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Family Medicine

COMMENTARY

Equity and Justice in Family Medicine Clinical Care and Teaching Must Incorporate a Reproductive Justice Framework

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ABSTRACT

Since European settlement, the United States has controlled the reproduction of communities of color through tactics ranging from forced pregnancies, sterilizations, and abortions to immigration policies and policies that separate children from their families. Lesbian, gay, bisexual, transgender, queer (or questioning), asexual, intersex, and gender diverse people (LGBTQIA+) have been persecuted for sexual behavior and gender expression, and also restricted from having children. In response, women of color and LGBTQIA+ communities have organized for Reproductive Justice (RJ) and liberation. The Reproductive Justice framework, conceived in 1994 by the Women of African Descent for Reproductive Justice, addresses the reproductive health needs of Black women and communities from a broad human rights perspective. Since then, the framework has expanded with an intersectional approach to include all communities of color and LGBTQIA+ communities.

Notwithstanding, reproductive *injustice* negatively impacts the health of already marginalized and oppressed communities, which is reflected in higher rates of maternal mortality, infant mortality, infertility, preterm births, and poorer health outcomes associated with race-based stress. While the impact of racial injustice on disparate health outcomes is increasingly addressed in family medicine, Reproductive Justice has not been universally incorporated into care provision or education. Including the RJ framework in family medicine education is critical to understanding how structural, economic, and political factors influence health outcomes to improve health care delivery from a justice and human rights perspective. This commentary describes how an RJ framework can enhance medical education and care provision, and subsequently identifies strategies for incorporating Reproductive Justice teaching into family medicine education.

INTRODUCTION

While the June 2022 Dobbs decision to overturn *Roe v Wade* seems to have woken the collective consciousness of many Americans about US abortion access, it is only one of many instances of unjust reproductive health policies and restrictions that has led to poor health outcomes for communities of color.[1,2] The Reproductive Justice (RJ) framework,[1] conceived in 1994 by the Women of African Descent for Reproductive Justice, addresses the reproductive health needs of Black women and communities from a human rights perspective. Specifically, RJ is defined as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[3] Achieving these rights requires the transformation of all systems that impact reproduction, including political, social, environmental, and economic institutions and policies. Since 1994, the framework has been expanded with an intersectional approach[4] to include all marginalized groups, encompassing both communities of color and lesbian, gay, bisexual, transgender, queer (or questioning), asexual, intersex, and gender diverse people (LGBTQIA+) communities.

While the impact of racial injustice on inequitable health outcomes is now increasingly recognized in clinical practice and family medicine education, the tenets of RJ have not been universally incorporated into care provision or family medicine education.[5] Including the RJ framework in family medicine education is pivotal for learners to understand how structural, economic, and political factors influence reproductive health outcomes so that, as a family medicine community, we may subsequently improve health care delivery from a justice

and human rights perspective. Notice that throughout this commentary, we use binary gender terms (eg, women) when such terms correspond to the related data, literature, specific framework, or gender identity of individuals being discussed; otherwise, as a demonstration of the Reproductive Justice principle of addressing intersectional oppressions, we use gender nonbinary terms (eg, pregnant people) to center and include all people who are capable of pregnancy.

US History of Reproductive Injustice

Since European settlement, the reproduction of communities of color has been systematically controlled in the United States, from forced pregnancies, sterilizations, and abortions,[2] to policies that separate children and families.[1,6–9] Oppressive systems, including racism, colorism, homophobia, transphobia, ableism, and misogyny, have disproportionately impacted the health and well-being of communities of color. Involuntary sterilization, including vasectomies, hysterectomies, and tubal ligations, began in the early 1900s with the eugenics movement.[1] State-sanctioned sterilization programs targeted Black, Indigenous, and Latine/x people, many of whom were in psychiatric institutions, incarcerated, or living in poverty.[6,10,11] Family separation and control of family formation have been practiced extensively since colonization[1,12] and the inception of American slavery.[2] Even in cases where a societal gain has been touted with respect to reproductive health, that gain often has come at a cost to communities of color. For example, now known as the mothers of gynecology, Anarcha, Lucy, Betsey, and other enslaved Black women whose names are lost, suffered innumerable experimental and tortuous surgeries at the hands of physician J. Marion Sims, who is credited with developing vesicovaginal fistulas repairs and the speculum, and has been touted as the father of modern gynecology. However, the names and stories of those he experimented on without consent or anesthesia are the true founders of gynecology.[6,13] While we praise the advent of the birth control pill, Puerto Rican, Mexican, and Haitian patients were primary subjects during the initial testing phases, which were conducted without consent and specifically targeted low-income, disadvantaged populations that were not informed of potential and known adverse reactions.[14]

The Problem: Contemporary Policies and Their Implications for Clinical Care

While marginalized and oppressed communities have long organized and resisted state-sanctioned reproductive coercion and control,[2] the dominant systems of modern medicine have maintained and promoted the status of reproductive injustice.[2,6,8,10] Systemic reproductive injustice perpetuates health inequities that disproportionately impact communities of color, particularly Black, Indigenous, and Latine/x people.[1,8,15] Notable inequities include disproportionate rates of maternal mortality,[15] infertility,[16] preterm birth,[17] and infant mortality.[18,19] State surveillance of pregnancy outcomes and poor health outcomes from family separation disproportionately impacts individuals and families of color.[20,21] Less obvious but just as critical are the social, political, and health care systems and policies that cause race-based stress,[17,22] leading to negative pregnancy outcomes, poorer infant and child health, and parenting in unsafe and unstable environments. Simultaneously, the health impacts on other communities are poorly understood due to a lack of data or refusal to disaggregate existing data.

The legacy of reproductive control, including eugenics, is reflected in laws, policies, and clinical recommendations developed to care for "at-risk" populations. Such policies and recommendations ultimately target communities of color, limiting reproductive autonomy and reinforcing environments of surveillance and mistrust.[23,24] Moreover, fertility control and pregnancy planning are often viewed as a panacea for economic empowerment and liberation, ignoring the root causes of inequities.[10,23] For example, reducing unintended pregnancy and abortion rates often is used as a marker for programmatic success, while reproductive autonomy is ignored. In 2015, multiple medical organizations, including the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, recommended a tiered-effectiveness contraceptive counseling model preferentially endorsing long-acting reversible contraception (LARC).[23] Yet, recent research shows that clinicians are more likely to recommend LARC for Black and Latine/x patients and patients with language barriers.[25] Further, clinicians routinely decline to remove LARC devices despite explicit requests from patients.[9] The focus on reducing unintended pregnancy results in the erasure of other reproductive health needs. For example, while infertility disproportionately impacts Black, Latine/x, and Asian individuals, persistent disparities exist in treatment outcomes and access due to inadequate research, lack of insurance coverage (especially among publicly funded insurances), and limited clinical provision.[26] Additionally, assisted reproductive technology and comprehensive reproductive health care are often unavailable to LGBTQIA+ individuals and families.[27]

State control over pregnant people's bodily autonomy and ability to raise children in safe environments has persisted and now manifests as criminalization of pregnancy loss, stillbirth, and abortion as well as family separation through the child welfare system—which again, disproportionately impact people of color.[24,28,29] Disconcertingly, the health care system often cooperates with the criminal justice system,[28] whether purposefully or compelled, in the disproportionate surveillance and criminalization of pregnant and birthing people of color and separation from their children.[24,29] Criminal investigations and arrests of individuals suspected of either self-managing or helping to self-manage abortion are rising, and a homicide consideration is two times more frequent in cases involving a person of color compared to cases involving a White person. Nearly half of criminal reports come from health care providers or social workers, despite the clear violation of patient privacy regulations, lack of any state or federal laws mandating reporting, and the similarities in presentation and management of early pregnancy loss

and self-managed abortion.[30] While White pregnant people have similar or higher prevalence of drug use,[31] Black and Latine/x pregnant people are more likely to be selected for nonconsensual drug testing; and those positive tests are more likely to result in punitive charges or loss of parental rights.[32] Black and Indigenous families are disproportionately more likely to be reported by health care providers for child abuse or neglect and to experience forced separation and termination of parental rights.[29] Black and Indigenous children also are more likely to enter the foster care system despite the availability of biologic and chosen families.[33] These examples of forced separation and surveillance reflect clear violations of one of the main, and perhaps most important, tenets of RJ: the right to parent children in safe environments, free from harm. Recent reports noting that many pregnant and birthing people and their families enter the criminal justice system at the hands of health care providers who notify the authorities should be cause for concern by educators and clinicians, and highlight the need for investing in relationships with community-based organizations to support families as alternatives to the unintended consequences of criminalization. As clinicians, we must remember our responsibility to protect our patients' rights.

Strategies for Incorporating RJ Into Family Medicine Residency Education

As a specialty, we can act to mitigate the problem of reproductive injustice. Family medicine has already made strides toward health equity by considering models of care that apply principles of justice and antiracism.[34] We would be remiss if we overlook the importance of teaching and applying an RJ framework to clinical care. Let us remind ourselves that our specialty prides itself on whole-person, multigenerational, community-based, comprehensive, and socially just care. As educators, we can include broader human rights and racial justice perspectives on delivering health care, including patient autonomy, decision-making, and liberation, using an RJ framework. We can incorporate RJ into family medicine residency through curricula, care modeling, and care delivery.

Curricula

First, sexual and reproductive health (SRH –which specifically includes the provision of and access to clinical sexual and reproductive health services) curricula in family medicine residency training can guide learners to community-led, community-centered educational resources that provide historical contexts of reproductive violence, genocide, and coercion of marginalized groups. These curricula include resources on RJ, intersectionality, human rights, decolonization, critical race theory, and the historic and contemporary legacy of white supremacy in medicine.[35] Such resources can be used as references and guides for educators and learners to begin to understand the contemporary contexts for inequities in SRH (Table 1). In addition, existing online curricula are available to guide both educators and learners[36,37] (Table 1, last row). Such web-based platforms present case-based modules to engage family medicine residents and assess their understanding of RJ principles and their clinical application through knowledge-based questions. The resources listed in Table 1 are specifically meant to provide background information for learners (including family medicine residents and faculty) about the importance of incorporating an RJ framework into teaching and clinical care so that learners understand their own biases and then consider how the knowledge provided and gained can be applied to clinical care and practice. Importantly, the incorporation of RJ and patient-centered care principles into the current Accreditation Council for Graduate Medical Education family medicine milestones[5] is another step that could be taken to help ensure that residents learn, apply, and master these important competencies.

Care Modeling

Next, clinical application of RJ principles in practice, as with any other important clinical skill, comes through experience with patient care and appropriate precepting and modeling by faculty. As educators, we can teach and model patient-centered care[38] that incorporates RJ principles during didactic sessions, iterative precepting, and clinical supervision of learners. A patient-centered model of care includes discussing and demonstrating care that respects patient values and viewpoints and follows patient guidance on reproductive health decisions, including contraceptive, family-building, pregnancy, postpartum, and abortion care while also providing appropriate clinical guidance to patients. As clinician-educators, we can reinforce that patients know best about their bodies, families, and communities—including their decisions about pregnancy and childbearing; this stance is especially important for racial and ethnic groups and other communities that have been historically denied reproductive autonomy.[23,39] Furthermore, we must model and provide patient-centered care for all patients, not just those deemed by the health care system to be "responsible," "intelligent," and/or "well-educated." We can model supportive and respectful care that not only elicits, but also centers patient preferences and choices with respect to SRH throughout the lifespan and for the duration of our relationship with the patient.[39] As educators, we must examine our biases first in order to subsequently impart to our learners important principles, such as listening to and trusting patients, and to provide evidenced-based, unbiased, noncoercive, desired information that reflects RJ principles[40] (Table 2). Moreover, educators can provide support and allyship for learners who may experience or witness behavior from other health care professionals (including other faculty/clinicians/staff) that is in direct opposition to RJ principles, such as the use of racist or demeaning language. We can identify common anti-RJ behaviors that learners may have witnessed and possibly even adopted as we work toward strategies for change.[34,41]

Care Delivery

Lastly, as family medicine educators committed to RJ, our job is to model and teach our learners, namely family medicine resi-

TABLE 1. Resources for Incorporating a Reproductive Justice Framework in Family Medicine Residency Education

Sections	Resources
1. Introduction to Reproductive Justice and Intersectionality	1. Reproductive Justice (12 mins). Activist Loretta Ross. https://www.youtube.com/watch?v=cPzqImu1lgU 2. Ross LJ, Solinger, R. Reproductive Justice: An Introduction. University of California Press; 2017. 3. Universal Declaration of Human Rights & RJ. https://justseeds.org/project/universal-declaration-of-human-rights 4. Silliman J, Gerber Fried M, Ross L, Gutiérrez E. Undivided Rights: Women of Color Organize for Reproductive Justice. Haymarket Books; 2016. 5. The Urgency of Intersectionality (19 mins). Critical Race Theorist Kimberlé Crenshaw. https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality?language=en
2. History and Legacy of Reproductive Violence and Oppression in the United States	1. Roberts, D. Killing the Black Body. Race, Reproduction, and the Meaning of Liberty. Vintage Books; 2017. 2. Dawes, DE. The Political Determinants of Health. Johns Hopkins University Press; 2020. 3. When California Sterilized 20,000 of Its Citizens. Alexandra Minna Stern. https://www.zocalopublicsquare.org/2016/01/06/when-california-sterilized-20000-of-its-citizens/chronicles/who-we-were 4. When Doctors Took 'Family Planning' Into Their Own Hands. Marcela Valdes. https://www.nytimes.com/2016/02/01/magazine/when-doctors-took-family-planning-into-their-own-hands.html 5. No Mas Bebes (documentary). https://www.pbs.org/independentlens/documentaries/no-mas-bebes 6. Some People Say It Was Part of Eugenics. We Say It Was Genocide. Jenn Stanley. https://rewirenewsgroup.com/2017/06/14/choiceless-backstory-episode-3-people-say-part-eugenics-say-genocide/ 7. RJ 101 timeline and facilitation guide. Forward Together. https://forwardtogether.org/tools/rj-101-timeline
3. Resources and Strategies for Change	1. Re-imagining What's Possible: A Future Where Reproductive Justice Is Achieved With Dr. Monica R. McLemore. https://www.pcrprograms.org/re-imagining-whats-possible-a-future-where-reproductive-justice-is-achieved-barnard-center-lecture-series 2. Ojo A, Singer MR, Morales B, et al. Reproductive Justice: A Case-Based, Interactive Curriculum. MedEdPORTAL. 2022;18:11275. https://www.mededportal.org/doi/10.15766/mep_2374-8265.11275 3. Black Mamas Matter Alliance. https://blackmamasmatter.org/resources 4. Black Women's Perspectives on Structural Racism Across the Reproductive Lifespan: A Conceptual Framework for Measurement Development. https://doi.org/10.1007/s10995-020-03074-3 5. Queering Reproductive Justice. https://www.thetaskforce.org/wp-content/uploads/2017/03/Queering-Reproductive-Justice-A-Toolkit-FINAL.pdf
4. Noncoercive Contraceptive Counseling	1. SisterSong and National Women's Health Network. Long-Acting Reversible Contraception Statement of Principles. 2021. https://nwhn.org/larcs/#statement 2. Beyond Efficacy: Applying a Reproductive Justice Framework to Contraceptive Counseling for Young People. Anita Brakman, Taylor Rose Ellsworth, Melanie Gold. https://www.reliasmedia.com/articles/142623-beyond-efficacy-applying-a-reproductive-justice-framework-to-contraceptive-counseling-for-young-people 3. Holt K, Reed R, Crear-Perry J, Scott C, Wulf S, Dehlendorf C. Beyond Same-Day Long-Acting Reversible Contraceptive Access: A Person-Centered Framework for Advancing High-Quality, Equitable Contraceptive Care. American Journal of Obstetrics and Gynecology. 2020;222:S878.e1-S878.e6. https://doi.org/10.1016/j.ajog.2019.11.1279
5. Interrupting Criminalization	1. Beyond Do No Harm: 13 Principles for Health Care Providers to Interrupt Criminalization. https://www.interruptingcriminalization.com/bdnh 2. Goodwin, M. Policing the Womb. Cambridge University Press; 2020. 3. Huss L, Diaz-Tello F, Samari G. Self-Care, Criminalized: The Criminalization of Self-Managed Abortion From 2000 to 2020. If/When/How: Lawyering for Reproductive Justice; 2023. https://www.ifwhenhow.org/wp-content/uploads/2023/10/Self-Care-Criminalized-2023-Report.pdf 4. Artiga S, Hill L, Ranji U, Gomez I. What Are the Implications of the Overturning of *Roe v Wade* for Racial Disparities? KFF. 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities
6. Existing RJ Inclusive Curricula	1. Innovating Education in Reproductive Health. Bixby Center for Global Reproductive Health. Module on Structures & Self: Advancing Equity and Justice in SRH. https://www.innovating-education.org/course/structures-self-advancing-equity-and-justice-in-sexual-and-reproductive-healthcare 2. Ogo A, Singer MR, Morales B, et al. Reproductive Justice: A Case-Based, Interactive Curriculum. MedEdPORTAL. 2022;18:11275. https://www.mededportal.org/doi/full/10.15766/mep_2374-8265.11275 3. RHEDI Justice and SRH Unit. https://rhedi.org/justice-srh-unit

Note: These resources can be used to learn about reproductive justice (RJ) and how to use the RJ lens in education and in clinical practice. As such, Sections 1-5 can be accessed independently as clinicians address specific topics or can be read and discussed sequentially as a curriculum. Resources in Section 6 also provide background information on the importance of incorporating an RJ framework into teaching and clinical care so that learners understand their own biases and then consider how they would use the knowledge provided and gained in the curricula in clinical care and practice. Section 6 can thereby be accessed to initiate learning or after accessing Sections 1-5 for holistic review.

TABLE 2. Sample Precepting Case

Resident (R): I just saw Stephanie, a 17-year-old cisgender woman with no significant past medical history. She is sexually active and has had a hormonal IUD [intrauterine device] for 6 months. She is in a romantic relationship with a cisgender man and states she would like to be a mother soon. She wants me to remove her IUD today. I think that's a terrible idea.
Preceptor (P): OK. Can you tell me more about why you think that?
(R): Well, she's too young. I don't think she is thinking this through, and I don't think she will be able to care for the child. I told her she needs to keep the IUD for a few years.
(P): Why do you think she needs to keep the IUD? Is there someone else in the room with Stephanie or on the phone with her? Does she seem nervous or hesitating—as if she is being coerced or forced to get pregnant?
(R): No, it's just her in the room. I don't think she's being coerced or forced into this decision. But . . . come on, she's still in high school, is living with her family. If she gets pregnant, she likely won't finish high school!
(P): OK, so it seems Stephanie is not being coerced into this decision as you said. This is important to determine, of course, because if coercion or abuse is suspected, we'd need to assess her safety as well as ways we could support her to continue to be protected against pregnancy if that's what she desires. Since Stephanie wishes IUD removal today, we will remove it. Otherwise, we are at risk of coercing her to keep a device in her body that she doesn't want. There is a long history in medicine of clinicians, wittingly or not, controlling the reproduction of the most marginalized patients through clinical encounters such as the one we are having today; this is especially true for patients of color and other marginalized populations deemed "unable" or "unworthy" to have children. Stephanie, her friends, her family, and even other community members may never feel comfortable or trust us to provide contraceptive services or any health care if we act coercively or impose our own views about her personal decision to get pregnant or not. This is an example of applying a Reproductive Justice (RJ) lens in clinical care. Are you familiar? Let's discuss more about RJ at the end of the session today. I will share resources.
(R): I've heard the term RJ, but don't know much about it. It would be great to learn more about it and how it relates to patient care. I'm just concerned about Stephanie's age.
(P): Would your perspective be different if she were 23? Or of a different racial/ethnic background?
(R): I'm not sure. Maybe.
(P): I understand your hesitation about the patient's age because that is what we may be used to or what we have been taught as clinicians, but we cannot make assumptions that Stephanie has no support, that she is poor, or that pregnancy prevention would somehow prevent poverty. (I can also share a good article that challenges that idea.) We are here to support Stephanie and provide evidence-based clinical information, not to coerce her to make a reproductive decision she does not desire. We can certainly counsel her about what to expect during pregnancy, provide resources for pregnancy and postpregnancy support, and counsel about STI [sexually transmitted diseases] testing. These are just a few things we need to consider. Let's see the patient together and talk with her, then remove the IUD and discuss the important next steps for a healthy and supportive pregnancy. We will also let her know if she changes her mind, we can restart or switch birth control methods at any time; and should she become pregnant and later decide that she does not want to continue the pregnancy, we can review the available options.

dents, how to make systemic changes that keep our patients as healthy and safe as possible. The Dobbs decision not only foreshadows that maternal and infant mortality rates will increase dramatically,[42] but also that pregnant people will be criminalized more than ever regardless of pregnancy outcomes, both of which will disproportionately impact racial and ethnic minorities.[30] We can strive to protect pregnant individuals and families from criminalization and racialized child separation. For example, we can model and teach learners how to protect patient information about abortion and early pregnancy loss from state surveillance and criminalization, perform urine drug testing during pregnancy only with informed consent and right of refusal,[43] and apply standardized tools and self-reflection questions when assessing for child abuse.[44] As clinicians and educators, we can choose not to criminalize our patients and to resist being agents of the harmful penal system.[45]

CONCLUSIONS

Family medicine educators are tasked with incorporating multiple competencies into residency training; understandably, changing or adding competencies can seem daunting. However, concepts such as social determinants of health and health inequity initially were resisted yet were eventually applauded as integral to our specialty and to understanding disease causation, patient behavior, and improved health outcomes. Similarly, the RJ framework can and should be integrated throughout family medicine curricula to incorporate, support, and uplift the provision of SRH for greater equity and justice. To move toward change, family medicine educators will need to gain historical and contemporary knowledge about our country's legacy of reproductive violence and oppression. We then can work as teams of educators and learners to deliver high-quality, patient-centered, justice-based, equitable care to our patients. We must, therefore, include the voices of those most impacted by injustice and inequity, namely our patients and their communities.[46] It is time for us to answer the call directly from the communities we care for by incorporating RJ into clinical care and education. Our communities have given us the tools to envision new paradigms of SRH delivery, allowing us to teach and model clinical care, advocacy, and scholarly activity with our learners to achieve true equity and justice for all. Learning about RJ is not sufficient; we also must challenge and change the current dynamic of family medicine education for the next generation of learners.

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