respondents who indicated the ability to provide procedural abortion also indicated the ability to provide labor induction termination. Whereas some institutions in restricted and intermediate settings indicated no ability to provide inpatient non-emergency induced abortions, all indicated the ability to provide emergent care. The sole respondent from a protective setting who indicated an inability to provide inpatient non-emergency procedural abortion stated ease of outpatient referral as the rationale for this practice. The reasons reported for inability to provide inpatient induced abortion care in non-emergency situations included state-level restrictions (specifically gestational duration limits) and limits from institutional colleagues (specifically identified as hospital CEOs, CMOs, and lawyers).

3.2. Inpatient induced abortion approval mechanisms

The approval mechanisms surrounding the provision of inpatient induced abortions in non-emergency and emergency situations are presented in Table 4. Across all situations and state settings, when mechanisms were present, written approval mechanisms were most utilized. Most respondents (7/11 [63.6%]) who indicated a requirement to notify individuals outside of the provider/patient relationship in emergent situations were from restrictive settings vs. intermediate or

Table 1
Characteristics of U.S. Labor and Delivery Medical Directors from Non-religious Hospitals by State Setting Restriction Category, 2024

Characteristic	All *N* = 29	State Setting Category*		
		Restrictive *n* = 11	Intermediate *n* = 9	Protective *n* = 9
Age (years)	44 (40-49.5)	45 (39-54)	40 (40-48)	44 (41.5-48)
Gender				
Female	22 (75.9%)	9 (81.8%)	5 (55.6%)	8 (88.9%)
Male	7 (24.1%)	2 (18.2%)	4 (44.4%)	1 (11.1%)
Race/Ethnicity				
White (non-Hispanic)	23 (79.3%)	10 (90.9%)	7 (77.8%)	6 (66.7%)
Black	3 (10.3%)	1 (9.1%)	0	2 (22.2%)
Asian	2 (6.9%)	0	1 (11.1%)	1 (11.1%)
Hispanic or Latino	1 (3.4%)	0	1 (11.1%)	0
Experience as Obstetrician and Gynecologist (years)				
5-10	11 (37.9%)	5 (45.4%)	5 (55.6%)	1 (11.1%)
11-20	13 (44.8%)	3 (27.3%)	3 (33.3%)	7 (77.8%)
21-30	4 (13.8%)	2 (18.2%)	1 (11.1%)	1 (11.1%)
> 30	1 (3.4%)	1 (9.1%)	0	0
Experience as Medical Director of Labor and Delivery (years)				
< 5	18 (62.1%)	7 (63.6%)	6 (66.7%)	5 (55.6%)
5-10	10 (34.5%)	3 (27.3%)	3 (33.3%)	4 (44.4%)
11-20	1 (3.4%)	1 (9.1%)	0	0
Personal Religion				
Agnostic	9 (31.0%)	2 (18.2%)	3 (33.3%)	4 (44.4%)
Christian - Non-Catholic[a]	9 (31.0%)	5 (45.4%)	0	4 (44.4%)
Christian - Catholic	4 (13.8%)	3 (27.3%)	1 (11.1%)	0
Jewish	3 (10.4%)	0	2 (22.2%)	1 (11.1%)
Atheist	2 (6.9%)	1 (9.1%)	1 (11.1%)	0
Hindu	1 (3.4%)	0	1 (11.1%)	0
Other: does not affiliate	1 (3.4%)	0	1 (11.1%)	0

All data presented as *n* (%) or median (interquartile range)
* Defined by Guttmacher Institute (Guttmacher Institute, 2024) January 24, 2024 abortion restriction map (Appendix A) with "most restrictive" and "very restrictive" states as restricted" settings, "restricted" and "some restrictions" states as intermediate settings, and "protective," "very protective," and "most protective" states as protective" settings
[a] Includes: Protestant, Episcopalian, Lutheran, Baptist, Methodist

protective settings (4/18 [22.2%]). When asked what form this outside notification takes, around half of respondents in restricted and intermediate settings indicated the need for explicit approval from one or more additional physicians for the following situations: induction of labor termination 6/11 (54.5%) non-emergency, 5/11 (45.5%) emergency, procedural abortion 4/9 (44.4%) non-emergency, 5/10 (50.0%) emergency. These approvals usually included a maternal-fetal medicine specialist to review, agree, and sign off on the plan of care. No respondents from protective settings indicated use of approval mechanisms requiring explicit approval from additional physicians.

Table 2
Abortion attitudes of U.S. Labor and Delivery Medical Directors from Non-religious Hospitals by State Setting Restriction Category, 2024

Abortion Attitude Question	All *N* = 29	State Setting Category*		
		Restrictive *n* = 11	Intermediate *n* = 9	Protective *n* = 9
Do you think abortions should be:				
Legal under any circumstance	21 (72.4%)	9 (81.8%)	5 (55.6%)	7 (77.8%)
Legal in most circumstances	8 (27.6%)	2 (18.2%)	4 (44.4%)	2 (22.2%)
Legal only in a few circumstances	0	0	0	0
Illegal in all circumstances	0	0	0	0
With respect to abortion issues, would you consider yourself to be:				
Pro-choice	29 (100%)	11 (100%)	9 (100.0%)	9 (100.0%)
Pro-life	0	0	0	0
Regardless of whether you think abortion should be legal, please choose whether you personally believe that abortion is morally acceptable or morally wrong.				
Morally acceptable	20 (69.0%)	7 (63.6%)	5 (55.6%)	8 (88.9%)
Morally wrong	0	0	0	0
Depends on situation	3 (10.3%)	2 (18.2%)	1 (11.1%)	0
Not a moral issue	6 (20.7%)	2 (18.2%)	3 (33.3%)	1 (11.1%)
Do you think abortion should generally be legal or generally illegal during each of the following stages of pregnancy:				
In the first 3 months of pregnancy				
Should be legal	29 (100%)	11 (100%)	9 (100.0%)	9 (100.0%)
Should be illegal	0	0	0	0
Depends	0	0	0	0
In the second 3 months of pregnancy				
Should be legal	26 (89.7%)	10 (90.9%)	8 (88.9%)	8 (88.9%)
Should be illegal	0	0	0	0
Depends	3 (10.3%)	1 (9.1%)	1 (11.1%)	1 (11.1%)
In the last 3 months of pregnancy				
Should be legal	11 (37.9%)	5 (45.4%)	3 (33.3%)	3 (33.3%)
Should be illegal	2 (6.9%)	1 (9.1%)	1 (11.1%)	0
Depends	16 (55.2%)	5 (45.4%)	5 (55.6%)	6 (66.7%)

All data presented as *n* (%)
* Defined by Guttmacher Institute (Guttmacher Institute, 2024) January 24, 2024 abortion restriction map (Appendix A) with "most restrictive" and "very restrictive" states as restricted" settings, "restricted" and "some restrictions" states as intermediate settings, and "protective," "very protective," and "most protective" states as protective" settings

Table 3
Ability to Provide Inpatient Induced Abortion* Care in Non-emergency and Emergency Situations per U.S. Labor and Delivery Medical Directors From Non-religious Hospitals, 2024

Abortion Method Provided	Non-Emergency Situation				Emergency Situation[a]			
	Total	State Setting Category[b]			Total	State Setting Category[b]		
	N = 29	Restrictive *n* = 11	Intermediate *n* = 9	Protective *n* = 9	*N* = 29	Restrictive *n* = 11	Intermediate *n* = 9	Protective *n* = 9
Labor Induction Termination	25 (86.2%)	9 (81.8%)	7 (77.8%)	9 (100.0%)	29 (100%)	11 (100.0%)	9 (100.0%)	9 (100.0%)
Procedural Abortion[c]	22 (75.9%)	8 (72.7%)	6 (66.7%)	8 (88.9%)	27 (93.1%)	11 (100.0%)	8 (88.9%)	8 (88.9%)

All data presented as *n* (%)
* Induced abortion defined as voluntarily ending an ongoing pregnancy using procedures or medications with the knowledge that the pregnancy will not survive or result in live birth
[a] Medical emergency defined as a condition of sufficient severity that the absence of immediate medical treatment could reasonably result in serious physical or mental disability or death
[b] Defined by Guttmacher Institute (Guttmacher Institute, 2024) January 24, 2024 abortion restriction map (Appendix A) with "most restrictive" and "very restrictive" states as restricted" settings, "restricted" and "some restrictions" states as intermediate settings, and "protective," "very protective," and "most protective" states as protective" settings
[c] Dilation and curettage or dilation and evacuation; all respondents who indicated provision of procedural abortion also provide labor induction termination

In non-emergent situations, respondents indicated an institutional gestational duration limit for abortion, with 14/25 (56.0%) applying a limit to labor induction termination and 17/22 (77.3%) to procedural abortion. Four respondents, all from protective settings, indicated no such limit. The remainder answered 'it depends' and provided free response answers. These open-ended responses revealed that the unique case details significantly impact the use of gestational duration limits. This idea was represented best by a respondent from a protective setting: "Above 22 weeks gestation, [induced abortion is] provided on a case-by-case basis for maternal health risks or fetal conditions noncompatible with life." Respondents utilized varied language to describe what meets criteria for an institutional gestational duration limit exception, including: "threat to the health/life of the pregnant person," "lethal/life-limiting diagnoses," "fetal condition not compatible with life," pregnancy characterized as "medically futile," or in settings of rape/incest. The use of an institutionally pre-approved abortion indication list was reported by 6/29 (20.7%) respondents, all from restrictive settings.

3.3. Rationale for the use of inpatient approval mechanisms

Medical Directors most commonly characterized the reasons for the existence of institutional approval mechanisms for non-emergency induced abortion to be a desire to avoid potential negative

Table 4
Approval Mechanisms for Inpatient Induced Abortion* Care Per Labor And Delivery Medical Directors Working in U.S. Hospitals that Provide Induction of Labor Termination (a) and Procedural Abortion (b), 2024

a) Induction of labor termination

	Non-Emergency Situation				Emergency Situation[a]			
	Total	State Setting Category[b]			Total	State Setting Category[b]		
	N = 25	Restricted *n* = 9	Intermediate *n* = 7	Protective *n* = 9	*N* = 29	Restricted *n* = 11	Intermediate *n* = 9	Protective *n* = 9
Type of approval mechanism								
Written	13 (52.0%)	7 (77.8%)	4 (77.8%)	2 (22.2%)	14 (48.3%)	7 (63.6%)	5 (55.6%)	2 (22.2%)
Non-written (verbally/culturally set)	8 (32.0%)	2 (22.2%)	3 (42.9%)	3 (33.3%)	10 (34.5%)	3 (27.3%)	4 (44.4%)	3 (33.3%)
No Approval Mechanisms	4 (16.0%)	0	0	4 (44.4%)	5 (17.2%)	1 (9.1%)	0	4 (44.4%)
Require notification of individuals outside provider/patient relationship	11 (44.0%)	7 (77.8%)	2 (28.6%)	2 (22.2%)	11 (37.9%)	7 (63.6%)	2 (22.2%)	2 (22.2%)

b) Procedural abortion[c]

	Non-Emergency Situation				Emergency Situation[a]			
	Total	State Setting Category[b]			Total	State Setting Category[b]		
	N = 22	Restricted *n* = 8	Intermediate *n* = 6	Protective *n* = 8	*N* = 27	Restricted *n* = 11	Intermediate *n* = 8	Protective *n* = 8
Type of approval mechanism								
Written	12 (54.5%)	6 (75.0%)	4 (66.7%)	2 (25.0%)	14 (51.9%)	7 (63.6%)	5 (62.5%)	2 (25.0%)
Non-written (verbally/culturally set)	3 (13.6%)	2 (25.0%)	1 (16.7%)	0	7 (25.9%)	4 (36.4%)	3 (37.5%)	0
No Approval Mechanisms	7 (31.8%)	0	1 (16.7%)	6 (75.0%)	6 (22.2%)	0	0	6 (75.0%)
Require notification of individuals outside provider/patient relationship	9 (40.9%)	6 (75.0%)	1 (16.7%)	2 (25.0%)	10 (37.0%)	7 (63.6%)	1 (12.5%)	2 (25.0%)

All data presented as *n* (%)
* Induced abortion" defined as voluntarily ending an ongoing pregnancy using procedures or medications with the knowledge that the pregnancy will not survive or result in live birth
[a] Medical emergency defined as a condition of sufficient severity that the absence of immediate medical treatment could reasonably result in serious physical or mental disability or death
[b] Defined by Guttmacher Institute (Guttmacher Institute, 2024) January 24, 2024 abortion restriction map (Appendix A) with "most restrictive" and "very restrictive" states as restricted" settings, "restricted" and "some restrictions" states as intermediate settings, and "protective," "very protective," and "most protective" states as protective" settings
[c] Dilation and curettage or dilation and evacuation; All respondents who indicated provision of procedural abortion also provide labor induction termination

legal outcomes (13/25 [52.0%]), most frequently from restrictive setting (9/13 [69.2%]), and to avoid controversy/disapproval among team members (8/25 [32.0%]), most frequently from protective settings (5/8 [62.5%]).

Thematic analysis of free responses as to why institutional approval mechanisms exist for inpatient provision of induced abortion revealed themes that differed between restrictive and protective settings. Respondents from restrictive settings emphasized the importance of strict compliance with state laws regulating abortion to reduce the risk of future legal challenges for both providers and institutions. This theme is well represented by one respondent from a restrictive setting: "[abortion approval mechanisms] help keep clinicians protected from legal threats coming from outside our institution. If clinicians follow hospital policy but we are still accused of providing illegal abortion services, our institution will provide criminal defense."

By the same reasoning, respondents emphasized the need for approval mechanisms to clarify and, in some cases, further define state legal exceptions to abortion bans. The need for clarity is represented by the following quote from a respondent in a restricted setting: "for cases that do not clearly qualify as an exception to the state abortion ban, we must contact the legal team. Two independent MFM providers must then separately document the case and why it is an exception." Respondents from protective settings expressed the need for clear institutional procedures and policies to reduce confusion, bias, and variation in the provision of routine hospital medical care. This idea was well stated by a respondent from a protective setting: "[policies] should hopefully help us to provide consistent and equitable care while trying to reduce potential biases from members of the medical team."

4. Discussion

Medical Directors of Labor and Delivery Units in our sample indicate that contemporary U.S. non-religious regional obstetric tertiary care hospitals are utilizing approval mechanisms to regulate whether patients can obtain inpatient induced abortion care. When utilized in restrictive and intermediate state settings, approval mechanisms encompassed use of gestational limits, requirements for physicians not directly involved in a specific patient's care to agree with the plan before care is permitted, and institutionally pre-approved lists of indications that meet state legal criteria. Medical Directors cited a desire to avoid controversy, both legal and among hospital team members, as the primary reason for instituting inpatient abortion approval mechanisms. This descriptive study provides background on how contemporary hospital systems are operationalizing inpatient abortion care amidst increasing state level restrictions. The focus for many hospital systems, particular in restrictive settings, is legal protection. Whether these institutionalized approval mechanisms provide true legal protection to individual healthcare providers or the hospital system is an important question, one that should be the focus of future interdisciplinary research.

Historically, in the face of medical and legal uncertainty over who should be provided with abortion care, hospitals formed Therapeutic Abortion Committees (TACs). TACs addressed whether a person's request for termination was valid; physician signatures were required before care would be deemed "therapeutic" and provided [8–10]. Ethicist Hyman Rodman outlined the role of TACs before federal abortion legalization in 1973 as: 1) serving as deterrents to the indiscriminate use of therapeutic abortion, 2) acting in the best interests of the patient, 3) being a medicolegal safeguard for the physician; and 4) serving as repositories for the accumulation of data [11].

National hospital leaders are facing a period of medical and legal uncertainty over who can be provided with induced abortion care, as they did when TACs were used in the past century. Our results suggest that, to address this uncertainty, hospitals have turned to groups of providers to review the legitimacy of abortion requests and have endowed these reviewers with the power to approve or deny care. Therefore, these approval mechanisms may be viewed as similar to TAC processes from the pre-1970 era. However, approval mechanisms in place today do not serve the same roles as historical TACs [11]. Of the previously described historical roles, medical directors reported the primary role of contemporary approval mechanisms as being a "medicolegal safeguard for the physician."

In our study, medical Directors in restrictive settings cited using approval mechanisms to clarify the state's vague definition of valid reasons for abortion and to mitigate the threat of provider criminal prosecution. Prior work has demonstrated this combination has severely impaired clinicians' ability to apply reasonable medical judgment to the provision of evidence-based care [3]. The use of abortion specific approval mechanisms is distinctly different from routine medical judgment applied to obstetric standard of care. For example, patients undergoing non-emergent and emergent Cesarean delivery do not require additional approval before care can be provided.

Institutions in restrictive settings will continue to face requests for induced abortion care, as the need for this care does not decrease when abortion is legally restricted [12]. Whether or not requests for abortion are approved or denied through these approval mechanisms, the end effect is both practical and problematic, allowing some select few people access to essential reproductive health care and, at the same time, stripping pregnant people of bodily autonomy. These approval mechanisms, if applied in an appropriate manner, have the ability to be used as a harm reduction tool to support institutional provision of medically essential abortion care. Hospital leaders should consider utilizing our findings to identify strategies to enhance, rather than limit, abortion access when needed in inpatient settings within their unique political contexts.

A strength of this study is that it elicits existing hospital approval mechanisms from the perspective of Medical Directors of Labor and Delivery units, a hospital leadership role tasked with routinely applying hospital policies to arbitrate complex and time sensitive inpatient problems. Furthermore, approval mechanisms are not always written, and surveying a different hospital leader, one not involved in the daily clinical care of Labor and Delivery, would potentially exclude the existing verbal or cultural unwritten mechanisms.

This survey-based study has several limitations; most notably, the 29 respondents may not represent the total scope of U.S. practice. Specifically, the entire sample identified as practicing in a non-religiously affiliated setting, which provides no understanding of the existing approval mechanisms in the US's many religiously affiliated hospitals [13]. All respondents identified as pro-choice, which could represent a selection bias of those who chose to participate in a study with abortion in the title. Although we asked about the composition of contemporary review committees, few participants provided details, which may limit broader application. Additionally, we did not ask for details of conditions on institutional pre-approved lists. The mechanisms reported are subject to the interpretation of individual Medical Directors. Lastly, because we designed the study to understand the approval mechanisms of U.S. hospitals that serve as referral centers for their communities, the results do not address practice patterns in community hospitals.

These findings provide an initial contemporary understanding of how Medical Directors of referral center Labor and Delivery units across the country manage requests for inpatient abortion care amidst increasing state level restrictions [1]. Given the immense challenges some health systems face to provide inpatient induced abortion care, proponents, particularly in restrictive settings, may consider applying approval mechanisms (e.g., approval committees, institutionally pre-approved abortion indication lists) as practical, albeit problematic, options for legitimizing the ongoing provision of inpatient induced abortion care.

Author contributions

M.J.C.: Writing – review and editing, Supervision, Formal analysis. H.A.R.: Writing – review and editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. M.D.C.: Writing – review and editing, Supervision, Project administration, Methodology.

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Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.contraception.2026.111364.

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