Clinician Perspectives on Ethics and COVID-19: Minding the Gap in Sexual and Reproductive Health

By Mary A. Ott, Caitlin Bernard, Tracey A. Wilkinson and Brownsyne Tucker Edmonds

Mary A. Ott is professor and Tracey A. Wilkinson is assistant professor, Department of Pediatrics; and Caitlin Bernard is assistant professor and Brownsyne Tucker Edmonds is associate professor and assistant dean for diversity affairs, Department of Obstetrics and Gynecology—all at the Indiana University School of Medicine, Indianapolis.

In the United States, policies and practices enacted in response to the COVID-19 pandemic—such as social distancing, sheltering in place, shifting to telemedicine and limiting care to "essential" procedures—are widening gaps in sexual and reproductive health (SRH) outcomes and access to services. As obstetricians-gynecologists, pediatricians and adolescent medicine specialists who are frontline providers of SRH services, we are seeing firsthand the documented decreases in access to SRH education, abortion and contraceptives (particularly long-acting reversible contraceptives, or LARCs), and increases in reports of gender-based violence.[1–4] These trends have disproportionately affected minoritized and marginalized groups, including adolescents, people of color, those living in poverty, immigrants and undocumented individuals, and those living in rural areas.[5,6] In this viewpoint, we provide a clinician's perspective on the gaps in services and outcomes between these and more privileged groups, and make recommendations to narrow these gaps, both now and in the future.

In some cases, the gaps in access to SRH services have been an unintended effect of COVID-19–related policies. For example, access to SRH services at federally qualified health centers and community-based clinics has been limited because of budgetary constraints,

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shortages of personal protective equipment and staff, and the facilities' need to care for sicker populations. This loss of access disproportionately affects youth and marginalized populations, who rely on these centers for health care. While the rapid expansion of telehealth has provided access to SRH providers for many individuals with established sources of care or insurance, the increased reliance on this technology has seriously reduced the initiation of LARC methods, which requires an in-person visit with a health care provider. For adolescents, in particular, reduced opportunities for in-person visits threaten to undo the gains made over the past 10 years in offering clients a wider range of contraceptive options, primarily through expanded access to LARCs.[7–9] Moreover, telehealth requires access to adequate and reliable Internet service, which is not available in some rural areas,[10] and many individuals who do not have Internet service at home (because of cost or geography) and had relied on public access points such as libraries or coffee shops no longer have these options available because of pandemic closures and social distancing.[11]

Although newer approaches for improving access to contraceptives, such as provision of hormonal methods through pharmacies, apps or telehealth,[12] have the potential to maintain access to contraception, these approaches are frequently not available to all, and may worsen disparities in SRH access among specific groups. For example, laws that regulate telehealth, authorize pharmacists to prescribe contraceptives, or permit minors to provide consent and obtain confidential services vary from state to state. In many states, these laws do not specifically allow adolescents to access contraceptives through telehealth, apps or pharmacies.[12,13] For women in rural areas, pharmacy access can be limited even in states with supportive laws.[14] Further gaps in access to SRH services have resulted from the postponement or cancellation of well-woman and well-child visits; in the absence of such visits, many women are not being screened for asymptomatic STIs, abuse, gender-based violence and contraceptive needs. Meanwhile, shelter-in-place requirements and quarantine restrictions have led to increases in gender-based violence, as individuals in violent or abusive relationships may be unable to leave unsafe homes.[1]

The impact of these pandemic-related barriers and outcomes has been exacerbated by the enactment of targeted policies designed to limit women's ability to obtain SRH services. Abortion, in particular, has been targeted with additional restrictions, creating, for all women, a gap between the services they need and their ability to obtain them. The designation of abortion as an "elective" procedure allowed states that actively restrict

abortion to immediately cut off access to this time-sensitive procedure.[15]

Our challenge as health care providers is to identify gaps in access that affect—intentionally or not—the SRH care that our patients need, and to advocate for changing policies that exacerbate gaps in access and outcomes. Cataloging (identifying and tracking) gaps will allow us to address barriers in access and worsening disparities in outcomes, as restrictions loosen.

During the current pandemic, policymakers, providers and health care system administrators have had to make difficult decisions and confront challenging ethical questions. What is essential care? When are restrictions too restrictive? Which restrictions can be relaxed safely, and when? In making decisions about individual patients, clinicians frequently employ a broad, principle-based medical ethics approach to balance autonomy, beneficence and justice. However, in a public health crisis, these principles often conflict with each other, and clear resolution may not exist. As SRH providers, we advocate for a public health ethics approach that combines an underlying respect for human rights with the application of the harm principle (adopting the least-restrictive approach) in cases when access to SRH services might be restricted.

Human Rights Approaches

Human rights are basic rights that all people are entitled to, without discrimination, and that affirm each individual's dignity and worth.[16] Human rights should be universally protected by nations, especially in times of crisis. Relevant SRH human rights include the rights to achieve the best attainable SRH, obtain SRH services (including education, prevention, screening and treatment),[17] choose a partner, control one's fertility and give birth safely. A human rights approach involves making high-quality SRH services available and accessible to all,[18] and reducing inequities in access to these services. Moreover, people should be able to realize their right to SRH in an environment that is free of coercion, discrimination and interpersonal violence, and states should provide the tools (e.g., information, access to services) needed to do so.[17]

People of color, people living in poverty and undocumented individuals have long faced challenges in realizing their right to SRH. Broad attention to social injustice is critical to prevent disparities in SRH from widening during the current pandemic. For example, women of color are two to three times as likely as white women to die of pregnancy-related

causes, and the disparity is even higher among women 30 or older.[19] Hospital visitation restrictions, especially on labor and delivery wards, may place women of color, who are already at heightened risk for maternal morbidity, without adequate support or advocacy from family, friends or doulas.[20,21] Disparities in access to postpartum contraceptive methods, particularly sterilization, can also lead to racial inequities. Data show that women of color, undocumented women and women with public insurance choose tubal ligation more often than their white counterparts do.[22–24] Unfortunately, tubal ligation procedures have been designated as "elective" by some hospital systems and thus are restricted. Because many underinsured and uninsured women have insurance coverage only during their pregnancy and immediate postpartum period, those who do not obtain a desired tubal ligation during this window of time may not be able to do so at a later date. Evidence suggests that rates of subsequent pregnancy are high among women who do not receive a desired postpartum tubal ligation.[22,24]

A human rights approach requires not just recognition of the right to SRH services and well-being, but that women can obtain these services—including comprehensive contraceptive care and abortion—in a confidential manner. Although the right to SRH extends to adolescents,[25] young people's ability to obtain care confidentially has been hindered during the COVID-19 pandemic by restrictions on personal movement and by reduced availability of in-person care.[15] Without confidentiality, adolescents are less likely to ask sensitive questions, disclose sexual health needs or obtain SRH care.[26,27] In many states, minors must obtain parental permission or court approval (often called a judicial bypass) to terminate a pregnancy.[13] Navigating the judicial bypass process, which is difficult under normal circumstances, has become nearly impossible with the imposition of pandemic-related restrictions, including increased restrictions on abortion and the closure of many jurisdictions' juvenile and family courts.[15,28–30]

Women who belong to minoritized or marginalized groups often not only lack access to SRH services, but also have disproportionately experienced economic and social stressors from the COVID-19 pandemic that affect their SRH needs and outcomes. These socioeconomic stressors include job loss and other loss of income, lack of child care, family illness, housing instability and violence; disparities in these stressors have been linked to poverty and structural racism. As a result, minoritized and marginalized individuals may find themselves unable to realize their civil, political, economic, social and cultural rights,

and thus may be vulnerable to negative SRH outcomes.[17]

Emerging data from China and Europe have documented the loss of basic SRH rights and an increase in negative SRH outcomes as a result of the pandemic. For example, freedom from coercion and violence are important SRH rights, yet reports document an increase in gender-based violence.[2,31] The right to control fertility is a core SRH right, and governments have the obligation to provide individuals with the tools to realize these SRH rights. However, conservative estimates from low- and middle-income countries suggest that limitations in services due to COVID-19 could result in more than 15 million unintended pregnancies, three million unsafe abortions and almost 30,000 maternal deaths.[32] We challenge health care systems, public health officials and policymakers to make sure that their responses to pandemic-related disruptions maximize access to SRH services and minimize disparities in SRH and the erosion of SRH rights.

Harm Principle

The imperative of protecting communities from COVID-19 has led to the restriction of individuals' rights to obtain SRH care and achieve sexual and reproductive health. However, as providers of SRH, we seek an approach that balances our individual patient's basic human right to SRH with the health of the community at large. John Stuart Mill's harm principle can be used by clinicians, health care systems and policymakers to strike a balance between public safety and restriction of individual rights to SRH during the pandemic and other public health crises. In 1859, Mill wrote that in just societies, the only acceptable exercise of power over an individual's rights is to prevent harm to others.[33] Key aspects of Mill's harm principle are recognizing that individual rights have moral importance in a just society, that these rights can nonetheless be limited to ensure the health and well-being of others, and that if these rights must be limited, then the least restrictive approach should be sought.[34,35]

Operationalizing the harm principle in a novel pandemic situation requires public health data and ongoing, careful consideration of contexts. To balance the maximization of public health with respect for individual rights, public health leaders will need to assess the effectiveness of enacted policies (e.g., social distancing), the probability and magnitude of harm to individuals, and the degree of restriction of individual rights.[34,35] As data emerge on deepening disparities in SRH, we are forced to contend with the challenge of identifying least restrictive approaches: Which aspects of ongoing policies can be changed without

significantly harming population health, so as to preserve individuals' health and rights to SRH services?

A lack of regard for the need to take a least restrictive approach to individual SRH rights was most evident when some states, ostensibly to preserve personal protective equipment, ordered immediate cessation of all abortion care. Out of the hundreds of time-sensitive office-based procedures, abortion was singled out and restricted, despite its low utilization of personal protective equipment. These policies have caused hardship to women seeking abortion services, as illustrated by reports of women traveling up to 20 times the usual distance needed to obtain an abortion,[36] and may result in physical harm to women, as abortions are more likely to be unsafe when access to the procedure is restricted.[37] As clinicians, academics, public health officials and policymakers gather more data on both the effectiveness and harm of different policies being promulgated across the United States, policy decisions should be revisited and revised using the harm principle to preserve the right to SRH.

A least restrictive solution could be one in which a disparity created by current policies is addressed by expanding access through new policies. In clinical ethics, an error of omission (not avoiding harm) may be considered as ethically problematic as an error of commission (causing harm). The widening disparities in women's ability to obtain confidential contraceptive care serve as an example of a situation in which our society is committing errors of omission. Restrictions on travel, in-person visits and access to safety-net clinics limit the contraceptive care that clinicians can provide, particularly to adolescents and marginalized groups. Without creative policy solutions, these restrictions will result in both immediate and long-term harms, including a rise in unintended pregnancy. Yet these harms can be minimized or prevented through programs and policies that provide alternative means of access.

An example of a creative policy solution would be to build upon successful, evidence-informed prepandemic experiences to expand adolescents' and adults' access to confidential contraceptive care through the use of telehealth or app-based services, or by permitting pharmacists to prescribe contraceptives. Currently, only 11 states and the District of Columbia allow pharmacists to prescribe contraceptives, and even in those states, many pharmacies (especially in rural areas) do not offer the service; telehealth is more widely available, but many states do not allow minors to consent to these services.[12,38–40] Broad

geographic expansion of pharmacy, telehealth and app-based contraceptive services could provide necessary access for adolescents and for individuals who lack transportation, have low incomes or live in rural areas. Nontraditional approaches may also be possible for other SRH services; for example, data from home-based STI screening programs, such as "IWanttheKit," suggest that such screening is feasible and acceptable, including for marginalized populations.[41]

The Health Care Community Must Act Now

Too often, basic rights to SRH are considered secondary, rather than a primary aspect of the human right to the highest attainable health. During a pandemic, SRH rights and care may be put on a back burner, and that may be appropriate when death rates are skyrocketing and health care systems are overwhelmed. However, in much of the country, local health care systems thus far have had sufficient capacity to provide routine SRH services most of the time. Early public health interventions, such as social distancing, sheltering in place and limiting the size of gatherings, blunted the initial impact of the pandemic in many places, and variations in how these measures are lifted or renewed will provide an opportunity to examine the effects of these policies on SRH.

Before inequities in SRH deepen further, we in the medical community must ask ourselves a series of urgent questions about the intended and unintended effects of COVID-related policies on SRH, and use the harm principle to guide our decision making. Providers and policymakers should start asking these questions now, so as to mitigate future harms:

- How are current policies affecting SRH rights (including access to care) and outcomes? What gaps or inequities are being created or exacerbated?
- Are these policies just? Do they disproportionately hurt specific populations? Who are we excluding? What SRH services should be considered "essential"?
- What action can be taken now to minimize restrictions on SRH rights and on any resulting inequities? Are there alternative policies that preserve both important public health benefits and basic SRH rights and services?

Addressing the most severe erosions of basic SRH rights, such as COVID-related abortion restrictions, will necessitate the coordinated efforts of both providers and policymakers and will likely require federal-level protections. However, some strategies for ensuring sexual and reproductive health and rights during the pandemic—such as expanding contraceptive

access through telehealth, app-based and pharmacy prescribing services—could be enacted easily and with very little possibility of COVID-related harm.

When the threat of COVID-19 lessens, decision makers, providers and advocates will need to take stock of the damage and begin the hard work of restoring services and pursuing equity in SRH for all. We will need to revisit the questions cited above, with an eye toward the pandemic's effects on SRH among marginalized individuals. We will need to catalogue and address disparities in SRH access and care, reallocate public health resources, and expand access through new policies and programs. Doing so in partnership with the communities most adversely impacted by the pandemic will facilitate effective and sustainable change by deputizing those most affected by the pandemic and by restrictive policies to become agents of change. These issues are important not only for how we approach this crisis, but for how we prepare for the next one. It will be essential to have in place not only the structures, strategies and stakeholder partnerships needed to mitigate damage to basic human rights to SRH, but also the ethical frameworks necessary to make just and equitable decisions about balancing individual human rights and public health.

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Author contact: *maott@iu.edu*

Author biographies:
Mary A. Ott is professor and Tracey A. Wilkinson is assistant professor, Department of Pediatrics; and Caitlin Bernard is assistant professor and Brownsyne Tucker Edmonds is associate professor and assistant dean for diversity affairs, Department of Obstetrics and Gynecology—all at the Indiana University School of Medicine, Indianapolis.