

The John. M. Rezendes Ethics Essay Competition

HELP, I'M TRAPPED:

Ethical Patient Advocacy in the Age of TRAP Laws

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Abortion is a highly controversial, yet incredibly common medical procedure in the United States, and it occupies a unique intersection of healthcare, politics, and ethics. Due to the precarious social position of this procedure, abortion advocacy looks different from other forms of healthcare advocacy. To be a healthcare advocate is to ensure people are able to access the healthcare they need; this a broad concept and has many applications. In general, improving access to healthcare means removing barriers to care, which can take almost infinite forms depending on the health service in question. Abortion care poses unique challenges for patient advocates because of the existence of TRAP laws – Targeted Regulation of Abortion Providers – that are specifically created to increase the impact of all of these barriers to care. Approaching TRAP laws through the lens of feminist bioethics highlights the ways in which TRAP laws gain power through hierarchal power-based institutions, and then use this power to strip patients of their autonomy. This constitutes a violation of the fundamental principles of bioethics that healthcare providers should be bound to. TRAP laws have created an environment in which ethical patient advocacy requires healthcare providers to be political activists, working to dismantle these laws.

The importance of patient advocacy in healthcare can be gleaned from the field of bioethics. The foundation of bioethics is widely cited as four primary ethical principles; autonomy, nonmaleficence, beneficence, and justice (McCormick 2013). Autonomy can be understood as believing that people are fundamentally embodied, and that an individual is capable of making decisions regarding their body. The other principles of bioethics stem from this principle of autonomy; the principle of nonmaleficence says that healthcare providers must not intentionally bring harm to their patient, the principle of beneficence says that healthcare

providers have an obligation to act as to benefit their patient, and the perhaps controversial principle of justice says that healthcare resources should be allocated justly (McCormick 2013). If a healthcare provider is to adequately adhere to these ethical obligations, they must advocate for their patients to access the highest quality, most affordable healthcare possible. In practice, patient advocacy can take many forms; it can manifest as an employee who is tasked with signing patients up for Medicaid, it can be a reduced-cost program for low income patients, or it can simply be listening to patients concerns and believing their pain is real. For certain patients and procedures, advocacy takes on even more nuance; a transgender patient may require aggressive correspondence with insurance companies to get hormones or surgery covered, or a patient who is hard of hearing may require auditory accommodations in office. There are countless other situations that require healthcare providers to perform specific tasks to maintain the patient's autonomy, bring no harm to their patient, do what is best for their patients health, and ensure that all of their patients have equal access to health services. One of the most complicated, nuanced healthcare situations requiring a unique form of patient advocacy from healthcare providers is abortion care.

Abortion care is notoriously wrought with misinformation, as many Americans underestimate the safety and commonality of abortion care. The most recent statistical data, from 2014, indicates that approximately 1 in 4 women will have an abortion in their lifetime, a rate that is 14% lower than it was in 2011 (Jones and Jerman 2017b). Less than 0.3% of abortions involve a complication requiring hospitalization, and the risk of dying from a first trimester abortion is four in a million – 14 times lower than the risk of dying from childbirth (Gold and Nash 2013). The American College of Obstetricians and Gynecologists has said that it is entirely safe for abortions to be provided in physician's offices, and the World Health Organization has

said that abortions can safely be performed in outpatient clinics as well (Gold and Nash 2013). It is also worth noting here that while much of the language surrounding abortion, including that of many of the studies cited in this paper, synonymize abortion and womanhood; the reality is that people who do not identify as women also get pregnant and require abortion care, and these people are equally affected by restricted abortion access as woman-identified people.

Abortion restrictions have been a subject of discussion ever since the Supreme Court made its infamous *Roe v. Wade* decision in 1973, which stated that a person's right to an abortion is covered under the 14th amendment (Llamas et al. 2018). In 1992, the Supreme Court decided another landmark abortion case, *Planned Parenthood of Southern California v. Casey*, and ruled that abortion restrictions must not place "an undue burden" on the person seeking the procedure (Llamas et al. 2018). However, these two decisions did not stop state lawmakers from trying to restrict abortion; many of the resulting policies are known as Targeted Regulation of Abortion Providers, or TRAP laws. There are some common TRAP laws that have been enacted using similar language throughout the United States. As of February 2019, most states and the District of Columbia have at least one TRAP law on the books. 42 states require abortion be provided by a physician as opposed to a nurse practitioner or other healthcare provider. 19 states require abortion be provided in a hospital, as opposed to an outpatient clinic or office, after a specified point. 43 states prohibit abortion after a specific gestation period. 33 states and Washington D.C explicitly prohibit the use of state funds – including Medicaid and other publically funded insurance programs – for abortion care, and 11 states also prohibit private insurance plans from covering abortion. 37 states require parental involvement for a minor to get an abortion. 27 states require a person seeking an abortion to wait for a specified amount of time between receiving counseling and actually getting their abortion, and 14 of those states have

such a long waiting period that multiple separate trips to the clinic are required. 18 states have laws mandating patient counseling; 5 states mandate that patients be given information on the supposed link between abortion and breast cancer, 13 mandate that patients be given information on the ability of a fetus to feel pain, and 8 mandate that patients be given information on the long-term mental health consequences of seeking abortion care, and none of these mandated pieces of information are backed by reputable scientific studies (Guttmacher Institute 2019). In some states, combinations of these laws have ensured that there are only a handful of abortion clinics left in the entire state, further prohibiting access to care. In the United States today, both providing and obtaining abortion care requires a complex knowledge and understanding of TRAP laws and their effects.

Aligning with the goals of patient advocates in other arenas of healthcare, the ultimate goal of any abortion advocate should be to make the procedure as accessible as possible for any patient who is seeking it, a goal that TRAP laws explicitly oppose. If abortion advocates hope to ever make abortion a normalized part of reproductive healthcare, they must first get rid of TRAP laws. Therefore, advocating for abortion access requires being a political activist, and taking all possible steps to dismantle TRAP laws. To be a political activist, one must be at least marginally knowledgeable about government and lawmaking, in order to take steps to change those laws. In practice, political activism from healthcare providers can be as simple as calling one's representatives and asking them to block a nomination to the Supreme Court or to vote for a bill. Providers can also offer voter registration cards in their waiting rooms, volunteer for a candidate or organization that is proposing legislation that would repeal TRAP laws, or go as far as to run for office themselves. Abortion access is constantly under attack by anti-choice activists, and preventing, repealing, and modifying TRAP laws is the most important component of ensuring

patients get the care they need, rendering it an essential component of patient advocacy.

Understanding that providers have an ethical obligation to advocate for their patients and ensure that they receive the highest standard of care possible, it follows that healthcare providers must take on this role of political activist to achieve the goal of being a successful patient advocate.

An ethical argument for effective abortion advocacy in the era of TRAP laws can be surmised from feminist bioethics. Feminist bioethics is a philosophical subfield that occupies the intersection between feminist ethics and biomedical ethics. Feminist ethics asks questions about power, and how and why certain voices become dominant, whereas bioethics asks questions about medicine, research subjects, and how the human experience relates to the nature of existing within a human body. Feminist bioethics was born in the 1980s, from thinkers who felt that the mainstream form of bioethics was not accounting for power dynamics found within medicine and life science research. These early feminist bioethicists argued that bioethics was operating within an oppressive institution, and was therefore unable to properly meet the needs of marginalized populations, including – but not limited to – women (Donchin and Scully 2015).

Approaching TRAP laws through the lens of feminist bioethics shows how TRAP laws gain power through power-based institutions, and use this power to strip patients of their autonomy. Respect for autonomy requires an understanding that an individual's autonomy is hindered by any controlling influence that leads to an individual making an uninformed or misinformed decision, or otherwise prevents them from making a voluntary act. (McCormick 2013). TRAP laws violate this principle in a number of ways, and women who live within multiple hierarchal power-based systems of oppression are stripped of their autonomy most often. Low income pregnant people directly have their autonomy removed by TRAP laws such as hospital requirements that force more accessible independent clinics to close, mandated

waiting periods, and prohibition of insurance coverage. Removing their ability to physically get to an abortion provider, forcing them to take multiple days off of work and risk losing employment, and/or requiring them to come up with hundreds of dollars when they are already paying for health insurance, are all ways in which TRAP laws exert controlling influences over these people and prevent them from making free and voluntary decisions regarding their healthcare. Young people have their autonomy stripped from them by TRAP laws requiring parental consent; there are whole bodies of literature regarding the ethics of parental consent laws in general that won't be discussed in this paper, but these types of TRAP laws create controlling influences that inhibit personal decision making by giving control to both the law and the patient's parents. People without internet access or comprehensive sexual education have their ability to make an informed decision stripped from them when they are subject to mandatory counseling that is not rooted in fact. The application of feminist theory to nonmaleficence, beneficence, and justice creates an understanding that one's definition of "harm," "benefit," and "justice" stem from that individual's life history, position within society, and privilege. Maintaining the requirement for respect for autonomy, it stands to reason that the definitions of these words that must be used by healthcare providers are the definitions created by the patient themselves. Ethical patient advocates would be cognizant of the ways in which TRAP laws use power to violate vital bioethical principles, and would therefore be dedicated to the end of these types of laws.

Any discussion of the abortion debate brings up questions of religious freedom and these questions have their own comprehensive ethical discourse. Many people, religious or not, have strong moral objections to abortion as a practice, and that is their prerogative. Returning to this feminist bioethics framework however indicates that when one becomes a healthcare provider,

they have an obligation to respect their patient's autonomy. Denying the patient their bodily autonomy and refusing to help them navigate the necessary policies and obtain an abortion – which is the current practice of many doctors – is unethical because this practice violates the fundamental principle of autonomy. One could argue that an anti-abortion healthcare provider would be practicing the principle of nonmaleficence, or even beneficence, by denying their patient abortion care, if this provider felt that abortion would be harming a life. However, the application of a feminist bioethical framework to this complicated and heavily debated ethical question would take into account the inherent power separation between patient and doctor. The provider's definition of bodily harm and the patient's definition of bodily harm are clearly at odds, and the provider is using their power to privilege their personal definition of harm over that of their patient, while willfully neglecting the patient's autonomy and life circumstances. If every patient seeking abortion care had equal access to the procedure, then one could make the argument that a provider who sees abortion as harmful is practicing nonmaleficence by doing no harm in not providing the abortion nor referring the patient elsewhere, as the patient would have equal ability to use their definition of harm and readily be seen by another provider. However, in the age of TRAP laws that ensure access to abortion is stratified and unequal, physicians have an ethical obligation to understand their patient's definition of harm based on their life circumstances, and to refer them to a provider that is willing to perform an abortion. If a provider does not want to provide abortion care, then they should also be arguing for the end of TRAP laws, as no more TRAP laws would ensure that their patients have easy access to abortion care, thus rendering their opposition to the procedure as not doing harm to their patient.

There are many other forms of abortion advocacy that exist outside of explicit political advocacy. In states where insurance companies are prohibited from funding abortion procedures,

residents have set up extensive abortion funds, such as SAFE (safemaine.org) in Maine. In states that are particularly hostile to abortion access, advocacy often takes the form of clinic escorts, volunteers who walk patients through the gauntlet of anti-abortion protesters. On college campuses, abortion advocacy often takes the shape of destigmatization campaigns, where students have abortion speak-outs, or perform plays telling abortion stories. While all of these acts are undoubtedly important, they are all simply treating the symptoms of the disease that is TRAP law legislation. While oppressive TRAP laws are still in place, these types of advocacy actions are completely vital, and without the continued strength of advocacy programs such as these, abortion access would be further hindered. It is true that providers who wish to adhere to the tenets of bioethics must engage with these forms of advocacy. However, until TRAP laws are dismantled and removed, equal access to abortion is not possible. For people that live in the margins of society, stigma or fear of violence from protesters do not create the physical, insurmountable barriers that TRAP laws do, and many of these current forms of advocacy are only essential because of the restrictions created by TRAP laws.

Understanding the necessity of specifically dismantling TRAP laws as a requirement for abortion advocacy, as opposed to the other actions discussed above, is best understood through the framework of Reproductive Justice. Reproductive Justice, a term created by the Sistersong Women of Color Reproductive Justice Collective, is defined as “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (Sistersong). Reproductive Justice acknowledges that while keeping abortion legal is a vital aspect of reproductive health, there is no choice if there is no access; even if abortion is technically legal, many marginalized people are unable pay for the procedure, travel the hundreds of miles to the nearest clinic, or otherwise access abortion care.

Reproductive Justice applies a feminist bioethics framework specifically to reproductive health, as the movement is centered on the idea that women, people of color, and trans* people are victims of systemic oppression that produces unequal access to reproductive healthcare, including abortion (Sistersong). Understanding that people living in the margins of society have different needs from the reproductive healthcare system produces an understanding that if a person says pregnancy or childrearing would be harmful to them and their life, that definition must be respected by healthcare providers in the name of respecting the patients' autonomy.

Reproductive Justice is central to the discussion of advocacy in the age of TRAP laws because TRAP laws disproportionately affect certain communities more than others, and this phenomena often amplifies various forms of oppression. In 2014, 49% of abortion patients were living with a family income below 100% of the federal poverty level, 33.6% of patients were between the ages of 20-24, and black women were the most overrepresented demographic, representing 27.1 patients per 1000, a much higher proportion than they represent in the general population (Jones and Jerman 2017b). While much of the decrease in the abortion rate has been attributed to increased contraceptive use and education (Jones and Jerman 2017a), the stratified impact of TRAP laws cannot be understated. If someone has a job that allows them to take multiple days off of work, has paid sick leave, lives in an urban area with more than one abortion clinic and a public transportation system to get there, has \$500+ in disposable income to pay for an abortion when their health insurance won't cover it, or has access to the internet and other reliable information sources to circumvent mandated counseling requirements, then abortion procedures will be far more accessible for them. People without these privileges are the same people that would be less able to continue an unintended pregnancy, and will be less able to access contraception and sex education, both of which contribute to a heightened need for

abortion care. The people that live these types of lives are, due to decades of institutional and structural racism, classism, and ageism, more often than not going to be young, low income, people of color – the same populations that are overrepresented in abortion statistics. These are the people that TRAP laws most strongly affect, and the people that most desperately need TRAP laws to be repealed. The multiple intersecting oppressive forces that shape their lives also shape their ability to control their reproductive health, and while creating abortion funds or campaigning to end abortion stigma will help these people, removing the barriers altogether would give them full control over their reproductive health.

Healthcare providers have an ethical obligation to advocate for their patients to access high quality healthcare, regardless of the personal beliefs of the provider. The framework of feminist bioethics makes it clear that this obligation requires political activism to abolish TRAP laws. TRAP laws create rigid definitions of “harm” and “benefit” that strip patients of their autonomy, thus violating the central principles of bioethics. The ultimate goal is to make abortion as accessible as any other medical procedure, and the most important step in accomplishing that goal is ending TRAP laws. The application of Reproductive Justice further informs the argument by highlighting the ways in which TRAP laws operate within intersecting levels of oppression, creating stratified access to abortion care for low-income people, people of color, and young people. Other forms of advocacy are essential in the meantime, but the repeal of all TRAP laws should be the ultimate goal of any ethical healthcare provider. If a healthcare provider intends to have an ethical practice, they must advocate for their patients, which requires recognizing the ways in which TRAP laws inhibit the application of bioethical principles and actively campaigning for TRAP law abolition.

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