2026, Volume 58, Issue 6, 450-451, e-ISSN 1938-3800

Family Medicine

NARRATIVE ESSAY

Pregnancy in a Time of Fear

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HOW TO CITE: Ruiz J. Pregnancy in a Time of Fear. *Fam Med.* 2026;58(6):450-451.
doi: 10.22454/FamMed.2026.446067

FIRST PUBLISHED: June 8, 2026

KEYWORDS: family medicine, health equity, immigration enforcement, maternity care, perinatal care, rural health

In November 2025, pregnancy care changed in my rural North Carolina community.

I noticed it first on my drive to the clinic. As I passed the chicken processing plant a few blocks away, the familiar smell hung in the air as it always had—but the parking lot was noticeably emptier. Fewer cars lined the edges. I did not see the usual groups of workers walking along the road in long rubber boots, heads down, preparing for a long day of hard work. Roads that were normally busy in the early morning were quiet. Grocery store parking lots sat half empty. Construction sites were silent.

By the time I arrived at the clinic, the schedule told the rest of the story: no-shows filling the day, many from pregnant patients who had never before missed appointments.

Immigration and Customs Enforcement activity had begun in nearby communities. Fear followed quickly.

I am a family physician practicing in a rural and underserved area where family medicine is not just primary care; it is maternity care, newborn care, and community care. For many patients, I am the physician who confirms the pregnancy, manages chronic disease, delivers the baby, and sees that child for well-child visits. This continuity is not incidental; it is the foundation of trust.

Many of my patients are Spanish-speaking and undocumented. In ordinary times, pregnancy care is built slowly—visit by visit—through consistency and conversation. We talk about nausea and fatigue, laboratory results, hopes for delivery, feeding plans, and family support. Over time, relationships form. That trust allows patients to show up early, accept referrals, ask questions, and return after birth when vulnerability is greatest.

In November 2025, that trust was tested.

Pregnant patients stopped coming. Some sent messages later, apologizing and explaining that they were afraid to leave their homes. Others disappeared without explanation. Women who had carefully followed prenatal schedules suddenly deferred care. One patient told me quietly, "*No quiero manejar por miedo a la migra*." I don't want to drive for fear of immigration enforcement.

In rural perinatal care, distance already matters. Specialists are far away. Hospitals are few. Travel is unavoidable. When fear enters that geography, distance becomes danger. Patients declined referrals to maternal-fetal medicine, not because they doubted the medical need, but because driving unfamiliar roads felt unsafe. Routine prenatal labs, ultrasounds, and glucose testing were postponed or skipped. Clinical decision-making—normally grounded in shared risk-benefit discussions—became inseparable from fear.

The clinic felt different. The waiting room was quiet. Staff spoke more softly. Medical assistants worried about pregnant patients they had not seen in weeks. The front desk fielded questions we had rarely heard before, now asked repeatedly: *Is it safe to come in? Can immigration come into the clinic? Will my information be shared?*

As a family medicine clinic, we responded the way we often do—by trying to protect our patients. We reviewed confidentiality practices. We trained staff on patient rights. We discussed how to respond if immigration enforcement appeared. We reassured families that clinics and hospitals exist for care, not surveillance.

But national immigration policies had shifted. Enforcement funding expanded. Deportation efforts intensified. Long-standing assumptions about protected spaces eroded. Clinics, hospitals, schools, places of worship, and community centers—places where trust is meant to live—no longer felt safe. For patients, the distinction between policy and practice did not matter. The possibility alone was enough.

At the hospital, deliveries continued. Babies arrive regardless of policy. Still, labor felt different. Some patients arrived later than expected, having waited at home as long as they could. Others asked repeatedly who might enter the room, whether security could keep people out, and whether it was safe to go home afterward. The delivery room—normally a place of vulnerability and trust—felt newly uncertain.

Postpartum care suffered as well. Newborn weight checks were delayed. Jaundice evaluations postponed. Lactation visits missed. Parents weighed concern for their newborns against fear of leaving home. For families already navigating poverty, language barriers, and limited transportation, immigration enforcement added instability at the exact moment when support matters most.

Family medicine's strength in perinatal care lies in continuity and presence. We know families, communities, and context. Immigration enforcement disrupted that continuity. It taught patients that visibility carries risk. It transformed engagement with care into exposure.

What struck me most was how collective the response was. Entire neighborhoods retreated inward. Roads stayed quiet. The chicken plant parking lot remained sparse. Clinic schedules hollowed out. Absence became the signal—not nonadherence, not lack of concern, but fear.

As family physicians, we are trained to adapt. We meet patients where they are. We adjust workflows. We build trust slowly. Yet there are limits to what adaptation can accomplish when fear keeps patients from coming through the door.

I write this as a reflection from the practice of family medicine. Policies crafted far from rural communities shape prenatal care, delivery timing, and postpartum follow-up. They shape who feels safe enough to be seen during pregnancy, who arrives early in labor, and who brings their newborn back for care.

In November 2025, immigration enforcement entered perinatal care not through direct presence, but through absence. For rural family physicians providing maternity and newborn care, that absence carries consequences—missed diagnoses, delayed interventions, and fractured trust.

Family medicine has always understood that health is relational. In pregnancy, birth, and postpartum care, trust is not optional—it is clinical infrastructure. When fear undermines that trust, maternal and child health suffer. Our responsibility, as family physicians, is not only to continue caring, but also to notice, to name, to bear witness, and when possible, to lend our voices to policies that protect the health and dignity of the communities we serve.