Health Care Access and Reproductive Rights

Linda Brubaker, MD, MS; Kirsten Bibbins-Domingo, MD, PhD, MAS

Evidence-based care for early pregnancy is well established and includes strong evidence for safe abortion as part of the reproductive health care spectrum.¹ Legal interference to provision of safe, accessible abortion diverts the time, attention, and skills of clinicians from other pressing health concerns, especially improving maternal health and birth equity. The rate of maternal mortality in the US, already unacceptably high, surged from 20.1 deaths per 100,000 live births in 2019 to 23.8 deaths per 100,000 live births in 2020; the increases were significantly higher for Black and Hispanic people.² Maternal deaths (during pregnancy or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management) are anticipated to increase as evolving abortion restriction laws undermine physicians’ ethical and professional mandate to prioritize patients’ well-being.

Nationally, Black individuals are 3 times more likely than White individuals to die of pregnancy-related causes.³ Legal interference with evidence-based abortion counseling and care will disproportionately affect Black and Hispanic individuals as well as all persons for whom low income, lack of health insurance, or other life circumstances (eg, related to employment, transportation, or family care responsibilities) pose a barrier for access to legal abortion services. Current estimates are that two-thirds of maternal deaths are preventable; the proportion of preventable maternal deaths will increase following the Supreme Court decision in Dobbs v Jackson Women’s Health Organization.

Beyond reproductive care, legal interference with clinical care makes it difficult for other groups of patients to receive evidence-based care, including access to medications such as methotrexate (widely used to treat rheumatoid arthritis), isotretinoin (used to treat nodular acne), and valproate (used to treat seizures). In addition, the Dobbs decision may create a barrier to an essential component of cancer care for adolescents and young adults with new cancer diagnoses, such as lymphomas, leukemias, sarcomas, and breast or reproductive tract cancers. These patients may no longer have access to standard fertility preservation techniques (eg, genetic testing, sperm and embryo cryopreservation, and embryo disposal).⁴ The legal interference may have implications beyond current practice as clinicians—faced with a markedly heightened risk of criminalization by providing routine outpatient, inpatient, emergency, or critical care—alter their current pattern of care. This issue of JAMA includes original research and 8 scholarly Viewpoints that provide data and perspective about abortion care and the larger context of evidence-based health care. Several research articles and Viewpoints highlight the current health risks associated with pregnancy and those that are expected to increase with criminalization of abortion health care. In their research article, Nelson and coauthors focus on unintended pregnancy, the reduction of which is a Healthy People 2030 public health priority.⁵ The rates of unintended pregnancy in the US, estimated at 38% of pregnancies between 2017 to 2019, remained highest for younger individuals, those in racial or ethnic minority groups, and those with low incomes. Based on their systematic review and meta-analysis that included 524,522 participants, the authors contribute evidence that unintended pregnancy was significantly associated with higher odds of maternal depression during pregnancy and the postpartum period, preterm birth, and low-birth-weight infants. Unintended pregnancy also exacerbated the risk for maternal experience of interpersonal violence, already known to be increased during pregnancy. The proportion of unintended pregnancies, with these associated risks, is expected to increase following the Dobbs decision.

In their Research Letter, Pineles and colleagues describe the increased risk of adverse maternal and delivery outcomes in children and very young (age ≤13 years) US adolescents.⁶ Compared with older adolescents and young adults, children and very young adolescents had a significantly increased risk of preterm delivery, which is associated with numerous adverse outcomes, some of which have lifelong consequences. As abortion access is restricted, it is anticipated that there will be an increase in pregnancies in children and very young adolescents.

Two Viewpoints underscore the health risk anticipated to increase with criminalization of abortion care. The Dobbs decision magnifies preexisting threats to birth equity, a foundational concept in the reproductive justice framework. In their Viewpoint, Crear-Perry and coauthors describe the disproportionate harm for Black pregnant people and their families, including continued poverty, intimate partner violence, and serious health problems.⁷ Current estimates project a 33% rise in maternal mortality for Black people, an unacceptable increase from an already unacceptable baseline.

In their Viewpoint, critical care specialists MacDonald and colleagues emphasize the importance of early recognition and timely treatment of events that increase a pregnant patient’s risk of adverse outcomes or death.⁸ This central tenet of critical care medicine is highly relevant for the evidence-based care
of pregnant individuals who need emergency termination of pregnancy. Withholding standard care may demonstrate to individuals without medical training the unambiguous nature of the emergency and the life-threatening risk to the patient. However, withholding early evidence-based care that would prevent impending morbidity and potential mortality goes against the prevention and early intervention strategy that is central to medical care. It is the physician’s duty and core responsibility to determine what constitutes a medical emergency, share an assessment of risk and treatment options with the patient, and implement medical care aligned with the patient’s values and preferences.

The Research Letter by Aiken and coauthors\(^9\) provides new data on the increase in telemedicine requests for self-managed abortion medication in the US following the leak of the draft Supreme Court decision in *Dobbs*, with further increase following release of the formal *Dobbs* decision. The authors suggest that with further limitations on facility-based abortion services, requests for self-managed medication abortions will continue to increase.

In their Viewpoint, Grossman and Verma discuss modern, evidence-based methods of self-managed abortion, which has strong evidence supporting its efficacy and safety.\(^10\) The authors describe what clinicians should be cognizant of as patients present to obtain care prior to or following a self-managed abortion. They highlight the importance of prioritizing evidence-based care, which will rarely differ based on whether the pregnancy ended spontaneously or through self-managed abortion. A JAMA Patient Page summarizes medication abortion.\(^11\)

Two Viewpoints in this issue discuss legal effects on clinicians and the larger society. Reingold and coauthors describe the ethical dilemmas and serious legal risks to clinicians posed by the breadth of post-*Dobbs* state laws.\(^12\) They highlight the chilling professional consequences with risks to career and livelihood for clinicians who are simply practicing evidence-based care, using their best clinical judgment, and counseling patients honestly. The authors urge physicians who believe that abortion laws violate ethical values or are unjust to work for changes in abortion restriction laws.

Changes in national laws are possible, as described by Romero and Ramón Michel in their Viewpoint detailing the legalization of abortion in Argentina in 2020.\(^13\) The authors note the high rates of maternal mortality in Argentina as a result of unsafe abortion care prior to legalization, as well as the events leading to the changes in the law and subsequent consequences.

**ARTICLE INFORMATION**

*Author Affiliations:* University of California San Diego, La Jolla, California (Brubaker); Associate Editor, *JAMA* (Brubaker); Editor in Chief, *JAMA* and the JAMA Network (Bibbins-Domingo).

*Corresponding Author:* Kirsten Bibbins-Domingo, MD, PhD, MAS, Editor in Chief, *JAMA* and the JAMA Network (kirsten.bibbins-domingo@jamanetwork.org).

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**REFERENCES**


The *Dobbs* ruling has implications for the training of physicians. The current program requirements of the Accreditation Council for Graduate Medical Education (ACGME) require inclusion of abortion training as a routine experience, while individual residents are able to partially participate, sometimes called “opting out.” In their Viewpoint, Mengesha and coauthors\(^14\) clarify the implications on residency training, as individual states restrict abortion. Given the evidence documenting the benefits of routine, integrated abortion training, the authors suggest that there may be a decrease in the number of obstetrician-gynecologists who have competency in the ability to perform safe abortion. They also highlight the risk of moral distress due to clinicians’ inability to provide timely standard care for their patients.

Two Viewpoints consider abortion care within the larger US health system. Borrero and colleagues describe how the creation of freestanding abortion clinics isolated abortion care and threatened the health and dignity of patients and their clinicians.\(^15\) The authors note that mainstream medicine has relied on a system that has marginalized abortion care and detracts from the rightful role of abortion as part of evidence-based health care. As clinicians, hospitals, and health care systems have been the often-unacknowledged beneficiaries of abortion access, the authors argue that 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.

In their Viewpoint, Walker and coauthors discuss the role of technology solutions that could better safeguard reproductive health information to ensure that a patient’s reproductive health information is not used by law enforcement who are responding to court orders, court-ordered warrants, or subpoenas.\(^16\) Existing laws are based on an assumption that data sharing would optimize health outcomes for individuals and populations, and the authors call for implementation of effective and intentional safeguards.

These articles in this issue of *JAMA* provide information about how abortion restrictions interfere with the autonomy of clinicians to provide evidence-based medical care and to engage in shared decision-making with their patients in accordance with their professional responsibilities. The evolving patchwork of restrictive abortion laws in the US does not align with modern medical care, poses risks to multiple groups of patients, and exacerbates injustices in health care. Legal interference between patients and their clinicians who are providing evidence-based care is unacceptable and ultimately harms patients, clinicians, and society at large.


