



July 14, 2022

The Honorable Jerrold Nadler
Chair
Committee on the Judiciary
United States House of Representatives
Washington, D.C. 20515

The Honorable Jim Jordan
Ranking Member
Committee on the Judiciary
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Nadler and Ranking Member Jordan:

On behalf of the American Academy of Family Physicians (AAFP) and the 127,600 family physicians and medical students we represent, I write in response to the hearing [“Whats Next: The Threat to Individual Freedoms in a Post-Roe World”](#) to share the family physician perspective on how the Supreme Court’s decision on *Dobbs v. Jackson Women’s Health* is impacting patient care and the practice of medicine.

Primary care physicians are often a patient’s first point of contact with the health care system, with more than half of all office visits made to primary care physicians.¹ Family physicians are integral to the reproductive health of adolescents, teens, and adults, providing preventive health, chronic disease management, family planning, preconception counseling, pregnancy, postpartum, and menopausal care for patients across the gender spectrum throughout their reproductive years. While some patients seek care from pediatricians or obstetrician-gynecologists (OB/GYNs), in rural and underserved areas, family physicians are often the primary or sole providers of reproductive health care.² **The AAFP believes that pregnancy and reproductive health services are essential to general health care.**³

The AAFP is concerned by the Supreme Court’s ruling on *Dobbs v. Jackson Women’s Health*. This consequential ruling struck down the longstanding protections afforded by *Roe v. Wade* and *Planned Parenthood v. Casey*, jeopardizing the health and reproductive autonomy of patients across the country. The decision limits the ability of physicians in many states to provide safe, evidence-based medical care and erodes the patient-physician relationship. **In response to the *Dobbs* ruling, the AAFP joined with the American College of Obstetricians (ACOG), the American Medical Association (AMA), and 75 other health care organizations in releasing a [statement](#) unequivocally opposing legislative interference in the patient-physician relationship.**⁴

The AAFP’s policy on reproductive and maternity health services states, **“The AAFP supports access to comprehensive pregnancy and reproductive services, including but not limited to abortion, pregnancy termination, contraception, and surgical and non-surgical management of ectopic pregnancy, and opposes nonevidence-based restrictions on medical care and the provision of such services.”**⁵ In the case of *Dobbs v. Jackson Women’s Health Organization*, the AAFP joined the AMA and other leading medical societies in filing an [amicus brief](#) articulating our position that “laws regulating abortion should be evidence-based, supported by valid medical or scientific justification, and designed to improve – not harm – women’s health,” and we maintain that position.⁶

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Without the federal protections afforded by *Roe*, numerous states have already enacted laws banning or unduly restricting access to abortion, and more are considering similar measures. **These laws jeopardize the health of our nation and will surely worsen health disparities.** In addition to undermining patients' bodily autonomy and potentially endangering their health and wellbeing by precluding or delaying access to induced abortions, the *Dobbs* decision may also jeopardize access to certain forms of contraception and negatively affect medically necessary maternity care.

Violating the Patient-Physician Relationship and Interfering with the Practice of Medicine

Family physicians are trained to care for their patients throughout the life cycle and appreciate the challenges that adolescence, sexuality, family planning, balance of family life and career, and aging have on their patients, in addition to socioeconomic and community factors such as environmental quality, income and education level, housing availability, neighborhood safety, and social-connectedness health. Because of this, family physicians are able to provide evidence-based medical care personalized to meet each patient's unique health needs. The AAFP maintains that physicians should be free to have open and honest communication with patients about all aspects of health and safety. **The AAFP staunchly opposes legislation that infringes on the content or breadth of information exchanged within the patient-physician relationship and legislation that interferes with the provision of evidence-based medical care, either of which can harm the health of the patient, the family, and the community.**⁷⁸

While only a minority of physicians — roughly 3% of family physicians and 24% of OB/GYNs — perform abortions, **nearly every clinician who cares for patients of reproductive age and practices in a state where abortion is banned is affected by the *Dobbs* decision.**⁹¹⁰ Since June 24, the AAFP and its state affiliates have received inquiries from members who are unclear about the definitions and requirements of their new or pending state laws. Below are some common topics of confusion and concern.

- **Treatment of ectopic pregnancies, pregnancies of unknown location, and complicated spontaneous abortions (i.e., miscarriages).** Many state laws create ambiguity about whether treatment for ectopic pregnancy is considered abortion, creating physician or hospital fears of violating laws and setting the stage for disagreements in clinical judgment, which can lead to delays in critical and medically necessary care.
- **Molar pregnancy.** This type of genetically abnormal pregnancy cannot end in fetal viability, but in some rare instances the abnormal fetus can have detectable cardiac activity, leading to confusion over whether “heartbeat laws” allow physicians to treat with a dilation and curettage (D&C).
- **Preterm premature rupture of membranes.** When membranes rupture prematurely prior to viability, the standard of care is to deliver the fetus with surgery or induce labor, which may be considered illegal in some states, even though the fetus cannot possibly survive. Failure to do so could lead to dire consequences for the patient such as intrauterine infections which could become life-threatening.
- **Cancer treatment for patient with pre-viable pregnancies.** Some cancer treatments require pregnancy termination before beginning, and others carry an increased risk of morbidity and mortality without immediate termination and surgical removal. Disagreements in clinical judgment or fears of violating laws can lead to delays in cancer care or incomplete counseling on treatment options. Abortion-ban laws and proposed bills in some states allow abortions only in severe, life-threatening emergencies. It is unclear if, under such laws, termination of a pregnancy is legal in these cases, delaying the pregnant patient's access to lifesaving treatment until after a pregnancy is carried to term.
- **Use of emergency contraception and IUDs.** Confusion over whether statutory definitions of “personhood” outlaw the use of emergency contraception, and if contraception methods which

interrupt the implantation of a fertilized egg will be considered an abortion under certain state laws, is fueling misinformation and fear and limiting access to contraception. Issues so far include pharmacists refusing to dispense prescriptions for ulipristal or stock/sell over-the-counter oral emergency contraception, hospitals discontinuing provision of emergency contraception to rape victims, and physicians being unsure about or unwilling to place copper IUDs as emergency contraception.

- **Dispensing of medications to manage miscarriages or treat other conditions unrelated to pregnancy.** Pharmacists refusing to dispense or delaying filling misoprostol prescriptions can lead to additional burden for the prescribing physician and delays in needed care for patients. In addition to inducing abortion, this drug is commonly used in the treatment of ulcers, miscarriages, and post-delivery bleeding. There have also been reports of pharmacists refusing to fill or physicians stopping prescribing methotrexate, which is commonly used to treat rheumatoid arthritis and psoriasis.¹¹
- **Treatment of infertility.** Patients and physicians alike are confused over whether statutory definitions of “personhood” will impact infertility treatments and assisted reproductive technology such as in vitro fertilization (IVF). Regardless of whether state laws intend to interfere with infertility care, the lack of clarity is already hindering patients’ reproductive decisions. In this instance, abortion bans may have the unintended consequence of preventing patients who want to become pregnant from being able to grow their families.

In 2018, the AAFP, the American Academy of Pediatrics (AAP), ACOG, and the American College of Physicians (ACP) adopted [joint principles for protecting the patient-physician relationship](#) in response to the growing number of policy proposals that inappropriately interfered in the practice of medicine.¹²

Our organizations and the more than 400,000 physicians and medical students we represent call on policymakers to put patients first by taking these actions.

1. **Support participation of any qualified provider in federally and state-funded programs.** Medicaid’s “any willing provider” and “freedom of choice” protections are enshrined into law to ensure that an adequate number of clinicians participate in the Medicaid program to care for beneficiaries. Evidence has demonstrated that restricting participation of qualified providers results in loss of access to critical care for our most vulnerable patients.^{13,14}
2. **Maintain coverage of evidence-based essential health benefits such as maternity coverage and women’s preventive services without cost-sharing, including contraception.** Preserving access to this existing coverage is critical to ensuring that American women and families have access to the care they need.
3. **Ensure that evidence-based federal programs, including Title X and the Teen Pregnancy Prevention Program (TPPP), receive continued federal funding and preserve evidence-based program requirements.** Title X is the only federal program exclusively dedicated to providing low-income and adolescent patients with essential family planning and preventive health services and information. Evidence-based sexuality education programs help young patients achieve their educational and professional goals by educating them about sexual health, including preventing unintended pregnancy and family planning. These and other federal programs must continue to provide non-directive, comprehensive, medically accurate information.
4. **Reject government restrictions on the information our patients can receive from their doctors.** Patients expect medically accurate, comprehensive information from their physicians. This dialogue is critical to ensuring the integrity of the patient-physician relationship. When outside entities restrict the information that can be given to patients of reproductive age or force physicians to provide them with medically inaccurate information, it can result in increased rates of unplanned pregnancy, pregnancy complications, and undiagnosed medical conditions.

Patient Safety Concerns

Family physicians are concerned about how overturning *Roe* will impact their practices. First and foremost, however, they are concerned about the health and safety of their patients and their patients' families. The AAFP [believes](#) that high-quality health care in family medicine is the achievement of optimal physical, mental, and behavioral health outcomes through accessible, safe, cost-effective, equitable care that is based on the best evidence; responsive to the needs and preferences of patients and populations; and respectful of patients' families, personal values, and beliefs.¹⁵ **Laws that unduly restrict, criminalize, or penalize the provision of safe, confidential, evidence-based medical care are a threat to patient safety.** Such laws not only interfere with the prevention, diagnosis, and treatment of health conditions but also prevent family physicians and their staff from [adapting their care](#) to meet the unique needs of their patients and communities.

Anecdotes and research on the impacts of institutional abortion restrictions offer evidence for how such restrictions put patients' health and lives at risk.^{16,17} Physicians in these settings recount cases in which abortion was medically indicated according to their clinical judgment but, because of an ethics committee's ruling, care was delayed until fetal cardiac activity was no longer detectable or in some cases the patient had to be transported to another facility. **What is clear is that the patient-physician relationship, patient safety, and patient comfort are compromised by arbitrary restrictions that force clinicians to act contrary to the medical standard of care.**

As confusion over new state abortion laws and anxiety about legal liability grow, cases such as these, in which patients experience delay or denial as they seek critical and in some cases lifesaving care, will multiply. The result will be worse health outcomes and greater health disparities nationwide.

The AAFP [advocates](#) for the development and use of patient-centered, evidence-based clinical practice guidelines that adhere to principles based on the National Academy of Medicine Standards for Trustworthy Guidelines.¹⁸ **The AAFP opposes enshrining non-evidence based medical guidelines into federal or state law.**

Criminalization and Penalization of Medical Care

The AAFP takes all reasonable and necessary steps to [ensure that evidence-based medical decision-making and treatment, exercised in accordance with evidence-based standards of care, does not become a violation of criminal law.](#)¹⁹

Recently, the AAFP, AAP, ACOG, ACP, the American Osteopathic Association (AOA), and the American Psychiatric Association (APA) issued a [statement opposing the criminalization of health care](#): **"We are deeply concerned that legislation and legal opinions across the country will endanger patients and clinicians by allowing private citizens and policymakers to interfere in health care decision-making. The patient-physician relationship, not politics, is the backbone of medicine."**²⁰

In the wake of the Supreme Court's *Dobbs* ruling, physicians in states that restrict abortion face a perilous new legal reality. Physicians who perform abortions risk violating the law, being sued, losing their medical license, and going to jail. In some extreme instances, even counseling patients who want an abortion, including those facing pregnancy complications, could expose the physician to criminal charges.

The AAFP has heard from family physicians in states that have banned or restricted abortion, and in states that have not, that they are worried about their own legal safety. **It is clear that the**

criminalization and penalization of patients and clinicians disrupts and detracts from medical care.

Physicians and hospital administrators worried about the threat of lawsuits or criminal charges for violating a state’s abortion ban may be inclined to practice “defensive medicine,” ordering unnecessary or excessive tests or procedures in order to thoroughly demonstrate that a patient meets the narrow definition for an allowable exception to an abortion ban. Evidence suggests that defensive medicine does not make patients any healthier but can lead to increased health care costs.²¹ **Family physicians have also shared concerns that having to wait on extraneous tests and second opinions can delay critical care in urgent and life-threatening situations.**

Family physicians report that they have received mixed or incomplete legal guidance from their employers in the past several weeks, leading to confusion or even confrontation among clinicians who are unsure of their standing or disagree about the best way to treat a patient while complying with new legal requirements. Small and solo physician practices do not have the luxury of in-house or contracted legal support to help them navigate rapidly changing state laws. Many of them are turning to their state and national medical societies, such as the AAFP, which typically lack state-specific legal expertise or are prohibited from offering individual legal advice.

Legal threats to the practice of medicine are also increasing physicians’ administrative burden and practice expenses. As a means of proactive legal defense, many hospitals, clinics, and health systems are advising or mandating that their clinicians enhance their medical documentation for reproductive health care and related services.²² This can mean changes to electronic medical records (EMR) systems and processes, which are costly, time-consuming, and add to physicians’ administrative burden. Smaller practices rely on off-the-shelf EMR systems and cannot readily automate new documentation requirements, meaning they must spend additional time conducting manual data entry.

Additionally, physicians and hospital administrators are worried that if they opt not to provide specific care based on their understanding of state abortion restrictions, they could face liability and/or violate federal requirements under the Emergency Medical Treatment and Labor Act (EMTALA). State laws that allow only narrow abortion exceptions when the mother is at risk of dying are at odds with the EMTALA standard, which focuses on conditions that seriously jeopardize health, bodily, or organ function.²³

The AAFP is [concerned](#) about high rates of professional burnout among physicians in the U.S., which negatively affects the quality of patient care and can result in physicians leaving practice.²⁴ **The costs and anxiety associated with abortion-related legal issues are negatively impacting the well-being of family physicians and will only compound physician burnout.**²⁵ If not addressed, this will ultimately lead to more physicians leaving the profession or moving into non-patient-facing roles, worsening health care workforce shortages and patients’ access to care.

Disrupting Medical Education and Exacerbating Health Care Workforce Shortages

The AAFP recommends that all medical students and family medicine residents receive comprehensive training in reproductive decision-making.²⁶ Family medicine residency programs teach clinical skills to provide counseling, screening and diagnostic testing, treatment, and appropriate referrals provided to patients during menarche, contraception, pregnancy, lactation, and menopause. This includes performing routine gynecologic procedures, patient-centered contraceptive counseling, placement of long-acting reversible contraception (LARC), preconception counseling, diagnosis of pregnancy, counseling for unintended pregnancy, assessment and management of complications and symptoms in the first trimester, pregnancy risk-factor screening, miscarriage

management and referral for surgical intervention when indicated for complicated miscarriages, D&C procedures, and assessment and management of obstetrical and other medical complications during pregnancy including consultation with obstetricians/medical subspecialists.²⁷²⁸

Because family physicians are trained to provide such a wide range of reproductive health services, they are well positioned to provide early abortion care to their patients in the primary care setting, which can enhance continuity of care, offer increased access for patients, and reduce stigma. **The AAFP recommends that family medicine residents have access to opt-out abortion training, to support widespread access to comprehensive training in reproductive decision-making while ensuring that no physician or health care professional is required to perform actions that violate personal beliefs.**²⁹ In addition to providing physicians with the critical procedural and counseling skills to care for patients who have induced abortions, abortion training also helps prepare physicians to meet patients' other obstetric needs, such as direct counseling, uterine evacuation and miscarriage management.³⁰³¹

The Society of Teachers of Family Medicine strongly opposes restrictions on educating family medicine trainees on the full scope of clinical care and advocates that Congress and federal agencies should not legislate or mandate restrictions on the educational content of training programs.³² Such restrictions limit and adversely affect medical education. In a [statement](#) following the Supreme Court's decision to overturn *Roe*, the Association of American Medical Colleges asserts, **"It is crucial that physicians have comprehensive training in the full spectrum of reproductive health care, since similar medical procedures address many health conditions."**³³

As states enact or contemplate laws banning or restricting abortion, medical schools, residency training programs, and educators are grappling with how to reconcile these laws with medical accreditation requirements. The Accreditation Council for Graduate Medical Education (ACGME) requires access to abortion training for all OB/GYN programs. While access to training is not required for Family Medicine programs, some offer integrated abortion training or local elective options, and ACGME does clearly require comprehensive reproductive health and contraception education as part of Family Medicine training.³⁴³⁵³⁶ A recent paper analyzing current OB/GYN residency programs found that around 45% are in states that have banned or are likely to ban abortion, and at least three family medicine residency programs offering integrated abortion training are in states that have banned the procedure in the wake of the Supreme Court's *Dobbs* decision.³⁷³⁸

In response, residency programs facing new state restrictions are considering providing their residents with access to clinical training in other jurisdictions without legal restrictions on abortion. However, **requiring or facilitating travel rotations to receive abortion training is unlikely to be feasible on a widespread scale, given the resources required and the disruptions to clinical care that resident absences cause.** Additionally, family planning clinics that often precept medical residents on rotation from other areas are already beginning to cut back on training because they are grappling with huge influxes of patients and lack the staff capacity to provide both patient care and medical education.³⁹⁴⁰

In addition to disrupting training for current medical students and residents, state abortion restrictions are likely to have a significant impact on future trainees. Students intending to provide family planning as part of their medical practice who are applying to medical school and residency programs will have to decide whether they are willing to risk being trained in a state that does not provide abortion care.⁴¹ Experts predict that medical schools and residency programs in those states will see fewer applicants, whereas programs located in states that still allow abortion care will be inundated.⁴² **In the short term, this will worsen the problem of unmatched medical**

students. Over time this will exacerbate maternity care shortages and intensify the maldistribution of physicians.

Experts also predict that physicians in states with abortion bans will begin to leave because they do not wish to practice in a place where they are not able to provide comprehensive, patient-centered care without government intrusion. **Given the current geo-political divide in the U.S., this will worsen access to care for rural communities and increase rural health disparities.**

Jeopardizing Contraception Access

Health promotion – including screening, counseling, and vaccination – is a foundation of family medicine, and for much of their reproductive lives most women try to prevent pregnancy, which is why **the AAFP believes physicians should counsel their patients to decrease the number of unwanted pregnancies, and why the AAFP advocates for public and private health plans to provide coverage and not impose cost-sharing for all Food and Drug Administration- (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all patients with reproductive capacity, including contraceptive methods for sale over the counter.**⁴³

Confusion over whether statutory definitions of “personhood” outlaw the use of emergency contraception, and if contraception methods that interrupt the implantation of a fertilized egg will be considered an abortion under certain state laws, is fueling misinformation and fear and limiting access to contraception. In one example, the AAFP heard from a family physician who, after their state enacted its trigger law banning abortion without exception for rape or incest, saw hospitals in their city temporarily stop offering emergency contraception to rape victims, despite the fact that clinical guidelines for treating sexual assault victims call for it to be provided.

The AAFP applauds recent actions by the Administration, including the July 8 Executive Order reaffirming the Affordable Care Act’s guarantee of insurance coverage for women’s preventive services, including birth control and contraceptive counseling, and directing the Centers for Medicare and Medicaid Services (CMS) to ensure patient access to family planning care and protect clinicians providing family planning services.⁴⁴

We urge Congress to pass legislation to protect and expand patients’ access to FDA-approved contraception methods and comprehensive, evidence-based contraception counseling. The AAFP has endorsed the Affordability Is Access Act ([S. 4347/H.R.7394](#)) and the Access to Birth Control Act ([S. 3223/H.R. 6005](#)). The AAFP also urges Congress to ensure robust and sustained federal funding for Title X family planning programs.

Potential for Abuse of Patient Data and Violation of Patient Confidentiality

A confidential relationship between patient and physician is essential for the free exchange of information necessary for sound medical care. Only in a setting of trust can a patient share the private feelings and medical, social, and family histories that enable the physician to properly counsel, prevent, diagnose, and treat. **The AAFP believes that patient confidentiality must be protected.**⁴⁵

The AAFP’s [policy on data stewardship](#), which addresses how de-identified clinical and administrative data derived from physicians’ EMRs are collected and used by third parties, states that submission of data from physician practice to third parties must be voluntary, third parties must provide written policies detailing the intended uses of such data, and data storage must adhere to industry and regulatory standards for confidentiality.⁴⁶

The Supreme Court's *Dobbs* decision has raised questions about whether and how technology companies should protect their users' data, particularly when the user is seeking reproductive health care. Experts believe that the United States' lack of strong digital privacy protections is likely to have profound implications on how state laws that ban or restrict abortion are enforced.⁴⁷ While clinicians and health care organizations must follow the Health Insurance Portability and Accountability Act (HIPAA)'s Privacy Rule, which protects against disclosures of protected health information (PHI), other entities and data that do not qualify as PHI are not bound by the same rules. Police and prosecutors could potentially obtain extremely detailed information about individuals from technology companies, including internet search histories, communications, finances, and location information and use that information to surveil or charge them for violating state abortion law. In the case of laws such as Texas' S.B. 8, which allow private citizens to sue suspected abortion patients and providers, such data could also be used to enable vigilante interference.

The AAFP applauds HHS for issuing guidance clarifying how federal laws and regulations protect patients' PHI and the circumstances under which the HIPAA Privacy Rule permits disclosure of PHI without the patient's authorization. However, because HIPAA does not generally protect the privacy and security of individuals' personal information stored on cell phones or gathered by search engines and third-party applications, **the AAFP calls on Congress to further examine the implications of overturning *Roe* on patient privacy and to enact laws to protect patients from inappropriate exploitation of their data, including criminal or civil punishments for seeking medically appropriate health care.**

The AAFP has endorsed the Health and Location Data Protection Act ([S. 4408](#)), which prohibits data brokers from selling and transferring customers' health and location data and requires the Federal Trade Commission to promulgate rules to implement and enforce these protections.

Exacerbating Health Disparities Experienced by Marginalized Patients

The Supreme Court's decision to overturn *Roe* will make it even more difficult for patients to access high-quality health care in the U.S. The risks will be felt most acutely by people of color, from low-income backgrounds, and who live in rural areas.⁴⁸⁴⁹

According to analysis by the Guttmacher Institute, nearly one in four women in the U.S. has an abortion by age 45.⁵⁰ **While the abortion rate has been declining over the past four decades, it remains a common procedure; however, abortion rates vary considerably by patient income and race and ethnicity.**⁵¹

Nearly half of all patients who have an abortion have incomes below the federal poverty level, and Black and Hispanic patients have abortions at considerably higher rates than non-Hispanic white patients.⁵² There are many reasons for these disparities, but studies show that Black and Hispanic patients are less likely to have access to health care – including access to high-quality contraceptive services – and are more likely to face racism and report negative experiences when they do seek health care.⁵³ People of color are also more likely to live in high-poverty neighborhoods and less likely to move out of poverty in adulthood than their white counterparts, due in large part to systemic racism and generational barriers.⁵⁴ Black women are three times as likely as white women to experience and unintended pregnancy, and Hispanic women are twice as likely.⁵⁵ Research has also found that low-income Black children are less likely to receive formal sex education,⁵⁶ and Black women also experience the highest rates of intimate partner and sexual violence, which can contribute to reproductive coercion.⁵⁷

Restricting abortion without addressing geographic, economic, and cultural barriers to comprehensive health care and family planning will worsen racial health disparities and perpetuate cycles of disadvantage for women of color.⁵⁸⁵⁹

The United States' maternal mortality rate is alarmingly high and reveals faults that exist within the current health care system. Approximately 700 women die from pregnancy-related complications annually in the United States.⁶⁰ There are numerous factors influencing pregnancy-related mortality and morbidities, such as advanced maternal age, education attainment, and underlying health status.⁶¹ **Large disparities in maternal health outcomes exist between women who belong to racial and ethnic minority groups and white women.** The U.S. Centers for Disease Control and Prevention's (CDC) 2019 *Morbidity and Mortality Weekly Report* stated that non-Hispanic Black (Black) and non-Hispanic American Indian/Alaska Native (AI/AN) women experienced higher pregnancy-related morbidity ratios (40.8 and 29.7, respectively) than all other racial/ethnic populations. (White PRMR was 12.7, Asian/ Pacific Islander PRMR was 13.5, and Hispanic PRMR was 11.5.)⁶² **Disparities for pregnancy outcomes also exist when comparing women living in rural areas with those living in urban areas.**⁶³

Black and low-income patients and patients from rural communities are more likely to live in states that have banned or are likely to ban abortion since the Supreme Court overturned *Roe*. **A recent study estimating the mortality impact of a total abortion ban, due to increased deaths from untermiated pregnancies, would increase pregnancy-related deaths, most acutely for Black women.**⁶⁴

According to the AAP, **laws that restrict access to reproductive health care also have a disproportionate impact on adolescents and teenagers, who typically do not have the resources or freedom to travel to another state to receive safe, legal health care.**⁶⁵ Family physicians are optimally trained, qualified, and experienced in evaluating and addressing the complex medical and behavioral health care needs of adolescents. The AAFP [values](#) the sexual health of adolescents and [advocates](#) for access to comprehensive medical and behavioral health care, evidence-based sex education, and increasing awareness of risks and signs of sexual abuse and trafficking, and [supports](#) a trauma-informed approach to health care.⁶⁶⁶⁷⁶⁸ **That is why the AAFP joins the AAP in affirming strong support for adolescents and teens to receive comprehensive evidence-based reproductive health care services, including abortion.**

The AAFP [recognizes](#) sexual assault as a serious public health issue and [supports](#) the rights of survivors of sexual assault, sexual violence, and all sexual crimes.⁶⁹⁷⁰ The AAFP [calls for](#) prioritization of the survivor's wellbeing, emphasizing the need for compassionate treatment, and supports a legal framework that codifies the rights of, and protections for, survivors of sexual assault.⁷¹ Rape is a cause of many unwanted pregnancies, with an estimated one in 20 women between the ages of 12 and 45 becoming pregnant due to rape.⁷² Rape is traumatic and often has long-lasting physical and psychological health consequences. **Laws that ban abortions without exception for rape and incest contradict the AAFP's [policy on trauma-informed care](#) and place rape victims at higher risk for future medical, psychological, and socioeconomic challenges.**⁷³

Family physicians report that, in states with abortion bans that allow exceptions in cases of rape or incest, eligible patients still face barriers to timely access to care. In order to qualify for an exception, patients and/or their clinician usually must provide a police report documenting the offense. Surveys indicate that fewer than a quarter of rape survivors report assault, and experts estimate the percentage is much lower for children, adolescents, and youth in foster care and juvenile systems.⁷⁴ Family physicians who care for victims of rape cite family and domestic violence and economic insecurity as possible response for non-reporting. **Requiring victims of rape and incest and their**

treating clinicians to jump through legal and administrative hurdles to document eligibility for a legal exception delays access to time-sensitive abortion care.

The AAFP acknowledges that LGBTQ+ individuals, youth in foster care or the juvenile justice system, and incarcerated individuals face exceptional hardships when attempting to access health care and are at greater risk for adverse medical and mental health outcomes and recognizes that state laws banning and restricting access to abortion will undoubtedly exacerbate the health disparities experienced by these vulnerable populations. We urge policymakers to study the implications of federal and state policy changes on these unique populations in order to develop appropriate solutions to mitigate the serious challenges they encounter.

Underscoring the Need for Universal Access to Health Care and Addressing Social Determinants of Health

The AAFP [recognizes health as a basic human right](#) for every person, regardless of social, economic or political status, race, religion, gender, or sexual orientation. The right to health includes universal access to timely, high-quality, and affordable health care services.⁷⁵ **We continue to [call on Congress](#) to pass legislation to expand access to comprehensive, affordable health care, including by expanding Medicaid and CHIP coverage to 12 months postpartum, ensuring 12 months of continuous eligibility for children enrolled in Medicaid and CHIP, closing the Medicaid expansion coverage gap, and making the American Rescue Plan’s enhanced marketplace subsidies permanent.** Family physicians understand that the health of their individual patients and communities is affected by social determinants of health, which is why **the AAFP urges lawmakers to adopt a “health in all policies” approach that considers the broad health implications of policies not traditionally discussed as health care–related (such as housing and urban development, transportation, education, etc.).** Expanding health coverage and addressing social determinants of health will undoubtedly reduce unintended pregnancies, improve maternal and child health outcomes, and ultimately improve the health and productivity of our nation.

The AAFP has [called on](#) HHS and other federal agencies to use every available lever to protect patient safety, support family physicians and other clinicians, and strengthen timely access to reproductive health care, including medication abortion and contraception, in accordance with federal law.⁷⁶

We now urge Congress to take swift legislative action and utilize its federal oversight authority to restore, protect, and improve patients’ access to timely, comprehensive reproductive health care and clinicians’ ability to provide evidence-based medical care.

The AAFP has [endorsed](#) the House-passed Women’s Health Protection Act ([S. 4132](#)), and we continue to [urge](#) the Senate to pass this critical legislation to codify federal protections for reproductive health care.⁷⁷ The AAFP also supports the Ensuring Access to Abortion Act ([H.R. 8297](#)) which protects patients’ rights to travel across state lines to seek abortion services. **Absent federal law guaranteeing all patients have the right to abortion, it is imperative that patients be able to travel to seek safe, quality medical care without threat of penalty of persecution.**

The AAFP stands ready to partner with the Committee to protect the patient-physician relationship and reproductive health care. Should you have any questions, please contact Erica Cischke, Director of Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,



Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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