

## Location, location, location: Where you live determines your access to abortion

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### *Abstract*

Through the hypothetical, but very plausible case of Julia, we illustrate that where a woman lives in the United States impacts her access to the best abortion care. Widespread state-level restrictions on abortion care have increased in recent years and negatively impact a woman's ability to access quality, unbiased, evidence-based care. Poor women and women of color are disproportionately affected by these restrictions. It is important as medical professionals to understand the political, not medical, motivations behind these laws so we can speak out against them.

Julia went in for her first ultrasound when she was five months pregnant. She and her husband were excited to bring their third child into the world; but the news was not good. The placenta was covering the cervical opening (placenta previa) and possibly invading her bladder (placenta percreta). Julia's two previous cesarean deliveries had put her at risk for this complication. She met with her obstetrician to discuss what could happen next. The bottom line: no matter what she did, there would be serious health risks for her and her baby. Spontaneous hemorrhage, resulting in the loss of her baby or her own life, could happen at any time during the pregnancy if allowed to progress. Delivery would most likely require that Julia receive a hysterectomy and massive blood transfusion, which could further endanger her survival. Heartbroken, Julia made the very difficult decision to have an abortion.

This hypothetical patient is similar to those treated at Columbia University Medical Center in the past. If Julia lived in New York City, she would have secure access to the safe, hospital-based abortion her case requires. However,

things would be very different for her if she lived in Mississippi. She might have to travel out of state for the safest abortion procedure and her insurance might not cover the cost. If Julia could afford neither the travel nor the abortion, she would be forced to continue the pregnancy while being cared for at home, waiting until her life was in danger.

Today in the United States, where a woman lives impacts whether or not she has access to the best abortion care. Reproductive health care for many women, including and beyond abortion, has been nearly eliminated in some parts of the country due to recent state legislative activity. From 2011-2015, states enacted more abortion restrictions than any other five-year period since the passage of *Roe v Wade* in 1973.<sup>1</sup> Most of these legal restrictions negatively affect a women's ability to access quality, unbiased, evidence-based care. Some medically unnecessary barriers include waiting periods of up to seventy-two hours, mandated and medically inaccurate counseling, structural physical requirements for clinics, bans on

insurance coverage, and restrictions on medical abortion regimens, to name a few.

Medical practitioners in New York may be unaware of the many obstacles women face in other parts of the country, because women experience relatively few abortion restrictions here. Our patients in New York have access to insurance coverage, both public and private, for their abortion. Minors are free to involve whomever they feel most comfortable with in their decisions about pregnancy.

Like all other physicians, abortion providers in New York can counsel patients on the most up-to-date, evidence-based information. We are not compelled to say anything we know to be scientifically untrue. We are able to speak freely and offer the best medical evidence to help patients make informed decisions. By contrast, in Mississippi, women and their doctors deal with a web of restrictions and barriers. Providers must counsel using state-mandated “information” such as connecting abortion to breast cancer: despite the fact that current evidence has never shown such a link.<sup>2</sup>

There is only one remaining abortion clinic in all of Mississippi, and it is not in a hospital where a patient like Julia would commonly receive care. Women in Mississippi are required to wait twenty-four hours after in-person counseling before obtaining an abortion. This requires them to make two separate visits, regardless of how far they need to travel. By law, providers are required to perform an ultrasound and listen to the fetal heartbeat. Regardless of the woman’s wishes, the provider must then offer the woman a copy of the ultrasound and a chance to listen to the heartbeat. The use of telemedicine for the performance of medical abortion is prohibited in Mississippi. Only obstetrician-gynecologists can perform abortions, excluding many trained family physicians. And finally, minors may not have an abortion without their parent’s consent.<sup>3</sup>

Mississippi has the highest prevalence of poverty in the United States; about one out of every four residents live below the poverty line.<sup>4</sup> Medicaid

in Mississippi covers abortion in cases of rape, incest, fetal impairment, or if the woman’s life is in danger; such cases comprise less than three percent of all abortions.<sup>5</sup> The rate of unintended pregnancy is five times higher in poor women than in women of higher income levels, and this disparity continues to increase.<sup>6</sup> Therefore, women of lower income need access to safe abortions the most; but in the poorest state in our country, abortion is almost completely out of reach.

One restriction in Mississippi (and ten other states)<sup>7</sup> requires abortion providers to have either admitting privileges or a transfer agreement with a local hospital. This law is still being legally contested in Mississippi; if this law were to go into effect, the one remaining clinic in the state would be forced to close. The clinic has been refused privileges for their board-certified provider despite application attempts at thirteen hospitals in the state. These privileges are difficult to obtain because a minimum number of annual admissions is often required, the provider must be a state resident, and the hospital can decide not to grant them, wishing to avoid the politics and attention surrounding this issue.<sup>8</sup>

Some of these restrictions may not appear harmful on the surface; indeed, politicians who have succeeded in passing these types of laws across the country claim that they do so in the name of safety. In reality, these laws make safe abortion less accessible for women. The safety record of abortion is well-established and medical researchers continue to improve care in statistically meaningful ways.<sup>9 10</sup> Laws like these do not make abortion safer, but do interfere with a physician’s practice and force women to trek great distances to acquire care.

Our patient Julia’s care, safety, and ultimate outcome depend on where she lives in the country. Pregnant women who live in New York receive different care than those living in Mississippi or Texas or Ohio. This striking health disparity causes unnecessary harm. As physicians, we know what kind of care Julia would need, and we should be able to provide it

for her. It is important to understand the political (not medical) motivations behind these laws, so that those of us in the medical field can speak out against them. Individual physicians can communicate to the public through traditional or internet-based media (e.g. letters to the editor, interviews, blogs, social media), join an

organization that seeks to protect reproductive rights, or participate in more organized advocacy (e.g. lobbying, petitions). Furthermore, we must hold our lawmakers accountable and stop them from continuing to pass laws that restrict access to abortion and harm our patients' health.

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### **Conflicts of Interest**

These authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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