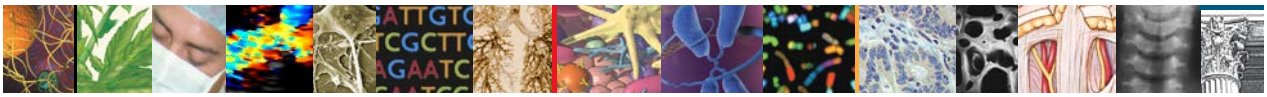

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Perspective

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Physicians and the (Woman's) Body Politic

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"The only amendment that didn't get offered today . . . was that a legislator be in the room. Some places, some decisions do not belong to you. You can't have them. You just can't."

— Representative Sondy Pope (D-Cross Plains) speaking in opposition to Wisconsin Senate Bill 206 requiring even medically unnecessary ultrasound before abortion (June 13, 2013).

Alicia Beltran is famous for her recent Kafka-esque pregnancy experience. She had stopped using painkillers and weaned herself off the antiaddiction medication. She provided full information to her health care provider. But instead of receiving prenatal care, she was ordered by the state to resume using antiaddiction medication. When she declined, she was arrested and, although she screened negative for all evidence of drug dependence or abuse, was committed to a facility for months before finally being released after a federal complaint was filed on her behalf.

If this were simply one of the hundreds of stories that the National Advocates for Pregnant Women has documented of pregnant women criminally charged, jailed, and civilly committed on suspicion that they're failing to fully protect their pregnancies and birth outcomes (see box), it would merely be a particularly shocking example of a regrettably frequent phenomenon. Instead, it is the latest example of a disturbing pattern of legislative and judicial misrepresentation and misuse of medical information in the pursuit of partisan aims focused on women and pregnancy. It's not that politicization of science isn't a problem in other contexts — think of the debates over climate change. Nor is this the only example of legislative interference in the doctor–patient relationship. As recently as 2012, five medical professional societies wrote in protest of legislative encroachments on this relationship related to issues as diverse as end-of-life decision making, firearms safety, and environmental exposures.[1]

But pregnant women and their physicians have been marked for particularly intense attention by legislators (and sometimes judges) acting as arbiters of medical knowledge despite their lack of expertise or detachment. Nearly every state has passed TRAP (Targeted Regulation of Abortion Providers) laws under the guise of protecting women and has subjected abortion providers to burdensome restrictions not imposed on other medical professionals, including requirements for surgical facilities, admitting privileges,

Selected Cases in Which Women Have Been Punished for Allegedly Failing to Protect Their Fetuses.*

Locked up in jails or prisons:
- A pregnant woman accidentally falls down a flight of stairs and is arrested on charges of attempted feticide.
- A woman who obtained the contraceptive Depo-Provera later has a miscarriage. She is held in jail for a year on murder charges.
- A pregnant woman who attempts suicide survives, but because she lost the pregnancy she is arrested on charges of murder.
- A woman is convicted of homicide by child abuse after she has a stillbirth and tests positive for an illegal drug.

Locked up in mental hospitals:
- A woman voluntarily seeks help for her opiate addiction. She is sent to a locked psychiatric ward where she receives no prenatal care.
- A woman is held in a locked psychiatric facility because she did not obtain a recommended follow-up gestational diabetes test. The facility never administers the test.

Deprived of liberty and subjected to medical interventions including surgery:
- A woman seeks to deliver vaginally but is denied access to any hospital unless she agrees to cesarean surgery. Her attempt to labor and deliver at home is discovered, and she is taken into custody by a sheriff while in active labor, transported against her will to the hospital with her legs strapped together, and forced to have the surgery.

* Information is adapted from Paltrow LM, Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. J Health Polit Policy Law 2013;38:299-343.

and hallway designs that are unnecessary for safe abortion provision. The acknowledged goal is to close clinics, even in instances in which physicians will have to abandon patients with little notice or opportunity for alternatives. The situation has become so extreme that the American Congress of Obstetricians and Gynecologists (ACOG) felt compelled to release a statement calling these measures unwarranted and unjustified legislative intrusions on medical practice.[2]

It's hardly a new phenomenon. In 2007, the U.S. Supreme Court upheld a federal statute banning dilation-and-extraction (D&X) procedures, which were occasionally needed for certain later-term pregnancy terminations. The Court relied on a legislative assertion that it is "a gruesome . . . procedure that is never medically necessary . . . to preserve the health of the woman." Testimony of physician experts contradicted this legislative "finding" but was ignored, and this "fact" became central to the Court's conclusion that banning D&X (and forcing physicians to perform a riskier dilation and evacuation) would be acceptable medical practice and not an undue burden for women.

Requiring physicians to use less than the best medical judgment and safest techniques is a tactic used for early terminations as well. Recently, states have passed laws requiring that medication abortions be performed using drugs at the precise timing and dosages listed on the approved labels, even though lower doses have since been found to be effective and safer, and even though off-label prescribing is a common legal practice that allows the standard of care to evolve.

Courts and legislatures have also misused medical information to justify requiring physical interventions, such as transabdominal and transvaginal ultrasonography, even when not medically indicated, solely to create images that might dissuade women from choosing abortion. Practice guidelines from the American Institute of Ultrasound in Medicine clearly state that the procedures should be performed "only when there is a valid medical reason," a statement endorsed by ACOG.[3] And under no formulation of medical ethics is it appropriate to force physicians to inflict stress and emotional pain on patients as a penalty for their legally protected choices.

It also is not consistent with medical ethics or any standard of care to force physicians to provide biased counseling or inaccurate information under the guise of "informed consent," yet 33 states have enacted legislation doing just that, purportedly to help women avoid "post-abortion syndrome," a condition unrecognized in the *Diagnostic and Statistical Manual of Mental Disorders* and consistently debunked at least since the days of President Reagan's surgeon general, C. Everett Koop. Nonetheless, a federal court recently upheld a provision requiring doctors to claim — inaccurately — that abortions lead to suicide, citing legislative "findings" and a study that was so flawed that the editor of the journal that published it was forced later to write that its "analysis does not support [the] assertions."[4] Similarly, other "informed consent" scripts written by legislatures require physicians to state, falsely, that abortion can cause breast cancer.

Meanwhile, an increasing number of states are claiming incontrovertible evidence that fetuses can feel pain as early as 18 weeks after conception, even though the neural structures necessary to ex-

perience pain have not yet developed and the ACOG states that rigorous recent data show that experiencing pain is not possible until the third trimester.[5] This evidence has not stopped politicians from "finding" otherwise and mandating that fetal anesthesia be available (thus closing many clinics that do not have this capacity) or that abortions be outlawed as early as the beginning of the second trimester. Indeed, the U.S. House of Representative has passed H.R. 1797, the "Pain-Capable Unborn Child Protection Act," and more than 40 senators are cosponsoring its companion bill, S. 1670.

It should come as no surprise, then, that Alicia Beltran's arrest and incarceration are consistent with a long history of legislative and judicial misrepresentation of the risks of drug use during pregnancy. Such misrepresentation began in the 1980s and early 1990s, when women were being prosecuted and jailed for "child abuse" (or some variation thereof) if they used cocaine during pregnancy. Without suggesting that cocaine use is safe or that all the effects are known, the 2010 National Institute on Drug Abuse report "Cocaine: Abuse and Addiction" states that the claims that "crack babies" would be born with severe defects or lifelong deficits were a "gross exaggeration." But those claims became the basis for laws such as the one used against Beltran in Wisconsin, where what started with crack cocaine expanded to encompass the state's power to incarcerate a pregnant woman who "habitually lacks self-control" (undefined) with respect to any number of substances, legal and illegal.

Thus was Beltran's liberty taken away, even though medical examination showed that she was drug-free and without symptoms of withdrawal and that her fetus was developing normally. The medical standard of care would call for ongoing monitoring in the course of prenatal care. It would not necessarily require Beltran to return to taking antiaddiction medications, as the state insisted. And it definitely would not call for incarceration in a setting that lacked prenatal care (and, ironically, also lacked capacity to administer the drugs that the state claimed were indicated).

For two decades, legislatures have been encroaching on the realm of medicine. Heedless of medical ethics or evidence-based standards of care, they have been declaring medical "facts," specifying or forbidding medical procedures, and dictating to doctors what they must say to their patients. *Roe v. Wade* was not only about a woman's right to abortion. It was also about the right to her physician's medical judgment and best care, unconstrained by partisan strategies. It is not only women's bodies that are being held hostage to politics; it is also the hearts, minds, and professional pride of their physicians.

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Prenatal Whole-Genome Sequencing — Is the Quest to Know a Fetus's Future Ethical?

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Researchers recently reported sequencing a fetal genome from cell-free fetal DNA in a pregnant woman's blood,[1] heralding the possibility of performing whole-genome sequencing as early as the first trimester of pregnancy. This possibility adds a new level of complexity to decisions about prenatal testing. Current methods such as chorionic-villus sampling and amniocentesis, which must