Ethical challenges for women's healthcare highlighted by the COVID-19 pandemic

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ABSTRACT

Healthcare policies developed during the COVID-19 pandemic to safeguard community health have the potential to disadvantage women in three areas. First, protocols for deferral of elective surgery may assign a lower priority to important reproductive outcomes. Second, policies regarding the prevention and treatment of COVID-19 may not capture the complexity of the considerations related to pregnancy. Third, policies formulated to reduce infectious exposure inadvertently may increase disparities in maternal health outcomes and rates of violence towards women. In this commentary, we outline these challenges unique to women's healthcare in a pandemic, provide preliminary recommendations and identify areas for further exploration and refinement of policy.

INTRODUCTION

In times of a pandemic, the duty of care rightly shifts from the individual patient to safeguarding the health of the community.[1 2] During the ongoing COVID-19 pandemic, the threatened strain on the healthcare system required governments and healthcare systems to make difficult policy decisions regarding allocation of scarce resources. Amidst larger sociopolitical forces, women's health has the potential to be sidelined in such discussions. COVID-19 has highlighted the unique challenges of women's healthcare and underscored the potential devaluation of women's health, with resultant long-term ramifications.

In this commentary, we explore how American healthcare policies developed during the COVID-19 pandemic to safeguard community health may disproportionately disadvantage women in the USA. Though similar disparities based on sex may be present worldwide, we focus on the USA as a case study given its unique healthcare system and policies. Other factors, such as race/ethnicity, age, sexual orientation, disability status and immigration status, also contribute to disparities in health outcomes disparities that the pandemic has likely further exacerbated. However, we limit our discussion to women's health given the current American sociopolitical climate characterised by movements and policies that seek to obstruct women's reproductive freedoms.

We argue that the deferral of elective surgery defined solely by non-reproductive adverse outcomes exemplifies the tendency of women's health to be devalued in policy discussions. Second, policies regarding the prevention and treatment of COVID-19 in the context of pregnancy demonstrate the ethical and legal tension inherent in the maternal–fetal dyad. Third, policies formulated to reduce infectious exposure may inadvertently increase disparities in maternal health outcomes for women of colour and result in an increase in rates of intimate partner violence. Here, we explore these unique and ongoing challenges of women's healthcare that have been underscored and amplified by the COVID-19 pandemic in hopes of raising awareness for future deliberation and revisions in policy.

SURGICAL TRIAGE AND REPRODUCTIVE OUTCOMES

The US surgeon general, Centers for Disease Control and Prevention (CDC), American College of Surgeons and American College of Obstetricians and Gynecologists (ACOG), among others, have recommended deferral of elective, or non-urgent, surgeries in order to limit infectious exposure and conserve medical equipment, especially personal protective equipment (PPE), in settings with high burden of COVID-19.[3–6] Guidelines for determining whether a surgery should proceed prompt surgeons to consider the impact of deferral on a patient's health and typically define morbidity as including death, loss of organ function and progression of malignancy.[7] Adverse outcomes related to undesired pregnancy or increasing surgical risk due to postponement were not explicitly mentioned and thus, reproductive surgeries such as termination of pregnancy or surgical sterilisation (for both women and men) were not initially recommended for prioritisation by many national organisations, excluded from coverage by insurance companies, and not permitted by healthcare institutions.[8]

This omission may be due to the fact that rather than being evaluated within a medical framework like other health outcomes, unintended pregnancy or increasing gestational age at time of termination are often sociopolitically viewed as value-laden and stigmatised as outside of traditional medical goals of care. Furthermore, by definition, undesired pregnancy can only be identified by the patient herself, thus making the diagnosis potentially less straightforward than health outcomes such as progression of malignancy or anaemia.

In the USA, multiple states have used surgical triage guidelines as a pretext to ban pregnancy termination, even when conducted virtually using medication instead of surgery.[9] Framing terminations of pregnancy as 'elective' in this context implies that these procedures are optional rather than simply less time sensitive than emergent or urgent cases. Additionally, such restrictions push terminations to a later gestational age, increasing procedural risks to patients.[10] Given increased

procedural costs, fewer abortion providers trained to perform terminations, and fewer abortion clinics able to provide services as gestational age increases, patients may be unable to access desired terminations if initially deferred. Finally, limitations on termination warrant special consideration even in a pandemic because of the deep impact of unwanted pregnancy and childbirth on women's lives, opportunities and freedoms. Among women seeking an abortion, continuing an undesired pregnancy has been linked to worse socioeconomic status, a lower likelihood of achieving personal goals, inferior physical health and higher rates of intimate partner violence.[11–14] Therefore, in order to avoid discounting adverse outcomes in women's reproductive health in surgical triage guidelines, reproductive morbidities, such as delays in termination of unwanted pregnancy and access to timely contraception and/or sterilisation, should be considered alongside non-reproductive morbidities when evaluating the urgency of surgical procedures.

PREGNANCY AND THE PANDEMIC

It is unclear how pregnancy should affect prevention and management strategies developed for COVID-19. In the early stages of the pandemic, the scarce data available did not demonstrate increased maternal or fetal morbidity during the pregnancy, though newer evidence suggests the possibility of both increased morbidity in pregnancy as well as the potential for transplacental infection.[15–18] Additionally, both the woman and fetus may be affected by sequelae of the disease. Regardless of whether the woman recovers, pregnancies affected by maternal illness, especially critical illness, may be more likely to be complicated by preterm birth and stillbirth.[19 20] Finally, pregnancy may reasonably change a person's willingness to assume even small increases in risk of infection when the resultant morbidity may affect their fetus or neonate, especially during a pandemic where data to guide such decision making is limited.[21 22]

For these reasons, some clinicians and healthcare organisations initially advocated for pregnant women to receive prioritisation for additional preventive measures such as PPE and removal from high-risk workspaces.[23–25] However, other organisations, including the CDC and ACOG, do not currently endorse such strict precautions given the initial lack of data demonstrating substantially increased risk, though newer studies have been resulted potentially prompting reevaluation.[26 27] COVID-19 has thus highlighted the ongoing lack of consensus in balancing evidence-based medicine (especially when based on incomplete and rapidly evolving information) and the precautionary principle (which supports caution in decision making when extensive scientific evidence is lacking) in terms of strategies to mitigate negative health outcomes in pregnancy. That newer evidence contradicts the initial data in pointing to both increased morbidity in pregnancy and the potential for transplacental infection demonstrates the importance of the latter, more risk-averse approach in early stages of a novel threat.

The exclusion of pregnant women from clinical trials of potential treatments for COVID-19 further illustrates this tension. In fear of fetal harm, pregnant women and even non-pregnant women of childbearing age were virtually excluded from all clinical trials until the 1993 Council for International Organizations of Medical Sciences declared such an approach unjust.[28] More recently, the 2018 revision to the Common Rule removed pregnant women from the list of vulnerable populations in the USA.[29] Nevertheless, pregnant women continue to be excluded from research related to COVID-19. Among the 310 COVID-19 drug trials registered in the US National Library of Medicine registry (ClinicalTrials.gov), 76% include pregnancy in the exclusion criteria.[30] Even investigations examining relatively safe or previously studied interventions exclude pregnant women, including trials of ascorbic acid, extracorporeal membrane oxygenation (ECMO), steroids and hydroxychloroquine.[30 31] Not only does such an approach unjustly deny pregnant women the opportunity to choose to participate in clinical research from which they and others may derive benefit, but also might it lead to harm with the lack of evidence to inform pregnant women's clinical care. The medical community must develop a clear and consistent policy to support equitable access for pregnant women to enrol in ethical, scientifically sound research.

Finally, whether pregnancy should result in prioritisation for treatment modalities also remains unclear. While American medical practice and government policy do not formally recognise fetuses as persons with rights, the state's interest in fetal well-being as well as ensuring a future population is well established.[32] Thus, that many state ventilator allocation policies include prioritisation of the pregnant woman highlights the undercurrent of pronatalism, or the sociopolitical promotion of childbearing and parenthood.[33–35] In this way, while not a legally recognised entity, the presence of a fetus may result in a pregnant person receiving prioritisation for a ventilator compared with a non-pregnant person. Some states prioritise pregnant women after the gestational age of fetal viability or later in gestation given the state's interest in a viable fetus, coupled with the medical uncertainty regarding fetal outcomes when there is need for maternal ventilator support early in pregnancy.[36 37] Prioritising pregnant women accordingly, if in concordance with the preferences of the pregnant woman or her proxy decision-maker, is aligned with the current legal context in the USA; available clinical evidence of risks to fetus and the pregnant woman; as well as the ethical principles of autonomy and beneficence. While the tension in the moral and legal status of the fetus is not novel, the COVID-19 pandemic has acutely highlighted the unclear policy and legal status of the fetus and society's privileging of the pregnant woman. Moving forward, better understanding of a pregnant woman's decision-making surrounding risk tolerance in pregnancy and clinical outcomes of COVID-19 during the pregnancy is needed to help inform ongoing and future prevention and treatment policies.

HEALTH OUTCOMES DISPARITIES

Finally, governments and healthcare systems must consider the potential to exacerbate pre-existing health disparities when restricting care to preserve resources and to limit COVID-19 exposure for patients and staff. Examples of such policies specifically in women's health include hospitals reducing the number of visitors permitted to labour and delivery, post partum and neonatal intensive care units; refusal of entry to doulas providing birth support; and reduction of in-person breastfeeding support.[38] Given structural racism, loss of trust in the healthcare system, and mistreatment during pregnancy and childbirth, women of colour suffer from appallingly poor perinatal outcomes such as increased rates of maternal death and preterm birth compared with non-Hispanic white women.[39–43] Support during labour has been linked to lower rates of caesarean section, higher 5 min Apgar scores and increased patient satisfaction; policies that reduce support may further exacerbate these disparities.[44]

Disparities in women's health may also be exacerbated by the public health response to COVID-19 in other arenas. For example, social distancing and shelter in place mandates further isolate women at risk of intimate partner violence. Telehealth

visits may be more difficult for patients with fewer resources such as smartphones and internet access. Given the increased weight given on a patient's self-provided history due to the limited ability to conduct a physical exam via a telehealth visit, patients with lower health literacy may also be impacted. Additionally, the early signs of the negative and disproportionate health impact of shelter-in-place and quarantine orders on women given the unequal burdens of domestic tasks and childcare are emerging though the magnitude of the lasting impact remains to be seen.[45–48] Thus, women—especially women of colour—may face further disparities in non-COVID-related health outcomes due to societal injustices in the public health response to the pandemic.

CONCLUSION

In conclusion, the COVID-19 pandemic has highlighted distinct challenges in women's healthcare that, although present under normal conditions, have become increasingly relevant in the context of a public health emergency. Reproductive health policy is controversial at baseline and must not be further politicised during an emergency in the USA nor elsewhere. The creation of just policy during pandemics should account for reproductive-based and sex-based differences in health outcomes, acknowledge the tension inherent in the maternal–fetal dyad, and mitigate the heightened impact on vulnerable populations such as women of colour. Further research is needed as to the impact of COVID-19 on women's health outcomes and the gendered consequences of surgical triage, infection prevention and treatment policies worldwide. Even after the COVID-19 pandemic has ended, a broader and more equitable conceptualisation and prioritisation of women's health is warranted.

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REFERENCES

1 Berlinger N, Wynia M, Powell T, *et al*. Ethical framework for healthcare institutions & guidelines for institutional ethics services responding to the coronavirus pandemic. Hastings Center. Available: https://www.thehastingscenter.org/ethicalframework covid19/ [Accessed 1 Apr 2020].
2 Emanuel EJ, Persad G, Upshur R, *et al*. Fair allocation of scarce medical resources in the time of Covid-19. *N Engl J Med* 2020;382(21):2049–55.
3 U.S. Surgeon General Hospitals & healthcare systems please consider stopping elective procedures until we can #flattenthecurve [Tweet]. Available: https://twitter.com/Surgeon_General/status/1238798972501852160 [Accessed 15 Jul 2020].
4 Centers for Medicare & Medicaid Services. CMS adult elective surgery and procedures recommendations. Available: https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf [Accessed 15 Jul 2020].
5 American College of Surgeons. COVID-19: recommendations for management of elective surgical procedures. Available: https://www.facs.org/covid-19/clinical-guidance/elective-surgery [Accessed 15 Jul 2020].
6 American College of Obstetricians & Gynecologists. Joint statement on elective surgeries. Available: https://www.acog.org/news/news-releases/2020/03/joint-statement-on-elective-surgeries [Accessed 15 Jul 2020].
7 American College of Surgeons. COVID-19: guidance for triage of non-emergent surgical procedures. Available: https://www.facs.org/covid-19/clinical-guidance/triage [Accessed 27 Apr 2020].
8 Pennsylvania Department of Human Services. Electives services should not be provided during the COVID-19 emergency disaster. Available: https://www.dhs.pa.gov/providers/Providers/Documents/Coronavirus%202020/Elective%20procedures%20during%20COVID%203.26.20.pdf [Accessed 30 Apr 2020].
9 Shepherd K. Appeals Court blocks Texas ban on medical abortions during pandemic. Washington post. Available: https://www.washingtonpost.com/nation/2020/04/14/medical-abortion-texas-coronavirus/ [Accessed 18 Jul 2020].
10 American College of Obstetricians & Gynecologists. Joint statement on abortion access during the COVID-19 outbreak. Available: https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak [Accessed 18 Jul 2020].
11 Foster DG, Biggs MA, Ralph L, *et al*. Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. *Am J Public Health* 2018;108(3):407–13.
12 Upadhyay UD, Biggs MA, Foster DG. The effect of abortion on having and achieving aspirational one-year plans. *BMC Womens Health* 2015;15(1):102.
13 Ralph LJ, Schwarz EB, Grossman D, *et al*. Self-reported physical health of women who did and did not terminate pregnancy after seeking abortion services: a cohort study. *Ann Intern Med* 2019;171(4):238–47.
14 Roberts SC, Biggs MA, Chibber KS, *et al*. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med* 2014;12(1):144.
15 Chen H, Guo J, Wang C, *et al*. Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. *Lancet* 2020;395(10226):809–15.
16 Breslin N, Baptiste C, Gyamfi-Bannerman C, *et al*. Coronavirus disease 2019 infection among asymptomatic and symptomatic pregnant women: two weeks of confirmed presentations to an affiliated pair of New York City hospitals. *Am J Obstet Gynecol MFM* 2020;2(2).
17 Ellington S, Strid P, Tong VT, *et al*. Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status - United States, January 22-June 7, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69(25):769–75.
18 Vivanti AJ, Vauloup-Fellous C, Prevot S, *et al*. Transplacental transmission of SARS-CoV-2 infection. *Nat Commun* 2020;11(1):3574.
19 Fell DB, Savitz DA, Kramer MS, *et al*. Maternal influenza and birth outcomes: systematic review of comparative studies. *BJOG* 2017;124(1):48–59.
20 Cartin-Ceba R, Gajic O, Iyer VN, *et al*. Fetal outcomes of critically ill pregnant women admitted to the intensive care unit for nonobstetric causes. *Crit Care Med* 2008;36(10):2746–51.
21 Lam M-Y. Pregnant in a pandemic. Washington post. Available: https://www.washingtonpost.com/lifestyle/2020/06/30/four-women-being-pregnant-time-uncertainty-upheaval/?arc404=true [Accessed 15 Jul 2020].
22 Blum D. 'You're already worried': navigating coronavirus while pregnant. New York Times. Available: https://www.nytimes.com/2020/03/16/parenting/pregnancy-anxiety-coronavirus.html?searchResultPosition=29 [Accessed 15 Jul 2020].
23 Boelin RC, Saccone G, Bellussi F, *et al*. MFM guidance for COVID-19. *Am J Obstet Gynecol MFM* 2020;2(2).
24 Wells I. Coronavirus: claim pregnant women put on sick pay. BBC. Available: https://www.bbc.com/news/uk-wales-politics-52590689 [Accessed 27 Jul 2020].
25 Royal College of Obstetricians and Gynecologists. Updated advice for pregnant healthcare workers and employers during the coronavirus outbreak. Available: https://www.rcog.org.uk/en/news/updated-advice-for-pregnant-healthcare-workers-and-employers-during-coronavirus-outbreak/ [Accessed 27 Jul 2020].
26 American College of Obstetricians and Gynecologists. Joint statement: recent developments regarding COVID-19 and pregnant women. Available: https://www.acog.org/news/news-releases/2020/04/joint-statement-recent-developments-regarding-covid-19-and-pregnant-women [Accessed 30 Apr 2020].
27 American College of Obstetricians and Gynecologists. ACOG statement on COVID-19 and pregnancy. Available: https://www.acog.org/news/news-releases/2020/06/acog-statement-on-covid-19-and-pregnancy [Accessed 25 Jul 2020].
28 Council for International Organizations of Medical Science,, World Health Organization. *Institutional ethical guidelines for biomedical research involving human subjects*, 1993.
29 Office of Human Research Protections. Revised common rule. Available: https://www.hhs.gov/ohrp/regulations-and-policy/regulations/finalized-revisions-common-rule/index.html [Accessed 15 Jul 2020].
30 Einav S, Ippolito M, Cortegiani A. Inclusion of pregnant women in clinical trials of COVID-19 therapies: what have we learned? *Br J Anaesth* 2020;125(3):e326–8.
31 Farrell R, Michie M, Pope R. Pregnant women in trials of COVID-19: a critical time to consider ethical frameworks of inclusion in clinical trials. *Ethics Hum Res* 2020;42(4):eahr500060):17–23.

32 Roe v Wade [1973] 410 U.S. 113.
33 Piscitello GM, Kapania EM, Miller WD, *et al*. Variation in ventilator allocation guidelines by US state during the coronavirus disease 2019 pandemic: a systematic review. *JAMA Netw Open* 2020;3(6):e2012606.
34 Cha AE, McGinley L. Who gets a shot at life if hospitals run short of ventilators? Washington post. Available: https://www.washingtonpost.com/health/2020/04/07/ventilators-rationing-coronavirus-hospitals/ [Accessed 18 Jul 2020].
35 Green E. The rebirth of American's pro-natalist movement. Available: https://www.theatlantic.com/politics/archive/2017/12/pro-natalism/547493/ [Accessed 18 Jul 2020].
36 Baker M, Fink S. At the top of the Covid-19 curve, how do hospitals decide who gets treatment? New York Times. Available: https://www.nytimes.com/2020/03/31/us/coronavirus-covid-triage-rationing-ventilators.html [Accessed 18 Jul 2020].
37 Jenkins TM, Troiano NH, Graves CR, *et al*. Mechanical ventilation in an obstetric population: characteristics and delivery rates. *Am J Obstet Gynecol* 2003;188(2):549–52.
38 Arora KS, Mauch JT, Gibson KS. Labor and delivery visitor policies during the COVID-19 pandemic: balancing risks and benefits. *JAMA* 2020;323(24):2468–9.
39 Evans MK, Rosenbaum L, Malina D, *et al*. Diagnosing and treating systemic racism. *N Engl J Med* 2020;383(3):274–6.
40 Chambers BD, Baer RJ, McLemore MR, *et al*. Using index of concentration at the extremes as indicators of structural racism to evaluate the association with preterm birth and infant Mortality-California, 2011-2012. *J Urban Health* 2019;96(2):159–70.
41 Armstrong K, Ravenell KL, McMurphy S, *et al*. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health* 2007;97(7):1283–9.
42 Vedam S, Stoll K, Taiwo TK, *et al*. The giving voice to mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health* 2019;16(1):77.
43 Centers for Disease Control and Prevention. Infant mortality. Available: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm [Accessed 15 Jul 2020].
44 Bohren MA, Hofmeyr GJ, Sakala C, *et al*. Continuous support for women during childbirth. *Cochrane Database Syst Rev* 2017;7.
45 Wenham C, Smith J, Morgan R, *et al*. COVID-19: the gendered impacts of the outbreak. *Lancet* 2020;395(10227):846–8.
46 Hesse M. The pandemic didn't create working moms' struggle. But it made it impossible to ignore. Washington Post. Available: https://www.washingtonpost.com/lifestyle/style/the-pandemic-didnt-create-working-moms-struggle-but-it-made-it-impossible-to-ignore/2020/07/07/bcc021c4-bbb8-11ea-bdaf-a129f921026f_story.html [Accessed 16 Jul 2020].
47 Cohen P, Hsu T. Pandemic could scar a generation of working mothers. Available: https://www.nytimes.com/2020/06/03/business/economy/coronavirus-working-women.html [Accessed 16 Jul 2020].
48 Del Boca D, Oggero N, Profeta P, *et al*. Women's work, housework, and childcare before and during COVID-19. VoxEU. Available: https://voxeu.org/article/women-s-work-housework-and-childcare-and-during-covid-19 [Accessed 16 Jul 2020].