Ethical Challenges Encountered in Women's Health Care During COVID-19

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Presenter

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Dr. Applewhite is the Director of the Alden March Bioethics Institute at Albany Medical College and holds the John A. Balint, MD, Chair of Medical Ethics in the College. She is a board-certified General Surgeon and is fellowship trained in Endocrine Surgery. Her undergraduate degree is in African American Studies from the University of Chicago and her medical degree is from Albany Medical College. She completed her General Surgery Residency at Lahey Hospital and Medical Center and her Endocrine Surgery training at the University of Chicago. She also completed a fellowship in Clinical Medical Ethics at the University of Chicago MacLean Center for Medical Ethics.

Her research interests include surgical ethics education, health care of the incarcerated patient population, utilization of limited resources, and quality of life after thyroid and parathyroid surgery.

Disclosures

- Dr. Megan Applewhite has no relevant financial or non-financial relationships to disclose relating to the content of this activity.
- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of Defense, nor the U.S. Government.
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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Identify the ethical challenges for women's health care that have been highlighted by the COVID-19 pandemic.
2. Outline how cessation of "non-essential" procedures was deleterious to the reproductive rights of women.
3. Recognize the impact of COVID-19 on domestic violence against women and what can be done to lessen this crisis.

Pregnancy and COVID-19

Rapidly Evolving Knowledge

- Initially unclear if pregnancy affects COVID disease process, later shown to increase morbidities (preterm birth) and low risk of transplacental infection
- Unclear if increased Personal Protective Equipment (PPE) and preventative measures would benefit pregnant women
- Many ventilator allocation guidelines prioritized pregnant women
- Balancing evidence-based medicine with the precautionary principle to optimize outcomes – prioritizing nonmaleficence.

(Vivanti et al.,2020)

"Scientifically Complex" Population

Pregnant women have been called "scientifically complex" given the physiologic and anatomic changes that occur that can change their response to medications & infectious disease. The following are advances…

- 1994 Institute of Medicine
  - Pregnant women should not be excluded from drug trials
- 2001 National Institute of Health (NIH)
  - Move from presumption of exclusion of pregnant women in human research to inclusion
- 2012 Industry-Sponsored Trials
  - 95% of trials that included women of child-bearing age specifically excluded pregnant women
- 2013 & 2016 Ebola Treatment and Vaccine Trials
  - Pregnant women excluded despite known high maternal & fetal mortality rates and expert recommendation to include them
- 2018 Revision to the Common Rule
  - Pregnant women removed from the list of "vulnerable" population in the United States

(Farrell et al., 2020)

Autonomy Compromised

- Societal values and beliefs about the autonomous choices of women in pregnancy may be “at odds” with the values and beliefs of the woman.
  - Pregnant women may not be “allowed” to take certain risks

- Pregnancy was an exclusion criteria in 76% of the 310 COVID-19 drug trials registered at clinicaltrials.gov
  - Hydroxychloroquine, human immunodeficiency viruses (HIV) protease inhibitors, vaccine trials requiring “effective contraceptives”
  - Unjustly denies them the opportunity to receive benefit
  - Leads to harm with the lack of evidence to inform the care of pregnant women later

(Farrell et al., 2020)

Surgical Triage & Reproductive Health

Duty to Care in Pandemic

- Individual patient ⟶ Health of the community
- Allocation of scarce resources
  - Health care workers
  - Hospital beds
  - Equipment (ventilators, dialysis machines, Extracorporeal Membrane Oxygenation (ECMO))
  - Personal protective equipment
- Protection of the community
- Minimizing non-essential medical interventions

Surgical Triage

- Deferral of non-essential procedures
  - Limits exposure, PPE use
- Who decides what is “essential”?
  - Individual surgeons? Departments? Hospitals?
  - Regional hubs? Specialty Societies? State or
  - National government?
- What is essential?
  - Imminent end organ damage, loss of limb, aggressive malignancy, “life sustaining”

(American College of Obstetricians & Gynecologists, 2020)

(American College of Surgeons, 2020)

Pertinent Omissions of "Essential"

- Adverse outcomes related to unwanted pregnancy were not considered essential to avoid.
  - Termination of pregnancy
  - Surgical sterilization

→ Not initially prioritized
Excluded from insurance coverage
Not permitted by health care institutions

- Surgical triage guidelines were initially abstracted to prohibit medical abortion of pregnancy in many states, although the reasons for triage were no longer applicable
- American College of Obstetricians & Gynecologists (ACOG) clear from 3/2020 that termination of pregnancy is not "elective" – delays can propose risks to women or make the procedure unavailable or more difficult to access (exacerbating socioeconomic disparities)

(Shepherd, 2020)
(Pennsylvania Department of Human Services, 2020)

Different Quality of Outcomes…

- Unlike many other procedures, terminating unintended pregnancies is value-laden and stigmatized
- "Undesired pregnancy" can only be identified by the patient herself, making the diagnosis and urgency less straightforward than other untoward health outcomes
- Limitations imposed on the liberties of women with unwanted pregnancies and childbirth that can have life-long effects

- Among women seeking abortion, undesired pregnancy has led to:
  - Worse socioeconomic status
  - Lower likelihood of achieving personal goals
  - Inferior physical health
  - Higher rates of intimate partner violence

(Bruno, 2020) (Upadhyay et al., 2015) (Ralph et al., 2019) (Roberts et al., 2014)

Gender-based Violence in COVID-19: "A Pandemic within a Pandemic"

"Violence against women is one of the most pervasive human rights violations worldwide and has enormous costs for women's health, safety, and well being. Globally, around 38% of murders of women are committed by an intimate partner. Almost one third of all women who have been in a relationship report that they have experienced some form of violence."

- From *Understanding the Costs of Violence against Women*
United Nations Women

(Untied Nations Women Asia and Pacific, 2016)

Background: Violence in Crisis

- Globally, 1 in 3 women have experienced physical and/or sexual violence in their lifetime.
  - "The most widespread but among the least reported human rights abuses"
- Gender based violence escalates in crisis (natural disasters, wars, epidemics)
  - Those at highest risk are older, displaced, refugees, and those living in conflict-affected areas
- Far-reaching consequences
  - Physical, mental, sexual & reproductive health problems like Sexually Transmitted Infections (STIs), unplanned pregnancies, life-altering changes

(World Health Organization, 2020)

Why are Risks of Violence Exacerbated in the COVID-19 Pandemic?

- Disruption of social and protective networks
- Decreased access to services
- People are encouraged not to leave the home, more close contact
- Unemployment, financial strains, economic losses
- Women bear more of increased care load for children
- More aggressive perpetrators may restrict access to soap and hand sanitizer, increasing risks of infection
- Services (hotlines, crisis centers, legal aid, shelters, protection services) may be scaled back, thereby reducing access to women in abusive relationships

(World Health Organization, 2020)

World Health Organization 4/2020

- World Health Organizations (WHO) warned that reductions in the availability of essential sexual and reproductive health care during the COVID-19 pandemic may result in thousands of maternal and newborn deaths
  - Unintended pregnancies
  - Unsafe abortions
  - Complicated deliveries
  - Inadequate prenatal care
  - Decrease access to urgent care when needed

(World Health Organization, 2020)

“Domestic violence is rooted in power and control. Right now, we are all feeling a lack of control over our lives and an individual who cannot manage that will take it out on their victim”

– Katie Ray-Jones, CEO National Domestic Violence Hotline

TIME

HEALTH • COVID-19

As Cities Around the World Go on Lockdown, Victims of Domestic Violence Look for a Way Out

BY MÉLISSA GODIN MARCH 18, 2020 1:58 PM EDT

DHA Defense Health Agency

- Inability to leave the home, victims are blamed for illness in the home
- Victims are trapped in their homes with their abusers, isolated from people and resources that otherwise could support them
- National Domestic Violence Hotline: "Perpetrators are threatening to throw their victims out on the street so they get sick. We've heard of some withholding financial resources or medical assistance."
- In China, the number of domestic violence cases reported to local police tripled in February 2020 compared to February 2019.
- Due to fears of contracting COVID-19, women are less likely to seek help for injuries sustained from domestic violence

(Godin, 2020)

Brazil: Protect Sexual, Reproductive Rights in Pandemic

Officials Who Defended Women's, Girls Rights Demoted

June 12, 2020 11:00AM EDT

- "Non urgent" services such as emergency contraception, treatment of STIs and abortion were limited or suspended
  - 42 hospitals in a country of 210 million people were performing abortions
  - Increased gender-based violence was predicted to lead to unwanted pregnancies
- The Brazilian Health Ministry: women and girls may encounter difficulty with sexual and reproductive health during the COVID-19 – measures should be taken to improve access
- Health Ministry Officials who recommended enhancement of services for protection and aid were taken out of leadership positions

(Human Rights Watch, 2020)

THE LANCET

World Report

COVID-19 has "devastating" effect on women and girls

Defense Health Agency

- Disrupted reproductive and sexual health services during COVID-19 will result in up to:
  - 7 million unintended pregnancies
  - 9.5 million vulnerable women & girls will lose access to contraception and safe abortion services in 2020
    - 2.7 million unsafe abortion
    - 11,000 pregnancy-related deaths
- In Columbia, gender-based violence during lockdown increased by 175% when compared with the same period last year
- In Australia, Telehealth consultations for early medical abortion have increased by 25% since the pandemic began

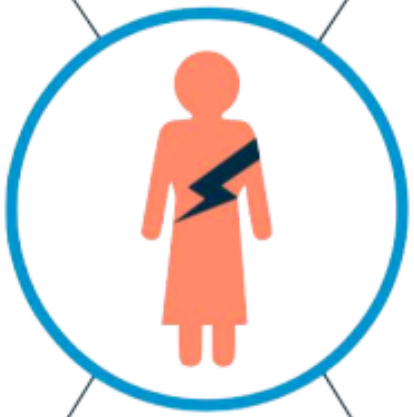
(Cousins, 2020)

COVID-19 and Ending Violence Against Women and Girls

Emerging data shows that since the outbreak of COVID-19, violence against women and girls (VAWG), and particularly domestic violence, has INTENSIFIED.

In **France**, reports of domestic violence have increased by **30%** since the lockdown on March 17.

In **Cyprus** and **Singapore** helplines have registered an increase in calls of **30%** and **33%**, respectively.



In **Argentina** emergency calls for domestic violence cases have increased by **25%** since the lockdown on March 20.

Increased cases of domestic violence and demand for emergency shelter have also been reported in **Canada, Germany, Spain, the United Kingdom** and **the United States.**

(Untied Nations Women Asia and Pacific, 2016)

What Can We Do?

Role of Health Systems

- Awareness of increased risk by providers in the emergent, inpatient, and outpatient settings can facilitate potential identification of those patients
- Those women at risk who work in health care settings may be at increased vulnerability due to their job
  - If immediately treating patients with COVID-19, may experience stigmatization, isolation
  - Lesser flexibility in their job to be available for childcare when necessary leading to economic/professional compromise and possible domestic turmoil.
- Considerations to provide psychosocial support, non-performance-based incentives, transport allowance, child-care support

(World Health Organization, 2020)

What can be done to address violence against women during the COVID-19 response

Although the COVID-19 pandemic has placed an immense burden on health systems, including frontline health workers, there are things that can help mitigate the effects of violence on women and children.

Governments and policy makers must include essential services to address violence against women in preparedness and response plans for COVID-19, fund them, and identify ways to make them accessible in the context of physical distancing measures.

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Humanitarian response organizations need to include services for women subjected to violence and their children in their COVID-19 response plans and gather data on reported cases of violence against women.

Community members should be made aware of the increased risk of violence against women during this pandemic and the need to keep in touch and support women subjected to violence, and to have information about where help for survivors is available. It is important to ensure that it is safe to connect with women when the abuser is present in the home.

Women who are experiencing violence may find it helpful to reach out to supportive family and friends, seek support from a hotline, or seek out local services for survivors. They may also find it useful to have a safety plan in case the violence escalates. This includes having a neighbor, friend, relative, or shelter identified to go to should they need to leave the house immediately for safety.

(World Health Organization, 2020)

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Community members should be made aware of the increased risk of violence against women during this pandemic and the need to keep in touch and support women subjected to violence, and to have information about where help for survivors is available. It is important to ensure that it is safe to connect with women when the abuser is present in the home.

Women who are experiencing violence may find it helpful to reach out to supportive family and friends, seek support from a hotline, or seek out local services for survivors. They may also find it useful to have a safety plan in case the violence escalates. This includes having a neighbor, friend, relative, or shelter identified to go to should they need to leave the house immediately for safety.

(World Health Organization, 2020)

"Medically Ready Force…Ready Medical Force"

What can be done to address violence against women during the COVID-19 response

Although the COVID-19 pandemic has placed an immense burden on health systems, including frontline health workers, there are things that can help mitigate the effects of violence on women and children.

Governments and policy makers must include essential services to address violence against women in preparedness and response plans for COVID-19, fund them, and identify ways to make them accessible in the context of physical distancing measures.

Health facilities should identify and provide information about services available locally (e.g. hotlines, shelters, rape crisis centers, counselling) for survivors, including opening hours, contact details, and whether services can be offered remotely, and establish referral linkages.

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Key Takeaways

- The autonomy of pregnant women is compromised when they are excluded from clinical trials in COVID-19, decreasing data available for others later
- Surgical triage during surges of COVID-19 requires definition of “essential” and “non-essential” cases, which can affect delivery of sexual and reproductive health care to women
- Domestic violence has increased significantly over 2020, due to COVID-19 and there are proactive measures at every level that can be taken to help prevent and better address this issue

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How to Obtain Continuing Education/Continuing Medical Education (CE/CME) Credits

To receive CE/CME credit, you must register by 0745 ET on 26 February 2021 to qualify for the receipt of CE/CME credit or certificate of attendance. You must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through 11 March 2021 at 2359 ET. Please complete the following steps to obtain CE/CME credit:

1. Go to URL https://www.dhaj7-cepo.com/content/feb-2021-ccss-emerging-priorities-womens-health
2. Click on the REGISTER/TAKE COURSE tab
   a. If you have previously used the CEPO CMS, click login.
   b. If you have not previously used the CEPO CMS, click register to create a new account.
3. Click "ENROLL."
4. Follow the onscreen prompts to complete the following for each session you wish to claim CE/CME Credit:
   a. Read the Accreditation Statement
   b. Select the CE/CME credit type(s) you are seeking
   c. Complete the Evaluation
   d. Take the Posttest
   e. Download your Certificate(s)
   f. Complete the Commitment to Change survey (optional)
5. After completing the posttest at 80% or above, your certificate will be available for print or download.
6. You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
7. If you require further support, please contact us at dha.ncr.j7.mbx.cepo-cms-support@mail.mil