Threats to reproductive health care: time for obstetrician-gynecologists to get involved

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The Scope of the problem

Receiving reproductive health care is becoming increasingly difficult for women in the United States. The most well-publicized restrictions are on access to abortion and contraception, but as we highlight in the following text, the access issues are much broader, placing women at risk of harm and eroding the quality of the doctor-patient relationship.[1] This Viewpoint provides clinical examples of these harms and recommended actions obstetrician-gynecologists can take to address the existing obstacles and prevent new threats women's health.

The barriers to reproductive health care have arisen for many reasons. First, many publicly funded hospitals are consolidating or closing, whereas religiously affiliated health systems are expanding, such that they accounted for more than 1 in 9 hospital admissions in the United States in 2011.[1] For example, in Washington state, almost 40% of hospital beds are in religiously affiliated hospitals.[2] These hospitals often consider the life of the fetus to be equal to that of the mother and thus restrict physicians' abilities to provide life-saving management of miscarriages or ectopic pregnancies.

Second, health care institutions limit the scope of reproductive health care because of hospital policies, financial pressures, and a desire to limit negative press. In some cases, large hospital systems dictate the types of reproductive health services that private practice clinicians with admitting privileges at their hospitals can provide while providing inpatient care. In addition, large hospital systems increasingly own physician practices, and those same limits are being forced into ambulatory office settings.

Finally, legislative decisions lead hospitals to limit reproductive health care services. For example, in 2011, the Virginia Board of Health demanded that clinics providing abortions adhere to the same architectural requirements as newly constructed hospitals.[3] This demand was later overturned because it became clear that these limitations compromised, rather than promoted, women's health and were not based in necessity.[4]

Recently the US Supreme Court struck down similar requirements for abortion clinics in Texas to meet ambulatory surgical center regulations because such regulations do not improve the safety of the procedure or promote women's health but do pose an undue burden to women's ability to access basic health care services.[5] Although we celebrate these small victories, we are mindful of the many challenges women still face in obtaining reproductive health care.

Clinical examples

The first step in solving a problem is identifying it. Thus, in this report we present several examples of ways in which restrictions on reproductive health care are putting women at risk of harm.

Miscarriage

Although most miscarriages occur in the first trimester and are uncomplicated, sometimes an early pregnancy loss requires urgent intervention. Premature rupture of membranes and other second-trimester pregnancy complications often require induction of labor or uterine evacuation to remove the previable fetus. Delays in treatment put women at risk of hemorrhage, infection, psychological trauma, and death.[6,7] However, some institutions forbid an evacuation if the fetus has cardiac activity,[8] and others require evidence of infection before clinicians are allowed to intervene.[9] Additionally, confusion about when or if exceptions are allowed can delay care.[10]

Ectopic pregnancy

In nearly all ectopic pregnancies, the fetus will not survive.[11,12] If not surgically removed or treated medically in a timely fashion, ectopic pregnancy can cause hemorrhage, impair the woman's future fertility, and even result in maternal death.[13] Despite these consequences, some hospital policies prevent practitioners from intervening before tubal rupture if the fetus has cardiac activity.[14] Such unnecessary delays in care have grave medical, legal, and ethical implications.[15]

Induced abortion

The American College of Obstetricians and Gynecologists (the College) has recognized abortion care as basic health care for women,[16] and the College encourages hospitals and women's health care providers to support abortion care as essential medical care for women and to eliminate barriers to the provision of such care.[17] All pregnancies carry risks of maternal morbidity and mortality, especially in the second and third trimesters, such as postpartum hemorrhage and

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cesarean delivery—related morbidities.[18] Although millions of women each year are willing to take these risks to have a baby, women with unwanted pregnancies should have access to the safer option, abortion, if that is their choice. Additionally, when women with desired pregnancies are diagnosed with maternal or fetal complications, they may choose abortion as the best treatment option for their clinical situation.

Prenatal diagnosis

Offering prenatal diagnostic screening to all pregnant women has become common practice in the United States over the last decade.[19] When hopeful parents-to-be learn that their fetus has a severe anomaly, they may choose to have an abortion. Because of this, or perhaps to limit up-front costs, many health care institutions limit the standard screening tests that physicians can offer to pregnant patients.[20]

Contraception and sterilization

Nearly half of all pregnancies in the United States are unintended, and approximately 40% of those are terminated.[21] To decrease unintended and unwanted pregnancies, women should have unimpeded access to all US Food and Drug Administration—approved contraceptive methods and sterilization procedures. However, many religiously affiliated hospitals and faith-based health insurance plans limit the contraceptive options of the women they serve, thereby infringing on patient autonomy and compromising health care quality.[1]

Emergency contraception

From 2011 through 2013, 9.6 million sexually active girls and women reported using emergency contraception[22] Women often seek emergency contraception after a contraceptive failure. When administered within 120 hours, emergency contraception (high-dose oral contraceptive pills or an intrauterine device, which has the added benefit of being effective for up to 10 years) are 80—99% effective in preventing pregnancy.

Additionally, women who are the victims of sexual assault are often in need of both psychological support and emergency contraception. Thus, the College guidance states that emergency contraception should be immediately available in hospitals and facilities in which the victims of sexual assault are treated.[23] However, some health care facilities will not provide such services, and a woman may not know that ahead of time, potentially subjecting her to additional emotional stress. In these circumstances, it is crucial that women receive "appropriate and timely referrals to overcome limits of faith-based [hospitals] or provider networks that are exercising a 'conscience exemption.'"[24]

Education and training

The Accreditation College of Graduate Medical Education requires that obstetrics and gynecology residents receive training in all aspects of the specialty, but residents cannot receive such training at hospitals with restrictive policies.[25] In the mid-1990s, approximately 12% of all residency training programs in obstetrics and gynecology were affiliated with Catholic hospitals,[26] which generally do not perform abortions and institute many of the limitations described in the previous text.

Given the increasing proportion of hospitals with religious affiliations limiting the scope of reproductive health care,[1,2] these limitations will continue to residency training programs. In 2014, 24% of fourth-year residents in obstetrics and gynecology reported that they trained at institutions that restrict contraception.[27] Although residents may opt out of training to which they conscientiously object, they should be offered complete training in the specialty.

A call to action

The American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists recently released a position statement highlighting these concerns and suggesting ways that obstetrician-gynecologists can respond.[28] We commend these actions and further suggest the following responses.

Get and stay involved in the legislative and regulatory processes of your community, institutions, and state and federal legislatures

These include the following:

1. Take advantage of the work done by the American Congress of Obstetricians and Gynecologists to keep you informed.
2. Identify the governmental relations professionals and advocacy groups that can help you identify the threats to reproductive health care before they become passed into law or written into regulations.
3. Question the impact of hospital mergers and/or change in ownership on women's access to comprehensive reproductive health care services.
4. Be involved in hospital and political leadership in your community.
5. Educate your students and trainees about the importance of women's health advocacy.

Act when threats to reproductive health care cause poor patient outcomes

These include the following:

1. Report incidences to accrediting bodies.
   - For inpatient facilities, this may include the state regulatory agencies (DNV GL, an accrediting organization for hospitals) and the Joint Commission.
   - For outpatient facilities, this may include the state regulatory agencies, Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or the Joint Commission.
2. Consider contacting the American Civil Liberties Union, which can accumulate data on which to make future legal