



Politicians' Efforts to Undermine Providers Are Imperiling Women's Health

Osub Ahmed July 17, 2019

Jeni R., at 21 weeks of pregnancy, visited her OB/GYN for a prenatal checkup and was devastated to learn that her pregnancy was not viable.¹ Her options were to either terminate the pregnancy or wait for the inevitable miscarriage. She and her partner chose the former. However, because Jeni lived in Texas—a state with some of the most restrictive and intrusive abortion bans in the country—she was forced to overcome a number of medically unnecessary and intentionally cruel hurdles to get the care she needed. This included being forced to listen to a provider recite a medically inaccurate script about the harms of abortion; waiting for two days after getting counseling before returning for the procedure; and receiving approval from two different doctors before getting the procedure.

Sadly, Jeni's story is not unique: Women across the United States face increasingly difficult, even insurmountable, barriers to receiving comprehensive reproductive health care, including abortion care.² In addition to erecting cost and other logistical barriers to accessing care, these restrictions purposefully interfere with the patient-provider relationship, dictating when, where, and how providers can interact with their patients.

The patient-provider relationship is a cornerstone of clinical care. In order for providers to administer personalized and quality care, they must establish effective communication with their patients, create an environment of trust, collaboratively engage their patients in decision-making, and safeguard their patients' confidentiality and privacy.³ In fact, when patients trust that providers are acting in their best interest, they are more likely to adhere to treatment recommendations and continue care with the same provider. Patients must also trust that providers are protecting their health information, as this allows them to more openly share sensitive information that providers can use to determine the best diagnosis and provide appropriate counseling.⁴ Any actions that undermine a provider's ability to create a safe, private, and trusting environment will ultimately lead to poorer patient health outcomes.

Protecting the patient-provider relationship is especially important for marginalized communities. For generations, medical institutions have devalued and debased women of color and their bodies through surgical obstetrical violence and federally sanctioned forcible sterilization, among other injustices.⁵ This history is compounded by the fact that women of color still receive substandard care compared with white women and experience discrimination in health care encounters.⁶ Due to the resulting deep-rooted mistrust of medical institutions and health care providers, any relationship a woman of color has with her provider must be grounded in trust, informed consent, and respect for her bodily autonomy. Similarly, confidentiality is key for LGBTQ individuals and young people, for whom any breach of privacy can be emotionally devastating and possibly dangerous.⁷ In addition to confidentiality, nondiscrimination protections—including ensuring that health care providers treat LGBTQ patients with respect—are key to strengthening patient-provider relationships.⁸ The effect of discrimination on LGBTQ people’s willingness to seek medical care is clear: LGBTQ people who faced discrimination in the past year were nearly seven times more likely than those who did not to report avoiding doctor’s offices due to fear of discrimination.⁹ That is why it is imperative for policymakers to reverse federal and state rollbacks of nondiscrimination protections in order to safeguard LGBTQ patients’ access to quality health care.

Despite clear evidence that the patient-provider relationship must be protected and strengthened, it is increasingly common to see this relationship undermined through ideological political interference by state legislatures and the federal government. This is especially true when it comes to abortion care. States have implemented numerous restrictions, from mandated biased counseling to gestational bans, while the federal government has enforced insurance coverage restrictions and undermined federal family planning grant programs.¹⁰ Not since *Roe v. Wade* was decided in 1973 has it been a more politically fraught or difficult time to be a reproductive health care provider, specifically one that provides abortion care.¹¹

Today, 29 states require providers to counsel women before performing an abortion. Thirteen of these states require that providers tell women about the fetus’s ability to feel pain, and six require that women are informed that personhood starts at conception.¹² In addition, 26 states include inaccurate information about the risks of abortion, such as falsely alleging that there is increased risk of breast cancer or infertility after obtaining an abortion.¹³ The information included in this forced counseling is medically inaccurate and has been thoroughly debunked by the mainstream medical community, including the American College of Obstetricians and Gynecologists; the American Medical Association; the National Academies of Sciences, Engineering, and Medicine; and many others.¹⁴ Yet this interference by state legislatures—many of which are predominantly led by and comprised of white men—has undermined health care providers’ ability to uphold their professional oaths and offer medically accurate and honest care to their patients. Meanwhile, patients are faced with the prospect that their providers may not be furnishing them with the full range of health care options.

Gestational bans are also used to insert politics into the exam room. In the small proportion of cases in which women must seek abortion care later in pregnancy, states have placed multiple barriers between women and their providers.¹⁵ When women seek later abortion care, their situations are often medically complicated—for example, a woman’s life is at risk or the pregnancy is not viable—and therefore require unhindered and transparent consultation with a trusted medical professional. In some cases, women are even forced into abortion care later in pregnancy because of a dearth of abortion services in their state and/or stringent requirements that create delays in care. These delays tend to fall hardest on low-income women, women of color, and young people, who are more likely to live in states that have the fewest abortion providers and the most hostile environments for people seeking abortion care.¹⁶ Whatever the reason, the decision to pursue an abortion is one that is made between a woman and her provider. When state legislators attempt to mandate when these conversations can happen, they are placing a woman’s health at risk.

On the federal level, abortion care is primarily restricted through limits to insurance coverage and federal funding. The Hyde Amendment—a legislative provision that prohibits coverage of abortion through the Medicaid program except in cases of rape, incest, or life endangerment—is a prime example.¹⁷ The late Justice Thurgood Marshall once wrote that the Hyde Amendment was “designed to deprive poor and minority women of the constitutional right to choose abortion.” As of 2017, the 13.2 million women of reproductive age on Medicaid are blocked by the federal government from using their health insurance to access abortion care simply because of their income.¹⁸ It is well-documented that women who are denied abortion care and forced to carry a pregnancy to term are four times more likely to live below the federal poverty level.¹⁹ And when women cannot obtain the abortion care they need, they are more likely to suffer from pregnancy-related complications, remain in abusive relationships, or experience mental health issues.

Another egregious example of federal overreach into the patient-provider relationship is the Title X domestic gag rule.²⁰ Established in 1970, Title X is the nation’s only federal domestic program focused solely on providing family planning and related preventive health services to more than 4 million low-income people, most of whom are uninsured or ineligible for Medicaid. Despite decades of bipartisan support for the program, the Trump administration issued a rule in June 2018 that would prohibit Title X grantees from providing women with a full range of pregnancy-related options, including abortion care, referrals, and information.²¹ The rule, which is currently tied up in litigation, will eliminate providers’ obligation to offer nondirective counseling to pregnant women on all their pregnancy options, including prenatal care, abortion, and adoption.²² Under the new rule, methods such as natural family planning will instead be encouraged. In addition, the rule’s family participation requirement will force providers to involve parents or guardians in young people’s family planning care, despite providers’ better judgement in consultation with the reproductive choices of their patients. This could lead to young people forgoing family planning services altogether due to possible breaches in confidentiality.

Thankfully, there has been some progress on the federal level to protect the patient-provider relationship. The House of Representatives recently reintroduced the Women's Health Protection Act, which would stop states from enacting restrictive laws such as those that require biased counseling, multiple in-person visits, and medically unnecessary procedures.²³ Congress must now advance this important piece of legislation and ensure that women can receive medically accurate information from their providers. States, too, have taken action. A few examples of pro-active state actions include:

- **Ohio and Pennsylvania:** In recent years, policymakers in Ohio and Pennsylvania introduced legislation—the Doctor-Patient Relationship Protection Act²⁴ of 2014 and the Patient Trust Act of 2014 and 2015,²⁵ respectively—to safeguard the patient-provider relationship. These bills, if passed, would have ensured that doctors were not forced to disseminate medically inaccurate information to their patients or perform medically unnecessary services.²⁶ State policymakers must continue to introduce bills aimed at getting politics out of the exam room and protecting women's health and rights, especially given the hostile environments that many women now face in their states when accessing abortion care.²⁷
- **Massachusetts:** In 2018, Gov. Charlie Baker (R) signed into law the Protect Access to Confidential Healthcare (PATCH) Act, which ensures that a member's sensitive health information is not shared with the named policyholder through the explanation of benefits or summary of payment forms.²⁸ Prior to the PATCH Act, it was possible for providers to share sensitive information pertaining to a patient's reproductive and sexual health services, mental health disorders, and treatment for sexual assault, among other things, with the named policyholder—for example, the patient's parent or partner. The PATCH Act addresses this loophole, for example, by allowing health insurers to send these forms directly to the patient who received the service and by allowing for the patient to choose how and where this information is delivered. This is important for young people as well as those in abusive relationships, for whom health care information privacy is vital to both continuation of care and safety.
- **Washington:** This legislative session, Washington state representatives introduced the Protecting Patient Care Act, which would ensure that providers are not prohibited from offering medically accurate and comprehensive information and services to their patient against their better judgement.²⁹ These types of prohibitions typically fall hardest on women, LGBT patients, and those in need of end-of-life care.

Clearly, more action is needed. As the Trump administration and state governments continue to enact regressive policies and legislation that curtail women's access to abortion services and that undermine the integrity of the patient-provider relationship, Congress and state legislatures must take swift action. With the future of *Roe v. Wade* under threat and the number of abortion providers quickly dwindling, the ability of providers to offer the best care and for women to have bodily autonomy depends on states, Congress, and the courts stepping in to protect the patient-provider relationship.

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