The A Word—Our Collective Scarlet Letter
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“Happy are you, Hester, that wear the scarlet letter openly upon your bosom! Mine burns in secret….The letter was the symbol of her calling.”

Why are we so reluctant or hesitant to say the A word out loud? Abortion is a highly prevalent procedure, with the Guttmacher Institute's estimates of 1 in 4 US women reporting having one by age 45 years. Abortion is an evidence-based, standard-of-care option, supported by numerous, respected professional societies for all persons who are pregnant. Abortion is a part of the my own specialty's board certification requirement that all obstetrics and gynecology physicians have the “knowledge, skills, and judgment relative to reproductive health rights, including access to contraception as well as to safe and legal pregnancy termination.” Indeed, abortion is part of comprehensive care to which every pregnant person should have access, as it is essential to routine pregnancy care. The American Board of Obstetrics and Gynecology states, “our commitment to these principles is firm and unwavering in support of OB/GYNs [obstetrics and gynecology physicians] who wish to provide comprehensive reproductive health care to the patients and families they serve. Patients place their trust in the sanctity of the patient-physician relationship, and they must have confidence that their OB/GYNs can provide the evidence-based counseling and care that they need without intimidation, retribution, or litigation.”

The June 24, 2022, Supreme Court decision regarding Dobbs v Jackson Women’s Health Organization overturning Roe v Wade was not based on standard-of-care medical practice, science, nor empathy related to 50% of the US population that can experience pregnancy up to 35 years each.

So, why don’t we, as health care professionals and leaders in our fields, enunciate the word abortion loudly and repeatedly? The World Health Organization estimates that more than 73 million induced abortions take place worldwide annually, 6 of 10 pregnancies globally end in induced abortion, 97% take place in developing countries, and unsafe abortion is a leading global cause of maternal mortality. Abortion is a safe procedure, regardless of the method, medication, or surgical procedure. Abortion is one of the most performed surgeries next to cesarean delivery (through which one-third of all births occur) and is safer than childbirth; pregnant persons are almost 14 times more likely to die during childbirth than from complications due to abortion.

When over half the US population can potentially become pregnant for about one-third to 40% of each of their lifetimes, why is the full spectrum of safe, well-studied effective care that is a part of pregnancy care banned or severely restricted by about half of the US states? Why do we allow politicians to use abortion as a voting strategy for their career benefit? The politicization of abortion causes creation of policies that directly affect abortion access and legalization as identified in 2 studies published in JAMA this week. Access has many dimensions; it is far more than just physical distance from clinical care. However, these 2 studies clearly detail the consequence of abortion restriction on access to care with respect to distance traveled. Other barriers include emotional, logistic, and financial challenges, not to mention, many experience discrimination, distrust, health literacy, and social and economic factors further exacerbating access.

Rader and colleagues performed a spatial analysis that depicted travel time to abortion facilities in the US to be significantly greater post- vs pre–Supreme Court decision to overturn Roe. In the post–Roe decision, the proportion of women who were located more than 60 minutes away from an abortion facility approximately doubled. They calculated the nearest abortion facility in the state of Texas increased by almost a full workday (8 hours) post-Dobbs decision. This is in the setting of Texas having over 60,000 abortions annually and a state with one of the highest rates of uninsured individuals. Similarly, White and team depicted a decrease in total facility-based abortions among Texas residents in response to a Texas ban on early-pregnancy abortion in September 2021. This study detailed the impact of one state’s abortion ban on surrounding states that absorb many of those cases, including detailing potential issues with capacity resulting in prolonged wait time for appointments and thus more procedures done at advanced gestational ages. Surgical abortion after 12 weeks’ gestation often requires multiple visits and costs more for patients. In addition, although rare, complications can be increased with more advanced gestational ages. Finally, challenges of travel along with fear and disinformation could contribute to pregnant individuals self-managing their abortion or continuing their pregnancies.

We need to find our path back to depoliticizing the A word. There is well-established communication research that the moment that voters decline to vote based on abortion is the minute our politicians will stop creating policies that promulgate harm impacting over 50% of the US population. Plain and simple, abortion is health care.

In this circumstance, where the health autonomy of people who can become pregnant and their health care team is in jeopardy, we must relentlessly and without political influence defend patients’ clear autonomy along with abiding by our Hippocratic Oath to first do no harm. Abortion should never be susceptible to political whim. Abortion counseling and provi-
sion is an essential component of good health care. Abortion is not and should never be political cachet. We must take a stand on the side of supporting half of the US population’s rights to health autonomy.

Throughout my career I have emphasized the relative power and position we in the medicine and science communities wield, especially when it comes to revealing structural inequities formed by systems of oppression including all the -isms. I write this from the very privileged position of being a tenured full professor of obstetrics and gynecology and a National Institutes of Health-funded scientist and member of the National Academy of Medicine at a top-tier medical school and university and mother of 4 teenagers, 3 of which have the capacity to become pregnant.

As we traverse our careers in medicine, I often reflect on our positionality, the interplay of our privilege, and the very diametrically opposing realities of the relatively voiceless (with respect to being heard by politicians, policy makers, and Supreme Court justices) women for whom I and numerous others care. It is without doubt that policy impacts health at all levels, and policies that relate to health disproportionately fall on those who are less resourced, marginalized, and minoritized in the US. The phenotypes we see in the US of pervasive health inequities consistently showcase across racial and ethnically minoritized populations over centuries. About three-quarters of abortion seekers in the US are from low-income backgrounds.17

Our duty as health care professionals and scientists is to bring the voice of the people through collecting their stories and data and bringing them to the policy-making table so policies can be better aligned with health needs. I believe in the transcendence of data and science to go not just from the bench to the bedside and the community but to our representatives in power who can make, change, or remove laws. Anyone or any institution that supports and promotes true precision medicine and the full translational spectrum of research must never leave behind communities and people themselves. In this circumstance, the justices and every politician who is supporting, creating, and implementing laws that prohibit or completely ban abortion is acting against well-established, scientifically sound medical care and advice.

Policy is not just about the creation, but importantly about the interpretation, implementation, and experience. One challenge to policy makers that have no medical training is to understand that contrary to popular belief, pregnancy is not easy nor safe for everyone. Pregnancy can impact not just physical harm, but also emotional, social, and economic harm for not only the pregnant person, but their family. Indeed, there are many preexisting medical conditions and co-occurring medical conditions that make it dangerous to carry some pregnancies to term. Cesarean delivery, which is the route of birth for about one-third of all newborns in this country, is not as safe as a surgical abortion procedure.9 Indeed, the rising rates of cesarean and repeated cesarean deliveries is driving an epidemic of placenta accreta spectrum disorders. Placenta accreta is increasing maternal morbidity and mortality rates.18 Complicating this rise in maternal mortality rates is the increase in knowledge and technology enabling people who have conditions that are contraindicated in pregnancy to become pregnant and carry a pregnancy. Moreover, from a mental health standpoint, pregnancy places a high toll on the pregnant person with depression, suicide, and substance use, impacting many of the preventable maternal deaths in the US.10 In addition, the economic impact of restricting abortion is substantial. When people who are pregnant are forced to carry a pregnancy to term, they face numerous economic and financial challenges to supporting their offspring and family.20 Inevitably, rulings and subsequent laws like these disproportionately fall on those in the US who have less resources, the majority of who are from minoritized groups and living in rural areas and Republican-dominated states.

Research detailing the consequences of this ruling is critical. It is upon all of us to continue to document the danger in which over half of the US population lives due to political whim. Regardless of where one stands on how they feel about abortion, those personal feelings should not drive judgement to vote on health care decisions and other people’s circumstances. Until people stop voting on abortion, we will not be able to deter politicians, judges, and non–medically trained individuals from abusing their power with medical malpractice through their policies to maintain employment and power. The capacity to shift this dynamic is in our hands. The onus is on us, and it is a matter of time that health autonomy for other surgical procedures and medical decisions will be next.

Justice Alito and his fellow signatories stated that overturning Roe then returns the decision back to the peoples’ representatives. This precedent is dangerous amid voters’ rights restrictions across the US. Those that bear the brunt of health inequities and the burdens from policies that drive ill health do not have the same opportunity to vote as the more privileged populations in this country. Voter restriction laws are rampant in many US areas, especially in the states that restrict or completely ban abortion. Most US voters despite where they live in terms of postal codes believe abortion should remain legal.21 The Supreme Court’s ruling to return this decision back to the peoples’ representatives is smoke and mirrors. Health care policy should be crafted based on the “we” and not the “me.” We have reverted to the segregation era in 2022. We may be “equal” but we are separate, especially when the “we” are the people who can become pregnant. Overturning Roe is not even close to what we learned in civics class. Those of us who can become or who are currently pregnant are not included in the US government standard of “of the people, by the people, and for the people.”
REFERENCES
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