Confronting the Medical Community’s Complicity in Marginalizing Abortion Care

Sonya Borrero, MD, MS
Center for Innovative Research on Gender Health Equity (CONVERGE), Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Mehret Birru Talabi, MD, PhD
Center for Innovative Research on Gender Health Equity (CONVERGE), Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Christine Dehnedorf, MD, MAS
Department of Family & Community Medicine, University of California, San Francisco.

Viewpoint
pages 1689, 1691, 1693, 1695, 1697, 1699, and 1703 and Editorial page 1707

The US Supreme Court’s ruling in Dobbs v Jackson Women’s Health Organization, which overturned Roe v Wade and eliminated federal protections for abortion care, is a decision with monumental effects on health and the practice of medicine. Permitting individual states to regulate any aspect of abortion not preempted by federal law opens the door to criminalization of a medical procedure that a quarter of US women experience and constrains access to needed and potentially lifesaving medical care simply based on the state in which a person lives.

The profound consequences of this decision were not lost on the more than 75 medical societies, including the American Medical Association and the American College of Obstetricians and Gynecologists, that issued a joint statement affirming abortion as essential health care and denouncing the Supreme Court’s ruling as a direct threat to people’s health and well-being and the provision of evidence-based, patient-centered care. This broad, cohesive mobilization of the medical establishment on a single issue is rare and especially notable given that abortion has been relegated to a parallel and stigmatized health care delivery structure outside of mainstream medicine. More than 90% of the nearly 1 million documented abortions each year in the US occur in freestanding clinics, whereas only 3% occur in hospitals. Moreover, a minority of obstetricians-gynecologists and primary care practitioners offer abortions as part of their practices.

The current abortion service landscape originated in the 1970s when the legalization of abortion after Roe v Wade and the concurrent introduction of vacuum suction devices enabled widespread provision of safe and simple outpatient procedures. Abortion rights advocates and feminists helped spearhead the creation of freestanding clinics that offered inexpensive, compassionate, specialized care. Although there were many advantages to this model, it had the unintended consequence of isolating abortion from the traditional health care delivery system and made abortion clinics highly vulnerable to targeted attacks. As protests, harassment, and violence against abortion clinics, patients, and clinicians escalated throughout the decades after Roe, hospitals and individual physicians were increasingly reluctant to provide abortions, and abortion care was further sidelined and stigmatized.

Marginalization of and stigma around abortion care serve to discredit the clinicians who provide these services and to delegitimize abortion as necessary health care.

Marginalization of and stigma around abortion care serve to discredit the clinicians who provide these services and to delegitimize abortion as necessary health care. Reinforcing this narrative, many hospital systems have opted out of providing abortion services, even for cases in which pregnancy is life-threatening. Hospitals that do provide abortion often limit their services to only abortions considered medically complicated and frequently do not openly acknowledge their involvement in this care. Medical education also reflects the way in which abortion is sidelined because it is not universally included in medical school or residency training. Furthermore, besieged abortion clinics have received little to no support from the broader medical community as they were forced to comply with unnecessary, burdensome, and politically motivated regulatory requirements for a procedure that is safer than childbirth or colonoscopy. The acquiescence of health care systems is likely due to a number of factors, including a desire to avoid the stigma associated with abortion, concern about inciting abortion opponents, and apprehension about jeopardizing state or other funding. Regardless of motivation, this silence actively perpetuates the stigmatization and politicization of abortion.

The systematic exclusion of abortion care coverage by major payers compounds these issues. Soon after Roe, Congress enacted the Hyde Amendment, which barred federal funds from paying for abortion services except in cases of rape, incest, and life endangerment, resulting in extremely limited coverage of abortion care under Medicaid and other federally funded plans. Because one of the most common reasons for abortion in the US is a lack of financial resources to parent, low-income individuals are substantially overrepresented among patients seeking abortion. Lack of insurance coverage in publicly funded plans likely diminishes health care systems’ motivation to provide abortion care and to engage in the protection of this health care service, even though robust data indicate that the ability to access safe abortion care is unequivocally associated with improved physical, psychological, and social outcomes. In contrast, health care systems have long reaped financial rewards from the provision of low-value services (eg, unnecessary imaging and surgery) that provide little to no benefit to patients.

Although mainstream medicine has been conventionally able to avoid the work and politics of abortion, it has relied on this care in ways that are increasingly evident. The influence of the Dobbs decision on the lives of
people needing to end a pregnancy in states with abortion restrictions has been substantial and intended, but the consequences of such bans, beyond abortion care, are now emerging in the public consciousness and being acutely felt by health systems and clinicians, who are finding themselves unable to provide timely and potentially lifesaving treatment for severe pregnancy complications in which fetal cardiac activity persists. These complications include ectopic pregnancy, hemorrhage in the context of inevitable miscarriage, and infection in the setting of preterm premature rupture of membranes. Physicians are caught between upholding their ethical and professional mandate to prioritize patients’ well-being and avoiding criminal prosecution under vague and sometimes rapidly fluctuating state laws.

This tension extends beyond pregnancy-related care into other areas of medicine, as demonstrated by emerging issues around methotrexate provision. Methotrexate is an effective and evidence-based treatment that is widely prescribed at low doses to nonpregnant individuals with autoimmune diseases. Methotrexate is also a teratogen and at higher doses has abortifacient properties. Within hours of the Dobbs decision, reports emerged that major pharmacies plan to require patients to document that they will not subvert their low-dose methotrexate for purposes of abortion. In addition, news and social media presented stories about women whose clinicians and pharmacies would no longer fill methotrexate prescriptions without documentation of a negative pregnancy test result or use of a highly effective contraceptive method, highlighting the potential for new avenues of widespread contraceptive coercion.

These scenarios reveal the invisible yet essential role that access to safe and legal abortion care has had for many primary care and subspecialty clinicians. Abortion access has served as a safety net that has enabled them to provide evidence-based and potentially life-altering treatment to patients with pregnancy capacity. Clinicians recognize that without abortion access, a person who becomes pregnant while using a teratogen that they prescribed might be forced to bear a child with congenital anomalies, potentially exposing clinicians to personal, legal, and professional consequences. New policies regarding methotrexate dispensing suggest that pharmacists also may be vulnerable to criminalization or loss of licensure if a medication they dispensed is found to be used to induce an abortion. These accounts suggest that even in the early days following the Dobbs decision, abortion restrictions are leading to conservative prescribing and dispensing practices for teratogenic medications that are not serving patients well. Rather, these practices designate women and people with childbearing potential as second-class citizens, who will be treated according to their reproductive potential rather than best clinical practice. This approach challenges the integrity of evidence-based medicine and compromises advancement toward equitable, just, patient-centered care.

The new and evolving landscape of health care provision post-Dobbs has revealed that despite the segregation of abortion care, clinicians, hospitals, and health care systems have been the often-unacknowledged beneficiaries of abortion access. If abortion care is indeed essential health care, then health care professionals have an obligation to collectively chart a new course forward to destigmatize and legitimize safe abortion care through clinical, education, research, and advocacy efforts. To help reinforce abortion as standard care, provision of abortion counseling, as well as medication and procedural abortion, should be incorporated into routine care, with streamlined referral pathways when needed, wherever possible.

In addition, creative strategies to safeguard abortion training throughout the country will be necessary to ensure a future workforce able to perform the full scope of necessary reproductive procedures. Earmarking research funding to evaluate the short- and long-term clinical and public health implications of abortion regulations is critical to inform programmatic and policy efforts.

Finally, as medical organizations and health care systems increasingly embrace antiracism and health equity agendas, they need to fully recognize abortion access (and the lack thereof) as a health equity issue. Abortion need is concentrated among low-income individuals who are, because of the effects of structural racism in US society, disproportionately Black, Indigenous American, and Latinx. Advocating for the abolishment of the Hyde Amendment could help mainstream abortion care and mitigate some of the particularly burdensome effects of insufficient abortion access on populations disadvantaged by classism and racism.

Now that the US has reached the point of a public health crisis in reproductive health care, the medical community is forced to reckon with the realization that lack of abortion access, and certainly the criminalization of it, directly threatens the health and dignity of all people with reproductive capacity, the safety and security of potentially any clinician who provides care for these patients, and the integrity of the medical profession. Far more than a joint statement is needed to alter the dangerous course the nation is on.

ARTICLE INFORMATION
Conflict of Interest Disclosures: None reported.

REFERENCES

© 2022 American Medical Association. All rights reserved.