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JOURNAL DISCUSSION

Legislating Abortion Care

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One Hundred Professors of Obstetrics and Gynecology. A statement on abortion by 100 professors of obstetrics: 40 years later. *Am J Obstet Gynecol.* 2013;209(3):193-199.

Minkoff H, Ecker J. When legislators play doctor: the ethics of mandatory preabortion ultrasound examinations. *Obstet Gynecol.* 2012;120(3):647-649.

Abortion is one of the most common medical procedures in the United States, with 1.1 million performed in 2011 [1]. It is also an aspect of medicine that greatly interests the public and politicians: in 2011, 24 states passed 92 legislative restrictions on abortion [2]. No other medical practice has invited such broad and detailed regulation of the patient-clinician relationship. It is essential for trainees, who are learning how to cultivate relationships with patients, to recognize the ethical and patient care implications of such laws. Two recent editorials published in obstetrics and gynecology journals highlight the harmful effects of such legislation on the practice of ethical and evidence-based medicine [3, 4].

The authors of “A Statement on Abortion by 100 Professors of Obstetrics: 40 Years Later” [3] reflect on a statement published just before the *Roe v. Wade* decision. The original 1972 article, also signed by 100 professors, envisioned a future of legal abortion and defined the responsibilities of obstetrician-gynecologists in ensuring access to safe abortion for women. Their optimistic 1972 vision centered on the anticipated positive public health impact of safe abortion and their certainty that the previously common complications of unsafe abortion would disappear. They discussed a number of medical points such as the importance of hospitals’ including abortions in the scope of caring for women and the need for physicians in training to be taught the skills of uterine evacuation. They envisioned that academic medical centers would be key in ensuring access to abortion services. The authors also discussed broader societal issues, such as their strong opinion that “abortion should be made equally available to the rich and the poor” [5].

The current 100 professors praise the predictions of the earlier authors and write with disappointment about the ways in which legislation has kept those predictions from being realized. For example, the Hyde Amendment, passed soon after the *Roe v. Wade* decision, prohibits federal financial support for abortion, and only 17 states use their own funds to pay for abortions [6]. This lack of funds makes abortion distinctly less accessible for poor women. The current 100 professors also note that

39 states now require parental involvement in a minor's decision to have an abortion, contradicting the original professors' hope that a pregnant teen would have the "freedom to determine the fate of her pregnancies" [7].

The current authors identify two types of legislative abortion restriction that directly and negatively impinge upon the patient-clinician relationship. The first relates to a clinician's ability to refuse to provide abortion care to patients on the basis of his or her beliefs. "Conscience clauses" supported by a number of federal and state laws protect clinicians from being forced to provide or being discriminated against for not providing abortion services [8]. While the original 100 professors recognized that some would be unwilling to provide abortion care, they expected that these doctors would refer their patients to others. However, as the current 100 professors note, current conscience clause legislation does not require the declining physician to refer patients.

In its practice bulletin "The Limits of Conscientious Refusal in Reproductive Medicine" [9], the American Congress of Obstetricians and Gynecologists states that professional ethics requires that health care delivery be respectful of patient autonomy and that it be timely, effective, evidence-based, and nondiscriminatory. It also states that physicians who cannot in good conscience provide a service must refer patients in a timely manner to another physician who can. Laws that protect conscientious refusal, however, do not uniformly stipulate referral. The interpretation that conscientious refusal need not include a referral is not limited to legislators. A study of 1,200 physicians in 2007 found that 29 percent believed that a physician is not ethically obligated to refer a patient for a desired, safe, legal procedure with which he or she disagrees [10]. Timely referral is especially important for abortion care, since delay in care is associated with an increase in morbidity [11]. Furthermore, the current 100 professors name five states that *prohibit* referral for abortion services by physicians who work in institutions that receive state funding. Such legal support for physician refusal to refer patients for abortion on conscience grounds obscures the fact that *providing* abortion is, for many, also a conscience and values-based decision [12].

The second category of abortion legislation that encroaches on the ethical dimensions of the patient-clinician relationship is regulation of the informed consent process. Learning the skill of providing unbiased, scientifically accurate information to guide patients as they make health care decisions is a critical part of medical trainees' professional development. The original 100 professors envisioned that women would be free to consent to abortion without impediment. However, 17 states now mandate that clinicians provide women seeking abortions with scripted counseling that includes false information on at least one of the following topics: a link between abortion and breast cancer, the ability of a fetus to feel pain, and long-term mental health consequences for women who have abortions [6]. These statements are not evidence-based and have been countered in the literature [13-15]. To require that clinicians give inaccurate information to patients is, to say the least, unethical.

The ethical violations of laws that interfere with informed consent are also addressed in a second editorial, “When Legislators Play Doctor: The Ethics of Mandatory Preabortion Ultrasound Examinations” [4]. Minkoff and Ecker review the recently proposed or enacted laws in North Carolina, Oklahoma, Louisiana, Texas, and Wisconsin that require women to view their fetuses on ultrasound before their abortions [2, 16]. The authors argue that this requirement violates the principle of respect for patient autonomy by introducing coercion into the informed consent process. Some may suggest that physicians routinely use ultrasound to date a pregnancy and that requiring it before an abortion is not an additional diagnostic procedure. But there are scenarios—for example when a patient has already had a dating ultrasound—in which a pre-abortion ultrasound is not necessary. Ultimately, Minkoff and Ecker argue that the decision to perform a diagnostic test before an abortion is the responsibility of the physicians and not the government, just as the decision to perform an angiogram before placing a cardiac stent is a clinical one, not something that should be codified in law.

Further, there is no medical reason to require that the patient look at the ultrasound results whether she wants to or not. It is not a necessary component of informed consent, as it does not familiarize the patient with the risks to herself, benefits, and alternatives of the procedure, and it does not affect her health. The authors offer the analogy that patients who choose to continue a pregnancy affected by fetal anomalies are not required to view a video depicting children with disabilities. Thus, Minkoff and Ecker argue, an ultrasound may be appropriate in the preabortion care of a particular patient, but the patient and doctor should decide “its timing, context, and the way in which it is used and viewed” [17]; this decision should not be scripted by law.

As Minkoff and Ecker acknowledge, the informed consent process is not a value-free exchange, but the physician’s role is to assist patients in making choices congruent with their own—that is, the patient’s own—values. Clinicians’ values, the authors emphasize, should not enter into the conversation, nor should the values of lawmakers. We would add that in medical education it is critical to help trainees assess their own values so that they can more effectively guide patients through the informed consent process in a value-neutral or unbiased manner.

Legislative policies that require a physician to misrepresent the risks of abortion to patients, and to show the patient an ultrasound and those that allow physicians not to provide referral for abortion create a “conflict between the physician’s obligation to the patient and to the law” [17]. Professionalism requires physicians to place the patient’s welfare first, and “market forces, societal pressures, and administrative exigencies must not compromise this principle” [18]. Legislative micromanagement of the content of patient-clinician interactions in abortion care, which exists to no comparable degree anywhere else in medicine, violate medical ethics, which oblige physicians to be truthful and respectful of patients’ right to self-determination.

It is crucial for medical students and residents to recognize the far-reaching implications of the political regulation of the practice of medicine through abortion legislation. Not only do these laws affect a woman's access to abortion, they also threaten the sanctity of the patient-clinician relationship, one that is ideally based on trust, truth, and adherence to ethical principles of respect for autonomy. These two editorials elucidate the ethical problems caused by legislative interference in this relationship.

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