

# Disjointed states of America: The medical is political

While those of us in medicine have become accustomed to abortion care being legislated and politicized, it is not the only care that has been dictated by politics rather than public health expertise and evidence-based medical practices



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Like many of you, I am an obstetrician-gynecologist who provides full-spectrum reproductive health care. Our jobs demand great intimacy—we are with patients as they meet their first born, learn of a miscarriage diagnosis, or decide to end their pregnancy. I have performed an uncomplicated, joyful vaginal delivery, then within an hour rushed a different patient's gurney to the intensive care unit as she became acutely hypotensive and hypoxic, developing ARDS after a stillbirth. The care we provide is uniquely personal, and in that, has become deeply political. We have spent a long time here—news pundits, members of our family, even us—viewing abortion and reproductive health as something innately political. Although abortion is at the forefront of legislative interference and politicization, more than 1,300 abortion restrictions have been

passed in the United States since *Roe v Wade* in 1973. It is not the only medical care affected by political interference.<sup>1</sup> The United States ranks last in maternal mortality among industrialized nations, and Black women are more than twice as likely to die.<sup>2</sup> As we grapple with the fallout of the *Dobbs v Jackson Women's Health Organization* opinion and begin to recognize how fractured medical care has become—based on zip code—we should take stock of the way legislation and politics have already dictated reproductive health care. Abortion is the salient example, but state policy and legislation have unjustly been determining medical care available to women and other patients on a broader scale for decades. Here are just a few examples.

## Postpartum care

The postpartum period is critical for maternal health; it is the time period in which many comorbidities emerge, including hypertensive disorders, postpartum thyroiditis,

and mood disorders. Fifty percent of maternal deaths in the United States occur postpartum. Despite the importance of this care, Medicaid coverage for longer than 60 days postpartum varies greatly state to state. After the Affordable Care Act was implemented, it was assumed that all states would expand their Medicaid programs to include parents in their coverage plans beyond the guaranteed 60 days, negating the need for a specific postpartum coverage time period. However, the 2012 Supreme Court decision in *National Federation of Independent Business v Sebelius* allowed states to opt out of Medicaid expansion.<sup>3</sup> In many states, postpartum patients lose their Medicaid insurance after 60 days if they do not meet the stringent income criteria.

The income level that makes patients ineligible for Medicaid coverage at day 61 postpartum varies widely. In Maryland, a patient can extend their Medicaid coverage for 12 months postpartum if their family of 4 earns less than \$73,260

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annually (264% of the federal poverty level). However, in Mississippi, an income of more than \$6,936 per year for a family of 4 (approximately 25% of the federal poverty level) renders mothers who are 61 days postpartum ineligible for Medicaid coverage.<sup>4</sup> Thus, many low-income postpartum patients (who are at twice the risk of maternal mortality as affluent patients) find themselves without access to this critical care depending on the decisions of their state legislatures.<sup>5</sup> The American Rescue Plan Act of 2021 (known as the COVID-19 Stimulus Package) included a provision that allows states to expand their postpartum Medicaid coverage from 60 days to 12 months; currently, 10 additional states are planning to expand postpartum Medicaid for 12 months. While encouraging, 14 states still have not announced plans to utilize this provision or apply for a waiver to extend Medicaid coverage in the postpartum period.<sup>6</sup>

### Treatment for substance use

Drug overdose is a leading cause of pregnancy-related death from unintentional causes.<sup>7</sup> Overdose deaths in the general population climbed between 2020 and 2021, reaching historic highs of more than 100,000 deaths in a 12-month period.<sup>8</sup> Given the impact of substance use and overdose on maternal mortality, health systems should be maximizing efforts to respond to this public health crisis by implementing effective screening and treatment interventions and establishing clinics and hospitals as safe places to seek care. However, many states have criminalized substance use in pregnant patients and mandate that clinicians report patients who use substances, creating an ethical dilemma for clinicians seeking to screen and treat



patients for substance use disorder. Twenty-three states consider substance use in pregnancy to be child abuse, and 3 states consider substance use in pregnancy to be grounds for civil commitment. In Wisconsin, a patient can be detained against their will for the duration of the pregnancy. Twenty-five states require health care professionals to report suspected substance abuse in pregnancy to child protective services or a similar state office.<sup>9</sup> Even when universal substance use screening is implemented, it has disparate impact on patients of color; Black women who screened positive for substance use in pregnancy were more likely to be reported to child protective services than their White counterparts.<sup>10</sup> The criminalization of pregnant bodies does not lead to improvements in individual, community, or public health, it infringes on the ethical principle of bodily autonomy and puts clinicians at odds with what is best for their patients.

### Gender-affirming care

Gender-affirming care is supported by major medical organizations and reduces the risk of depression and suicidality in transgender youth.<sup>11</sup> Despite this evidence, several states have passed legislation restricting or banning this care, criminalizing the doctors who provide it. Idaho's house of representatives passed House Bill 675,<sup>12</sup> which would make providing gender-affirming care a felony, punishable by up to a life sentence. This would extend to parents trying to access care for their children as well as clinicians.

Although abortion is the medical care most conspicuously manipulated by politics and legislation, it is far from the only example. No area of medicine will be untouched by eliminating access to reproductive health care and by the regulation and criminalization of health care workers who provide it. This is a sea change, although state legislative interference and disparities in reproductive health care have been

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a tocsin of such change for years. We can no longer afford to believe there is a separation between politics and medicine; this directly interferes with our Hippocratic oath to do no harm. A politician in Ohio should not decide whether or not a 13-year-old patient should have to carry a pregnancy to term; the house of representatives in Idaho should not put someone's transgender child at increased risk of depression and suicidality by making their medical care a felony. Colleagues in Texas should not be punishable by life in prison for providing abortion care.<sup>13</sup> As a physician, I cannot stand by when, facing a maternal mortality crisis, state politicians decide whether a patient living below the

poverty line should have access to postpartum care.

I am neither a politician nor a legal scholar. I am a physician who takes care of people in this intimate and powerful space of healing and support between doctor and patient. What should we do? We need to come together to find the answers. We need to vote if we haven't before. And we need to vote differently if we have elected lawmakers who politicize and dangerously interfere with medicine, the well-being of our patients, and our ability to carry out our duty as physicians in our patients' best interests. We need to tell our stories—to each other, to our newspapers, to our neighbors, and to our legislatures. If we are

leading organizations, we can use the power held in our institutions to commit to providing care to the fullest extent possible, commit to protecting our clinicians providing evidence-based care, and encourage legislators who use medicine as a political bargaining chip to reverse course. Medicine is not an apolitical field, and we can no longer uphold that paradigm. Our patients lives, and our livelihood as healers and caretakers, depends on our collective action against it. ●

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