

# Rethinking “Elective” Procedures for Women’s Reproduction during Covid-19

by MARIELLE S. GROSS, BRYNA J. HARRINGTON, CAROLYN B. SUFRIN, and RUTH R. FADEN

In mid-March 2020, the U.S. Centers for Medicare & Medicaid Services called for curtailing “non-essential adult elective medical and surgical procedures” to conserve resources and support “flattening the curve” of Covid-19 infections.<sup>1</sup> State-and-hospital-specific policies followed, ranging from recommendations to outright mandates that elective procedures be canceled or postponed. Although the term “elective” is open to multiple interpretations, decisions about how to adjust the provision of procedural services during the pandemic have largely turned on implications for physical health and survival.

Reproduction-related surgical procedures such as abortion, surgical sterilization, and in vitro fertilization (IVF) have implications for physical health, but they also advance other important aspects of well-being, including self-determination, personal security, economic stability, equal respect, and the creation of meaningful social relationships.<sup>2</sup> Because Covid-19 surgical cancellation policies have relied so heavily on the single criterion of physical health impact, they deprioritize reproduction-related procedures. Many reproduction-related procedures have been designated as elective, resulting in restriction of at least some abortions, surgical sterilizations, and assisted reproductive procedures during the pandemic.

Categorizing procedures as necessary or as elective exclusively in terms of how they promote physical health fails to capture the value of these procedures and may propagate gender injustice. A new framework based in a broader understanding of well-being would be fairer and more respectful of women in the near term, provide conceptual basis for the prioritization of reproduction-related procedures in recent guidance for resuming procedures,<sup>3</sup> and perhaps promote women’s rights and interests in the post-Covid era.

---

Marielle S. Gross, Bryna J. Harrington, Carolyn B. Sufrin, and Ruth R. Faden, “Rethinking ‘Elective’ Procedures for Women’s Reproduction during Covid-19,” *Hastings Center Report* 50, no. 3 (2020): 40-43. DOI: 10.1002/hast.1130

## The Right to Not Reproduce

Procedures instrumental to the right not to reproduce have been affected by the public health need during Covid-19 to delay or cancel elective medical care, including abortions and tubal ligations.<sup>4</sup> Calling abortions “elective” is not new to the period of this pandemic, however. The designation has been used to marginalize and delegitimize abortion as a mere matter of optional, personal preference (“choosing” to have an abortion), in contrast to a profoundly consequential decision informed by major life-affecting considerations. This label has its roots in the days before abortion was legal in the United States, when hospital committees had to adjudicate between “therapeutic” abortions that could be performed legally and “elective” abortions that could not.<sup>5</sup>

There are some cases in which abortion is performed for the immediate physical health of a person. Many abortions, though, are indicated for reasons that less directly affect physical health yet have a foundational impact on a person’s overall well-being. Timely access to abortion is critical to a woman’s exercise of self-determination over the course of her life and to her closely connected interest in controlling if, when, and how she has children. For some women, economic stability for themselves and existing children as well as mental well-being hang in the balance.<sup>6</sup> Access to abortion, already compromised in many states by restrictive state laws,<sup>7</sup> has been further destabilized by inconsistencies in Covid-19 responses across health systems and states.

For example, at least eight states in which abortion is particularly politically fraught have capitalized on the proscription of elective surgeries to issue legal injunctions specifically restricting abortions, threatening potential criminal charges and fines for those who continue services.<sup>8</sup> Meanwhile, medical professional societies have taken a stand against the cancellation of abortion services during Covid-19, asserting that the procedures are “essential and time-sensitive.”<sup>9</sup> The defense of access to abortion during the pandemic by

*To think about the provision of reproduction-related procedures during a pandemic, when triage becomes necessary, physicians and health care systems need a framework that features multiple dimensions of well-being, nonphysical as well as physical.*

the American College of Obstetricians and Gynecologists and others reveals an explicit appreciation for the impact of abortion on well-being beyond health. Abortion providers are working to expand telemedicine use for medical abortions, an option that is theoretically ideal in the pandemic setting yet logistically challenging due to existing policy. Several organizations have mounted legal counterclaims to block the statewide bans.<sup>10</sup> As legal battles have been playing out in court, however, women's well-being has suffered.<sup>11</sup> Abrupt changes in services have caused some to miss a critical window for getting an early abortion—or even to lose a chance to get one at all—and have imposed the burden of traveling perhaps hundreds of miles to seek care out of state at a time when travel risks are increased.

Like abortion, access to surgical sterilization (such as tubal ligation) or reversible contraceptive devices has great bearing on women's interests in exercising control over their lives and bodies. Unlike abortion, however, these procedures have not been defended by national organizations as essential and nonelective during Covid-19. Instead, delays of sterilizations or contraceptive device placements have been justified by the availability of alternative contraception methods.<sup>12</sup>

The general rule that surgeries should be deferred when medical alternatives with acceptable outcomes are available is reasonable. When it comes to contraception, however, the existence of alternatives does not ensure that comparable outcomes are likely. For some women, surgical sterilization is the only form of contraception appropriate for their values or life circumstances; for others, nonsurgical contraception is not appropriate for them medically due to health contraindications to those methods.<sup>13</sup>

At baseline, there are racial and socioeconomic disparities in access to surgical sterilization as a result of issues ranging from Medicaid restrictions to age-and-parity-related “relative contraindications.”<sup>14</sup> Delays and cancellations are often tantamount to effective denials of desired sterilizations. Stay-at-home orders and social distancing practices have increased intimate-partner violence<sup>15</sup> and other obstacles to reliably accessing alternative contraceptive methods, such as supply chain shortages and transportation barriers,<sup>16</sup> and these factors are likely to increase the numbers of undesired pregnancies. For women who disproportionately experience these risk factors for undesired pregnancy, cancellation or delay of desired sterilization or device placement creates

significant challenges to their well-being, particularly as cumulative pregnancy risk increases over time.<sup>17</sup>

### **The Right to Reproduce**

Procedures facilitating reproduction include assisted reproductive treatments, like IVF, and a range of gynecologic procedures treating anatomic conditions that compromise the ability to get and stay pregnant, like myomectomies (surgical removals of uterine fibroids). These reproduction-promoting surgical procedures, too, are valuable more for their contribution to other components of well-being than for physical health. These components include many of the interests that are at stake in the right not to reproduce in addition to the interest of creating valuable relationships through family building.

However, some protocols for triaging procedures during Covid-19 place IVF in the same category as cosmetic surgery,<sup>18</sup> wherein the “elective” designation suggests that reproduction-promoting procedures are discretionary. This perspective devalues the extent to which becoming a parent is a deeply important aspiration for many people. The inability to have a child may be experienced as a deep personal loss, an emotional toll that may be heightened under social isolation in which building meaningful connections has become even more precious. Further, even among women who recognize their value or understand their life plans to be independent of fertility, the inability to become pregnant may impose interpersonal strife, humiliation, and shame.

There are profound racial and socioeconomic disparities in access to IVF at baseline. Patients who are closer to the end of their fertility window or whose ability to afford treatment is compromised by Covid will be those most severely disadvantaged by pandemic-related restrictions. Women who require fertility treatment to build their family have experienced these cancellations as unfair, especially by comparison to the lack of a recommendation against pregnancy for those who do not require medical assistance.<sup>19</sup> This perspective is consistent with updated guidance for reopening and further periods of restriction wherein embryo transfer and other surgical treatments for infertility are included as priority procedures, in contrast with their deprioritization in the initial phase of the pandemic. However, this approach is inconsistent with current guidance affecting another category of women who cannot get pregnant without medical

assistance, as recommendations propose deferral of long-acting contraceptive device removal where possible.

### A Triage Framework Informed by Well-Being

The pandemic calls for urgent reconsideration of health care practices, with some inherent tensions between individual rights and public health. Health care systems' resource-allocation calculus prioritizes health metrics, such as morbidity and mortality. Yet health utility alone does not account for the critical importance of reproduction-related procedures to values other than health, including self-determination, personal security, equal respect, and family building. Furthermore, systematic restriction of reproduction-related procedures during the crisis is particularly harmful given both historic, gendered control over women's reproduction and women's dependence on these procedures for reproductive autonomy and other components of well-being. In light of these concerns, the threshold for restricting reproduction-related procedures during the health crisis should be raised, and perhaps raising it will support efforts after the pandemic to address inequities in access to these critical procedures.

To think about the provision of reproduction-related procedures during a pandemic, when triage becomes necessary, physicians and health care systems need a framework that features multiple dimensions of well-being, nonphysical as well as physical. Such a framework will inform the ranking of reproduction-related procedures within broader surgical categories and also of individual cases within procedure types. Here is an example of such a framework:

- 1) Abortion would never be delayed. Methods and policies that minimize the number of required visits should be used whenever possible, and procedures should be performed in outpatient settings wherever possible.

- 2) Surgical sterilization and reversible contraceptive implant placement would never be denied when there is either no medically appropriate alternative or no personally acceptable one. Clinical visits for these procedures should take priority over other routine outpatient visits within modifications to social-distancing practices. If delays are necessary due to clinical capacity, indefinite delays should be avoided. We recommend automatically rescheduling the procedure within four weeks, with reassessment as needed.

- 3) Long-acting contraceptive device removal and assisted reproductive procedures should not be denied to women on the outer edge of their fertility window or for whom future access may be jeopardized by the pandemic's impact. IVF should not be halted mid-cycle, and for egg retrieval, priority should be given to patients whose fertility is most limited and those who intend to proceed with IVF the soonest.

- 4) Individuals' dependence on clinical visits for exercising reproductive autonomy should be minimized by, for example, increasing the use of telemedicine, making oral contraceptives available over the counter,<sup>20</sup> and supporting at-home artificial insemination.

- 5) Decisions should be transparent, fair, and consistent across state lines, reflecting reproduction's sociopolitical significance for self-determination and personal security. Providers should collaborate with patients in informed, shared decision-making.

- 6) The reversal of restrictions should prioritize cases based on principles of harm reduction in view of the cumulative effect of given procedures on patients' well-being. For example, the first cases to be rescheduled should be for women at greatest risk for unplanned pregnancy and those most vulnerable to financial or insurance-status changes that may limit access in the future.

- 7) Both during the reintroduction of procedures and in future phases of restriction, triage should account for the impact of procedures on overall well-being, the use of outpatient settings should be prioritized, and clinical redundancies or ancillary personnel, such as clinical students, should still be eliminated.

Ultimately, a more individualized, well-being-centered approach to triage of reproduction-related procedures that is sensitive to social-structural contexts and the diversity of community values related to reproduction may yield a more just outcome and mitigate pandemic-related exacerbation of inequities. Concerns to address include the burdens on clinicians, potentially misaligned incentives to provide or further restrict services (such as claims of exceptionalism and financial motives), dexterity in matching restrictions to an evolving health threat, the need for ongoing ethical oversight and evidence-based assessment, and residual risk of systematic disenfranchisement of the most disadvantaged and at-risk patients. Reproductive rights are not "elective," not even during a pandemic.

1. Centers for Medicare & Medicaid, "Non-emergent, Elective Medical Services, and Treatment Recommendations," April 7, 2020, <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>.

2. M. Powers and R. R. Faden, *Structural Injustice: Power, Advantage and Human Rights* (New York: Oxford University Press, 2019).

3. Society of Gynecologic Surgeons et al., "Joint Statement on Reintroduction of Hospital and Office-Based Procedures in the Covid-19 Climate for the Practicing Gynecologist," April 28, 2020, [https://societyfp.org/wp-content/uploads/2020/05/Revised\\_Reintroduction-of-Hospital-and-Office-Procedures-w-REI\\_final.pdf](https://societyfp.org/wp-content/uploads/2020/05/Revised_Reintroduction-of-Hospital-and-Office-Procedures-w-REI_final.pdf).

4. D. Carter, "Abortion Access during Covid-19, State by State," *Rewire News*, April 14, 2020, <https://rewire.news/article/2020/04/14/abortion-access-covid-states/>; P. F. Stahel, "How to Risk-Stratify Elective Surgery during the Covid-19 Pandemic?," *Patient Safety in Surgery* 14 (2020): article 8.

5. K. Luker, *Abortion & the Politics of Motherhood* (Berkeley: University of California Press, 1985).

6. M. A. Biggs et al., “Women’s Mental Health and Well-Being 5 Years after Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study,” *JAMA Psychiatry* 74, no. 2 (2017): 169-78.

7. “An Overview of Abortion Laws,” Guttmacher Institute, accessed April 1, 2020, <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>.

8. Carter, “Abortion Access during Covid-19, State by State.”

9. “Joint Statement on Abortion Access during the Covid-19 Outbreak,” American College of Obstetricians and Gynecologists, March 18, 2020, <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-Covid-19-outbreak>.

10. “ACOG Leads Coalition of Nearly 1 Million Medical Professionals to Oppose Texas Restrictions on Abortion during the Covid-19 Pandemic,” April 3, 2020, American College of Obstetricians and Gynecologists, <https://www.acog.org/news/news-releases/2020/04/medical-professionals-to-oppose-texas-abortion-restrictions>.

11. S. Tavernise, “‘Overwhelmed and Frustrated’: What It’s Like Trying to Get an Abortion in Texas,” *New York Times*, April 14, 2020.

12. “Covid-19 FAQs for Obstetrician—Gynecologists, Gynecology: How Should Provision of Contraception Be Optimized?,” American College of Obstetricians and Gynecologists, accessed May 17, 2020,

<https://www.acog.org/clinical-information/physician-faqs/Covid19-faqs-for-ob-gyns-gynecology>.

13. American College of Obstetricians and Gynecologists, “Committee Opinion Number 530: Access to Postpartum Sterilization,” *Obstetrics and Gynecology* 120, no. 1 (2012): 212-15.

14. Ibid.; J. Morris et al., “Desired Sterilization Procedure at the Time of Cesarean Delivery according to Insurance Status,” *Obstetrics and Gynecology* 134, no. 6 (2019): 1171-77.

15. A. Taub, “A New Covid-19 Crisis: Domestic Abuse Rises Worldwide,” *New York Times*, April 6, 2020.

16. C. Anna, “Lockdowns Mean Millions of Women Can’t Reach Birth Control,” AP News, April 9, 2020.

17. American College of Obstetricians and Gynecologists, “Committee Opinion Number 530.

18. Stahel, “How to Risk-Stratify Elective Surgery during the Covid-19 Pandemic?”

19. S. Pfeiffer, “Women ‘Falling off the Cliff of Fertility’ as Pandemic Puts Treatments on Hold,” NPR, April 12, 2020, <https://www.npr.org/2020/04/12/831706118/women-say-they-are-falling-off-the-cliff-of-fertility-as-pandemic-puts-treatment>.

20. D. Grossman and L. Fuentes, “Over-the-Counter Access to Oral Contraceptives as a Reproductive Healthcare Strategy,” *Current Opinions in Obstetrics and Gynecology* 25, no. 6 (2013): 500-505.

# Digital Contact Tracing, Privacy, and Public Health

by NICOLE MARTINEZ-MARTIN, SARAH WIETEN, DAVID MAGNUS, AND MILDRED K. CHO

Using mobile technology for contact tracing efforts is emphasized in many plans to “reopen” countries and states because of the need to rapidly identify the possible contacts of a person diagnosed with Covid-19, many of whom the infected individual might not know personally.<sup>1</sup> These digital tracing projects prioritize privacy protections that emphasize local storage of data on phones and deidentified information. What these projects fail to recognize, however, is that standard ethical frameworks for biomedical research—developed to guide how to weigh values such as autonomy, justice, beneficence, and non-maleficence—are not necessarily appropriate in the context of a pandemic. These projects also highlight the inadequacy of current regulatory frameworks to evaluate safety and ef-

fectiveness of software-based technology applied to public health.

Technologists in the United States and Europe have been racing to build digital systems for contact tracing to contain Covid-19. The general concept behind these projects is to use Bluetooth technology in smartphones to register proximity between the phones of people diagnosed with Covid-19 and other smartphone users; if a user reaches a predetermined threshold for risk of SARS-CoV-2 transmission, a digital “token” (such as a contact number) is generated and stored locally on the user’s phone. If the user is diagnosed with Covid-19, then the app is triggered to send notices to other smartphones to alert users that they were in contact with someone diagnosed with the illness.<sup>2</sup> The contact data is deleted after about fourteen days. Google and Apple, in particular, teamed up to develop Bluetooth-oriented tools for an “exposure notification system” on their operating systems, through which other developers can cre-

Nicole Martinez-Martin, Sarah Wieten, David Magnus, and Mildred K. Cho, “Digital Contact Tracing, Privacy, and Public Health,” *Hastings Center Report* 50, no. 3 (2020): 43-46. DOI: 10.1002/hast.1131