The Medical Profession and the Lost Promise of Legalization:
Creating the Abortion Provider Shortage

by

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Introduction

As a patient support volunteer at the Planned Parenthood clinic in St. Paul, Minnesota last summer, I saw firsthand the realities of abortion care. I learned the protocol for dealing with all varieties of anti-abortion harassment, from making four right turns and driving to a well-lit area if someone follows me home, to who to contact in the event of a butyric acid attack or a bombing\(^1\). Within the clinic, I became adept at calming patients down when they were anxious on the operating table, and knew the five-minute procedure well enough to walk them through each step as it happened. I watched one of the workers examine the products of an abortion at fourteen weeks and felt myself recoil at the sight of a tiny pink hand, while remaining committed to the patient’s need and right to have the surgery. I saw doctors quickly move back and forth between procedure rooms to finish all of the day’s abortions on time, and talked with the nurses, medical assistants, and physicians about how they coped with what was often emotionally exhausting work.

This experience as a volunteer with Planned Parenthood directed my interests for this thesis. For years I had heard and talked about abortion in relation to politics, ethics, and feminist theory, and after seeing the actual practice of abortion up close, I wanted to examine the issue from a new place—through the eyes of those who encounter it every day, and who make this all or a part of

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\(^1\) While none of these occurred during my time with Planned Parenthood, just several months after I had finished volunteering at this site, a man drove his SUV into the front door of the clinic on the anniversary of the *Roe v. Wade* decision. “Jesus told me to do it,” he said. Fortunately, no one was hurt, as the protestors who normally occupied that spot had, conveniently, moved their protests across the street that morning for the first time in years.
their life's work. My own longstanding fascination with medicine and medical practice led me to focus specifically on the role of physicians and the medical profession in the work of providing abortions.

This thesis follows from the premise that elective abortion care ought to be available and accessible to those who need it. I see abortion as just one essential component of the comprehensive reproductive health care that all people should have access to, and I rely on the concept of reproductive freedom put forth by women of color activists in the late 1970s. This approach encompasses a wider variety of reproductive needs—including the right to be free from forced sterilization, to terminate a pregnancy, to have a child, and to parent that child—and also emphasizes that reproductive oppression results from a combination of societal and structural inequalities in healthcare, education and more, and that the struggle for reproductive freedom is inherently connected to the larger fight for social justice and human rights (CARASA 3). Though this thesis focuses specifically on just one aspect of reproductive care—abortion—I do not wish to imply that this is the most important part of reproductive justice. Rather, by focusing on the provider shortage as it relates to issues of inadequate access, I hope to emphasize that the social reality in which reproductive health care exists is just as, if not more, significant than the laws that govern it.

Unfortunately, the fact that abortion services have become less accessible in recent years makes this work increasingly relevant. Women of color, young women, rural women, and poor women currently face the most restricted access to abortion services due to the plethora of legal restrictions and social taboos
currently in place. These women face a number of barriers when attempting to obtain an abortion, including the prohibitive cost of the procedure itself, which is rarely covered by medical insurance and almost never covered by Medicaid, long travel distances to a clinic or hospital, the effects of paternalistic state laws mandating waiting periods or parental consent, the resulting increase in time off of work or travel costs, and harassment from anti-abortion activists, among others (“About Access”). In some areas, the situation has become so dire as to cause an increase in illegal self-abortions, which women are attempting in both safe and unsafe ways when they cannot access legal abortion care (Joffe, “Reproductive Regression”). Perhaps this rise of illegal abortions is unsurprising, given that there are entire states with no local provider, like South Dakota, where the single abortion clinic is staffed exclusively by non-residents who travel by plane to work there (Burns).

As this data suggests and as this thesis will explore, many of the barriers women face stem from a lack of available abortion providers. There is a chronic and well-documented shortage of physicians willing and able to perform abortions, and it is no small problem: of the over 100,000 practicing physicians in America today, less than 1,800 currently provide abortion services to their patients (Jones 12). Though nearly 40 percent of U.S. women will have an abortion by the time they are 45, less than half of one percent of all medical

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Though I have used the term “women” here and throughout this thesis, I would like to point out that not all people who have or need abortions identify with the category “woman.” Trans individuals are routinely excluded from discussions about abortion care and from the care itself, and there is a need for further study and awareness of this topic. This is beyond the scope of this thesis, and while I will use gender-neutral worlds like “patient” and “individual” when possible, I will also use the term women to refer to abortion patients out of technical ease. When speaking of an individual of unknown gender identity, I will use “they” and “their” to indicate gender neutrality.
doctors provide this service (“Facts on Induced Abortion”). Unfortunately, the number of practicing abortion providers continues to decline, as it has for decades, despite the fact that the number of abortions performed has remained relatively stable (“Trends in Abortion”). The dismal number of providers becomes increasingly serious when compounded with their distribution: the majority of abortion providers reside and work in urban areas, leaving over 95 percent of rural U.S. counties without a local abortion doctor (Jones 15).

In addition my desire to explore the roots of inaccessible abortion care, I also chose to focus on the shortage of practicing providers because it is an under-researched field within the study of abortion. The majority of abortion-related scholarship tends to focus on the legal and public policy aspects, statistics about procedural safety and the women who have abortions, and the issue of biomedical ethics. While many texts on the subject reference the barriers that patients face when seeking abortion care, they rarely go into any depth about the specific reasons there are so few providers. Researchers within medicine and public health have, however, completed a number of studies on abortion training within medical education over the years, and I have thoroughly explored their findings in relation to the provider shortage in the beginning of Chapter Three. Furthermore, the Guttmacher Institute has been an invaluable resource for this project, as they have been conducting research on abortion and abortion provision for decades. I have also utilized memoirs, news articles, and other journalistic works that explore the provider shortage to a limited degree. These sources of information, though useful, do not provide the whole picture. By
bringing contemporary stories and statistics together with the relevant historical context, and by contributing some of my own original research\(^3\), I hope that this thesis will fill in some of these gaps to present a more comprehensive view of the development of the current abortion provider shortage.

This work is characterized by my own interdisciplinary education, and has been informed by scholarship and schools of thought in a variety of fields, from sociology to psychology to feminist and gender studies. Additionally, the works of the following theorists and scholars have all been critical in shaping my understanding of the changes in abortion provision, medicine, and science in America over the past 200 years. Michel Foucault’s concepts of discourse, discursive formation, and power are at the foundations of my approach to discussing institutions and their effects on individuals. The theory of intersectionality put forth by Kimberly Crenshaw has also been an important aspect of this thesis, as my discussion of both individual physicians and the medical profession as a whole relies on the idea that different socially constructed categories and processes interact with one another to produce varying configurations of oppression and inequality.

Judith Butler’s works *Gender Trouble*, *Bodies That Matter*, and *Excitable Speech* have influenced my views on gender and performativity more generally, and I in Chapter Three have applied the idea of performative identities to the culture of medicine that students learn to adopt and embody over the course of

\(^3\) My own research was limited, and involved formal and informal interviews with a number of activists, medical students, and abortion providers. The formal interviews are cited in the bibliography as such, whereas informal interviews were more for the purpose of directing additional research.
medical training. Eliot Freidson has also provided a sociological model of medical professionalism and power that directly informed my discussion of the medical profession throughout this thesis, and his work is particularly powerful when considered alongside Paul Starr’s comprehensive history in *The Social Transformation of American Medicine*. Likewise, the historical accounts presented in *Doctors of Conscience* and *When Abortion Was A Crime*, by authors Carole Joffe and Leslie Reagan, respectively, were essential for the completion of this project.

These works, and many others, have influenced the direction of my discussion of the origins and causes of the current abortion provider shortage. This discussion begins in Chapter One nearly 200 years ago, at a time when abortion practice bore little resemblance to its modern-day counterpart. By tracing the history of abortion practice as it transitioned from a private and uncontroversial event into a medically controlled criminalized act, I demonstrate how the growing medical profession that was responsible for this transition helped to set the stage for the crisis that would follow legalization. Furthermore, this chapter exposes the fact that abortion care was not always under the control of the mainstream medicine, and that the medical profession may in fact be largely responsible for the politicization of abortion in America.

What follows in Chapter Two is an exploration of the changes and major events in abortion practice, medicine in general, politics, law, and anti-abortion activism in the years after legalization. I will show that, while under the supervision of the medical profession after 1973, abortion care grew increasingly inaccessible due in part to the profession’s failure to incorporate this care into
mainstream medicine. After establishing the historical and social contexts that led to the marginalization of abortion care within medicine over this period, I will move into the present and discuss the practice of abortion today, focusing specifically on the types of abortion care provided, the location for this care, and the shortage of providers. To conclude the second chapter, I consider the debate around physician conscience and argue that by virtue of their monopoly on the procedure and the negative impact of the provider shortage on patients, physicians do hold a moral obligation to learn medically accurate information about abortion and to refer their patients to other willing providers, if not to perform the procedures themselves.

Chapter Three then moves from the larger scale social causes of the provider shortage to the more immediate factors that influence individual physicians’ desire and ability to perform abortions. This includes an in-depth look at perhaps the largest contributor—the lack of abortion education at both the medical school and residency level. By evaluating existing research, I will trace changes in abortion training since legalization in relation to declines in the number of physicians performing abortions. Next, I expand upon the importance of this training or lack of training for the future of abortion provision by discussing the ways in which socialization occurs over the course of medical education. Finally, I present anecdotal evidence that attempts to explain the reasons for the gap between receiving abortion training and going on to actually perform abortions later in one’s career. This section delves into the practical barriers that may prevent some physicians from incorporating abortion care into
their work, as well as the more personal or emotional hurdles physicians may need to combat when getting involved with abortion provision.

In the conclusion I will then summarize my findings and introduce possible directions for new research and activism aimed at reversing the chronic lack of abortion providers in America. These suggestions will draw from weaknesses in previous research and ideas from others in the field, and I hope that, in its entirety, this thesis will present a testament to the dedication of abortion providers working today while also acting as a call to action for others within medicine.

Finally, as a Feminist, Gender, and Sexuality Studies major at Wesleyan University, I have come to appreciate the effect that an author’s personal characteristics have on the work they produce, and I am certain that my own personal background has influenced the content and direction of this thesis tremendously. Thus, in a spirit of full disclosure, I wish to point out that this work comes from the point of view of a white, cis-gendered\(^4\), agnostic American female who hails from a mixed-class background. I am healthy and able-bodied, and I realize that my relationships with men have caused me to evaluate abortion on a personal level as well as a political level. Surely, all of these components of my identity have influenced both my interest in this topic and my approach to writing about it.

\(^4\) Meaning that I am not trans, or the biological sex that I was born into matches the gender role that I identify with.
Chapter One:

Medical Authority and the Creation of an Abortion Controversy

This chapter begins in nineteenth century America, long before the advent of the abortion provider shortage that is the focus of this thesis. In fact, we begin at a time when abortion was conceptualized in a completely different way, and the word was not yet a regular fixture in politics or religion. Medicine, at this point in history, had no ownership over abortion care or pregnancy, and it held little social authority. We will see how medicine underwent the process of professionalization during this period to become the powerful entity it is now, and how this was achieved in part by exploiting the abortion issue. The story of the criminalization and, later, the legalization of abortion in America will shed light on the nature of the relationship between the modern medical profession and the practice of abortion, and this history will set the stage for the development of abortion politics in the twentieth century.

Menstrual Regulation: A Different Kind of Abortion

On February 24th, 1842, the New York Sun paper ran ads from competing female physicians\(^5\), Madame Costello and Mrs. Bird, side-by-side (Brodie 254).

\(^5\) Though the advertisements refer to “female physicians,” neither practitioner was trained with or a part of the “regular” medical profession at the time. Instead, they would today be considered midwives, pharmacists, naturopaths, or herbal healers (Brodie 254)
Madame Costello’s ad informs readers that she is “prepared to receive ladies on the point of confinement, or those who wish to be treated for obstruction of their monthly periods” (Brodie 254). Mrs. Bird, on the other hand, touts German “Female Renovating Pills” as an “effectual remedy for suppression, irregularity, and all cases where nature has stopped from any cause whatever” (Brodie 254). Though it may not seem obvious upon first glance, both women are advertising what we would today classify as abortion services, and they are doing so openly, for profit, and without consequence.

Mrs. Bird and Madame Costello, along with countless other nineteenth century abortionists, reference “obstructed” or “suppressed” menses rather than pregnancy. Such euphemisms can shed light on the way health, pregnancy, and abortion were thought about in the early nineteenth century. These euphemisms are suggestive not only of the taboo that existed around issues of sex and women’s bodies, but they also reflect a radically different way of thinking about abortion. In fact, at the time, the term “abortion” referred only to natural miscarriages that occurred after quickening—the point at which a mother feels fetal movement—and no one would have used this term to describe the effects of “Female Renovating Pills” (Smith-Rosenberg 219). The services provided by practitioners like Mrs. Bird and Madame Costello, which generally consisted of abortifacient herbs or instrumental assistance, occurred before this point, when there was no way to know if a woman had been pregnant at all (Reagan 75).

The health of a body, as seen through the dominant viewpoint of the early nineteenth century, was a function of balance and equilibrium, and virtually all
“regular”\(^6\) medical practice assumed that “a disruption in the healthy body…required a visible, often violent, physical response to treatment in order to restore equilibrium,” a philosophy also known as “heroic medicine” (Reagan 9). Just as most illnesses and bodily functions were viewed through this lens, so were menstruation and pregnancy. Menstruation, which ought to occur in set cycles, was indicative of a woman’s health, and “the cessation of the menses indicated a worrisome imbalance in the body” such that “restoring the flow” ensured a woman’s well being (Reagan 8). At the time missed periods did not necessarily correspond with potential pregnancy, so the removal of menstrual “blockages” was not always associated with what we now call abortion (Baehr 2). In the words of historian James Mohr, “not until the obstruction moved could either a physician or a woman, regardless of their suspicions, be completely certain that it was a “natural” blockage—a pregnancy—rather than a potentially dangerous situation” (Mohr 4). Some physicians and women even believed that menstrual regulators “promoted, not ended, pregnancy” (Riddle 201). Neither the law, nor the Catholic Church, nor the public at large believed that human life existed before quickening, so even if an obstruction of menstruation was associated with pregnancy, its removal had little to do with stopping fetal life (Reagan 8).

In addition to being generally noncontroversial, in the early 1800s and before, the act of restoring the menses was not an explicitly medical undertaking. Rather, information about abortifacient herbs was widespread and frequently

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\(^6\) Using the terminology of the day, here “regular” refers to the orthodox medical profession that would become today’s allopathic physicians, while “irregular” was the term that these physicians used to lump together the many other healers that practiced then, like naturopaths, midwives, herbalists, chiropractors, and more.
shared among women by word-of-mouth and published in home medical guides (Reagan 9; Mohr 6). It was relatively simple to grow or acquire most these herbs, and women of all social positions were able to at least attempt a self-abortion⁷, making these early abortions a primarily domestic practice (Reagan 9). As such, the practice remained a private one for most women, and was only brought to public light in the event of an accidental overdose (Mohr 9).

While white women during this time often used these abortive remedies to stop an unwanted or shameful pregnancy or to limit their fertility (in 1800, the birth rate was around 7 births per woman), black women in slavery often self-aborted for these reasons in addition to others specific to their circumstances: out of refusal to bring children into a world of forced labor, because of rape, and in acts of desperation and resistance to the system that saw their children and bodies as capital (A. Davis 205; Ross 144). Women from all social classes practiced abortion for many reasons, then as today, and it is important to acknowledge their agency in the matter—though “blocked menses” were not always associated with pregnancy and women did aim to regulate menstruation for health reasons, some also aborted with the idea that they were stopping a pregnancy.

If these herbs and other home remedies failed, most women could easily find a variety of practitioners willing to assist, either by providing different drugs or herbs, or with instrumental support (Reagan 10). A woman in need of these services could have turned to a large number of midwives, homeopaths, herbal healers, other “irregulars,” or to orthodox physicians to help her remove

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⁷ Which is not to say that all women did attempt abortion.
“menstrual blockages” for most of the nineteenth century (Mohr 15). Virtually none of these practitioners—who could be chosen on the basis of cost, proximity, family connection, or word-of-mouth—were awarded the same authority and respect as most medical professionals are today (Starr 19). In fact, in much of the country (particularly smaller towns), Americans rejected orthodox medicine and instead claimed “the right to practice medicine as an inalienable liberty, comparable to religious freedom,” believing that “ordinary people were fully competent to treat illness” (Starr 31, 33).

To some degree, even the regular physicians themselves were skeptical about the effectiveness of their own medicine, and noticed an influx of poorly trained lay-people joining their ranks despite having no formal instruction (Starr 34, 39). An enormous range existed not only between the quality of these physicians' training, but also in their social statuses and pay (Starr 81). In stark contrast to today's physicians, the regulars most often occupied a relatively low place in society and earned little, partially as a result of the increasing number and variety of practitioners (Starr 63). Though these early doctors adamantly defined themselves in opposition of what they saw as incompetent “irregulars,” they were unable to control the boundaries of their own profession and found little way to distinguish themselves from these other practitioners (Starr 37).

Both regulars and irregulars provided what we would today classify as abortion services to those in need, and their services were often similar. Generally, their instrumental assistance involved the insertion of a catheter, cotton tampon, or other device or drug into the cervix and uterus, which the
woman would leave in until she “got sick” (Riddle 234). We know that these practices were fairly common throughout the nineteenth century, as birth rates declined significantly between 1800 and 1900, with the biggest drop occurring in 1840\(^8\) (Smith-Rosenberg 219). The overwhelming majority of these procedures (both herbal and instrumental) occurred before what was then seen as the crucial determinant of pregnancy: the point at which quickening occurs (Reagan 11). As a bodily sensation experienced by the mother, quickening was generally not subject to external diagnosis, and could occur at different times in different women. Despite its subjective nature, popular and medical thought in the early nineteenth century and before gave this developmental milestone huge weight. It was the moment at which actual fetal life was thought to begin, and when the fetus was awarded an element of independent life (Reagan 10). There is little record of abortions occurring after this point, in part because the procedure is significantly more difficult than earlier in pregnancy, though it did happen (Mohr 10).

Quickening was morally, legally, and medically recognized, and after it occurred “women recognized a moral obligation to carry the fetus to term” (Reagan 9). The weight that virtually all of American society awarded the concept of quickening is significant for many reasons, one of which is the bodily authority and autonomy that women enjoyed by virtue of being able to define

\(^8\) A significant amount of this drop can be attributed to abortion, as birth control methods tended to be undeveloped and unreliable at this time. Additionally, it is unclear whether or not African-American birth rates are included in these statistics, but it is likely safe to assume that they are not.
their own pregnancies\(^9\). That the woman herself, without any assistance from a male authority figure, could define pregnancy and its possible treatment in private presents a stark contrast to today. Also significant is how thoroughly engrained it was in popular thought. In popular literature, a woman who was pregnant was described as “quick with child,” indicating that pregnancies only existed, really, after this point. Laws that related to pregnancy sometimes even left out the quickening distinction because it was so ubiquitous as to be assumed (Mohr 26).

Legal regulations surrounding the matter of pregnancy, quickening, and abortion echoed public opinion. While no statutes regarding abortion existed in the United States before 1800, those passed between 1821 and 1841 followed the British Common Law model, and most concluded that “abortion before quickening did not constitute a criminal offense” (Smith-Rosenberg 219). Instead, “the criminality of abortion lay not in its attack upon fetal life, but in the danger it posed to the mother’s life” (Smith-Rosenberg 219). The primary aim of the first set of anti-abortion legislation in America, passed in the 1820s and 1830s, was to protect women from unnecessary death at the hands of unskilled practitioners or those selling dangerous herbs in an attempt to make a profit, and these regulations have generally been classified as anti-poison measures designed to protect white women (Reagan 10).

In this period of early American history, what we would today call “abortion” was legally condoned, frequently practiced, and generally considered

\(^9\) But this must not be confused with a more general bodily autonomy or equality.
a private woman’s matter. Though not a utopian time for reproductive health by any means, especially for black women in slavery, it is important to note that there was a time in American history when women’s bodies were not medicalized as they are today, and when a radically different way of thinking about pregnancy and abortion prevailed. However, American culture transformed dramatically in the century following this era with the massive changes that accompanied world wars, industrialization, the end of slavery, immigration, and professionalization. With this transformation, abortion slowly became a major political and social issue in America for the first time.

*The AMA and the First Anti-Abortion Campaigns*

With the proliferation of medical and quasi-medical practitioners in the early 1800s, competition for patients and revenue was fierce, especially in large cities. Some of the most reliably sought-after services these practitioners could provide were those pertaining to menstrual regulation. In a cycle that peaked mid-century, the frequency and visibility of the practice of abortion increased alongside the availability of practitioners willing to provide abortive services, and the birth rate dropped most dramatically in the same year as abortionists from all ranks increased their public advertising (Reagan 10). Their advertisements for herbal “regulators” and other services could be found circulating in “newspapers, magazines, popular health manuals, and religious publications” in all major cities (Costa 4).
Abortionists’ heavy advertising contributed to the increasing commercialization of abortion, which transformed from a private, domestic event, to a commodity that could be bought, sold, and profited from. The “penny press,” or mass-circulation, cheap, tabloid-style papers that flourished with industrialization to become a staple of larger cities in the mid-nineteenth century, also contributed to the commercial visibility of abortion (Smith-Rosenberg 223). They brought a wider audience to printed papers, and were filled with advertisements. Abortion-related ads, specifically, became a very lucrative source of income for such papers, and generated profit for abortion providers as well, prompting even more vigorous advertisement by abortion purveyors (Smith-Rosenberg 225). The euphemisms used in these advertisements were well understood by much of the public, and the frequency of the ads in such widely read papers increased the visibility of the abortion trade dramatically.

In addition to advertisements, many of these “penny press” papers, along with more expensive and reputable newspapers, began to publish exposés about abortionists and their clients around this time (Smith-Rosenberg 226). These scare stories were popular and sold well, so they were published in all variety of papers (Smith-Rosenberg 226). A writer for the New York Police Gazette, for example, wrote of corrupt and murderous abortionists who “sold the bodies of aborted babies to medical schools for experimentation,” and the well-to-do women who were “disappear(ing) from respectable homes” (Smith-Rosenberg 226). Though the facts may have been dubious, the newspapers stood to benefit financially from such articles.
Popular newspapers, through both advertisements and features, thrust the common practice of “restoring the menses” into the public spotlight, making the fact that Americans practiced abortion what historian James Mohr calls “an obvious social reality, constantly visible to the population as a whole” (Mohr 46). Initially, there was “no substantial popular outcry for anti-abortion activity,” but as news articles began to suggest that “the clientele of these busy [abortion] clinics were primarily married, white, native-born Protestant women of the upper and middle classes” the issue of abortion became increasingly visible and controversial (Mohr 42; Reagan 10). While private abortion practices were well tolerated in America up until the 1840s, they were generally seen as a refuge for poor or unmarried women when associated with pregnancy termination. That white, married, high-class women were aborting to limit fertility rather than for health reasons was shocking to many of the men in power, who were already concerned that the falling “reproductive prowess” of their wives would endanger Anglo-Saxon political control (Reagan 10; Beisel 499). Furthermore, abortion among these women represented an attempt to relinquish sexual responsibility, and a reach for personal freedom that was seen as unacceptable.

A rapidly decreasing birth rate among bourgeois women\(^\text{10}\), coupled with massive immigration\(^\text{11}\) and high birth rates among immigrant groups generated great fear among those in power—fears that would worsen after the Civil War and 13\(^\text{th}\) Amendment (Riddle 234; Beisel 501). Leaders of government and

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\(^{10}\) The birth rate was reduced from 7.04 children per 1000 women in 1800 to 5.42 in 1850, and declined thereafter to 3.56 by 1900 (Riddle 234).

\(^{11}\) Between 1851 and 1880 almost five million immigrants arrived in the United States (Beisel 501).
industry saw Anglo-Saxon political control threatened by the high birth rates among immigrants relative to bourgeois women, as their power in politics depended on numerical dominance at the polls (Beisel 499). Voluntary pregnancy termination among upper class Anglo Saxon women came to be associated with the practice of mestrual regulation, and was then seen as a selfish rejection of motherhood and a potential contributor to “race suicide” (Reagan 10). The idea of “race suicide” was widely circulated, and representative of the anxieties about social makeup and demographic changes that had come to permeate the upper classes and would later provide crucial support for an anti-abortion movement.

In the midst of what was becoming a public controversy about pregnancy rates and abortion, orthodox physicians were attempting to define their struggling profession. At this time, medical training was unregulated and medical “degree factories” flourished, and the “regulars” did not have the power, nor the public support, to stop the irregulars who challenged their dominance from practicing (Starr 54). Orthodox physicians tried repeatedly in the early nineteenth century to push for licensing laws that would prevent competition and enforce firmer boundaries for the profession, but public opinion and government rejected this licensure (Starr 58). Doubting both the effectiveness and popularity of the treatments they could offer at that time, regular physicians were in the midst of a crisis of legitimacy. Theories of professionalism describe the need for specialized knowledge, norms of practice, the separation of members and non-members, and
social authority for the development of a legitimate profession, and at this time in history, orthodox medicine possessed none of these on a regular basis (Starr 8).

One thing that set the “regulars” apart from the other practitioners was their adherence to the Hippocratic Oath, which they believed to condemn abortion¹² (Mohr 35). And while some regulars at the time certainly provided abortions, many of the practitioners who advertised their services and provided abortions exclusively were irregulars (Mohr 34). All practicing physicians at the time recognized that a woman who went in for an abortion would often remain with the same physician for all of her health care, and would frequently bring the business of her family and friends as well (Smith-Rosenberg 232). As most medicine at the time was carried out in private practices, the ability to lure and keep patients was crucial to a doctor’s success, so an inability to provide a service that could bring in additional patients put the “regulars” at a distinct disadvantage (Smith-Rosenberg 232). Economically, it was in the regulars’ best interest to perform abortions, but many felt that they were prohibited from doing so by their profession’s conventions.

Regular physicians had also begun to differentiate themselves by emphasizing specialization, but those specializing in obstetrics or gynecology faced intense criticism from the general public and the medical reformers (Smith-Rosenberg 231). First, these typically male gynecologists were the objects of moral suspicions by a socially conservative public, which saw their interest in the

¹² In fact, recent scholars suggest this might not be true, but merely an incorrect translation. They believe that Hippocrates intended to condemn a specific form of abortion that was harmful to women (See The Hippocratic Oath and the Ethics of Medicine by Steven H. Miles).
female body as questionable, and therefore their sexual morality as well (Reagan 12). Additionally, unlike some other specialties, “male obstetricians offered few specialized skills with which to justify their invasion of the female body or of female birth mysteries” and their understanding of gynecology and even female ovulation was extremely limited, especially when compared to midwives with more experience (Smith-Rosenberg 231). The function of these early gynecologists was questioned even further when these physicians refused to provide the care and services their patients desired.

Historian Paul Starr, in his Pulitzer Price winning work _The Social Transformation of American Medicine_, explains that the regulars had two hurdles to overcome at this time in order to establish professional authority: “One is the internal problem of consensus; the other is the external problem of legitimacy” (Starr 80). Up until the mid-nineteenth century, it seemed unlikely that the regulars could achieve either. They faced “mutual hostility among practitioners, intense competition, differences in economic interest, and sectarian antagonisms,” and these internal divisions made physicians incapable of working toward unification or winning over a skeptical public (Starr 80).

In 1847, a small group of younger, more ambitious regulars founded the American Medical Association, or the AMA, in hopes of combating these troubles (Starr 90). The AMA gave these younger physicians a venue in which to pursue the tasks of professionalization and standards-raising, but the Association’s first major action was the launch of a vigorous anti-abortion campaign (Mohr 147). Led by Dr. Horatio Storer, the campaign saw abortion as
unsafe, immoral, and socially dangerous, and it sought to make abortion at any stage illegal (Costa 9). These views, which were new in America, stemmed from fears of “race suicide,” increasing freedom and perceived sexual immorality on the part of middle class white women, and scientific advances that shed light on the existence of the fetus earlier in pregnancy (Mohr 35). Moreover, its leaders sought to advance their own professional group at the expense of their competitors. As such, it became clear to much of the AMA’s membership that an effective anti-abortion campaign could potentially restore the profession’s prestige and put a stop to the competition if it was legally sanctioned, publicly accepted, and based on appeals to the public’s moral sensitivities (Mohr 37). In 1859, the AMA, which would later become the most powerful U.S. medical organization, officially passed a resolution condemning what they termed “criminal abortion” (Mohr 156).

The anti-abortion campaigns occurred on two fronts over the forty years that followed. First, the regulars worked toward changing the laws about abortion. Then, they discovered that these new laws were poorly enforced in part because much of the public still believed in the quickening doctrine and because it was difficult for law enforcement to prove both that a woman had been pregnant and that her practitioner’s motive was to induce pregnancy (Mohr 41). To combat this, they realized they needed to target their efforts on changing public opinion. Though the AMA eventually found support in both government and religion, it was their desire to establish professional authority was the most significant driving force behind these anti-abortion crusades.
Regular physicians had previously been denied the ability to license medical practice directly, but they managed to gain some amount of legal professional authority by helping to push through anti-abortion legislation (Beisel 506). Many regulars also worked in law making and were able to lobby enough support for their cause with other legislators to achieve criminalization laws in every state by the 1880s (Smith-Rosenberg 221). The Comstock Laws, passed in 1873, provided legal support by prohibiting the transport of “obscene material” (including abortifacients) through the mail, one of the primary ways that “irregulars” profited from the abortion trade (Costa 9). A key loophole in the abortion criminalization laws was the exception that was made for regular physicians to provide abortions when a woman’s life was in danger, effectively placing the ability to control the practice of abortion solely in the AMA’s hands (Mohr 38). Attaining legal support for the AMA’s criminalization crusade “won recognition of their particular views, as well as some state control over the practice of medicine,” and forged a lasting alliance between the regular medical profession and the State (Reagan 11). This moment can be seen as the true beginning of medical professionalization, as it was the first time physicians had been able to win government support for their group at the expense of other medical practitioners, which translated into a degree of power the regulars had not seen before.

While physicians’ legislative activities brought an amount of legal and social authority to the fledgling profession, by around 1900 they realized that they

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13 At the time it was not uncommon to be involved in more than one occupation, and a pairing of medicine and law was a standard way to obtain social prestige.
had failed to inspire a significant shift in public opinion, as the widespread practice of abortion continued (Beisel 501). The leaders of the anti-abortion campaign\textsuperscript{14} next aimed to convince society leaders and the general public that abortion was immoral and dangerous, and rather than arguing on the basis of professional advancement, they focused on arguments based on fears about a rapidly changing society. In doing so, regulars could simultaneously stop the spread of irregulars and convince the public that they were morally upstanding and had the Anglo-Saxon family’s best interests at heart.

After and during the passage of criminalization laws up to and immediately after 1900, America underwent enormous social change. The country was divided and, some would say, reunited after the Civil War in the 1860s, where over 500,000 men were killed. The 13\textsuperscript{th} Amendment officially outlawed slavery, and massive immigration from Europe continued (Beisel 499). White, upper-class feminists organized for suffrage and birth control rights. The government sponsored forced sterilization of women of color, and the eugenics movement was beginning to take hold. The KKK held a prominent place within the government, and the fears that Anglo-Saxon men in power had about changing social demographics had intensified since before the AMA’s first attack on abortion earlier that century.

The regulars, who adhered to scientific principles that were becoming better developed and more culturally accepted, used their scientific authority to convince religious leaders of their beliefs in an effort to increase public support

\textsuperscript{14} As the AMA’s campaign occurred over a span of several decades, it is safe to assume that these leaders may have been different than those who spearheaded the legal efforts.
(Reagan 13). Anti-abortion physicians attacked the quickening doctrine by claiming to know that no one developmental point in pregnancy could be any more significant than another, and that quickening was invalid as a determinant of pregnancy because it was unstandardized and “but a sensation” (Reagan 12). Their “unique” scientific knowledge that fetal life began at conception was a huge blow to centuries of common law belief (Mohr 35). This also discredited the woman’s experience of pregnancy and medicalized it such that the validity of a pregnancy ought to be determined not by the woman but by her physician—simultaneously disempowering pregnant women and increasing the scope of the medical profession. If life begun at conception, then they saw abortion even before quickening as the murder of a child. Many of the regulars likely believed this to be true and saw abortion as a genuine moral ill, but many also saw that if they could “effectively identify ‘irregular’ physicians in the popular and political mind with abortion, and abortion with the murder of innocent children and the disruption of the happy family” then they might be able to successfully win their war against the “irregulars” (Smith-Rosenberg 233).

By threatening to change the conceptions of when life begins, physicians managed to claim the “scientific authority to define life and death,” which could place them above religious leaders as moral authorities (Reagan 12). The knowledge they claimed to have regarding the beginning of life helped the anti-abortion regulars to enlist the support of the Catholic Church and many of the Protestant clergy in their drive toward criminalization, effectively establishing yet another powerful social alliance (Smith-Rosenberg 218).
At this point, legal, religious, and medical authorities worked in concert to convince the public of the dangers of abortion, but the AMA and the regulars remained the most determined. While also arguing that “irregular” practitioners were incompetent and dangerous, they exploited the fears of the social elite and utilized racist, sexist, and class-based arguments to further their cause (Joffe 28). “Race suicide,” one of their most powerful tools, was the idea that “the consequence of women’s abuse of their fertility would be the demise of the Anglo-Saxon race” (Beisel 500). Newspapers had exposed the white, upper class married woman’s use of abortion to regulate fertility, and with declining birth rates among the upper classes, and these women’s willful rejection of motherhood was represented as a crime against the state.

Physicians frequently “employed racial arguments in their anti-abortion rhetoric by equating abortion with infanticide in ‘barbarous’ nations and women who aborted with barbarians,” but they faced a problem (Beisel 507). They could not completely condemn the white women who were the focus of their argument for their moral depravity on the basis of poverty or race, so they opted to explain their behavior as resulting from “ignorance about fetal life,” and the physicians positioned themselves as educators there to rescue women from themselves (Beisel 507). The anti-abortion crusaders still, however, attempted to convince the male bourgeois politicians that abortion among their wives “constituted a threat to social order and to male authority” and pushed for a return to proper motherhood among these women (Smith-Rosenberg 235).
Leslie Reagan, author of *When Abortion Was a Crime*, describes that “though professional issues underlay the medical campaign, gender, racial, and class anxieties pushed the criminalization of abortion forward” (Reagan 11). The anti-abortion activities of the orthodox medical profession were part of a backlash among Anglo-Saxon men in power to the social and political struggles of women, immigrants, the poor, Catholics, and African Americans. Partially as a result of their anti-abortion campaigns, regular physicians were able to come together for a cause, and they established medical societies\(^{15}\) around the country with their newfound social legitimacy (Starr 109). As the next section will demonstrate, the regulars were ultimately successful in their campaign to criminalize abortion, thereby bringing the practice under their control, and they eventually came to dominate medical practice.

*Criminalized Abortion in the Hands of a Conflicted Profession*

Laws prohibiting “criminal abortion” had spread throughout the country by the turn of the twentieth century, and those with political and social power had finally come to denounce the practice of abortion after years of prodding from the AMA and its associated medical community. Though abortion had become more socially unacceptable, especially in the upper classes of society, women’s need for this service remained—as it would for the duration of the

\(^{15}\) By 1900, the AMA had only eight thousand members, however, while the total membership of all medical societies (local, state, and national) was approximately 33,000, while another 77,000 practitioners belonged to no association (Starr 109). This indicates that the AMA, while politically powerful, was still in its infancy during this time.
criminalization era. The practice of abortion, and not the need for it, was what changed during this time, and women of all social classes continued to attempt self-abortion and to seek out practitioners willing to help them abort.

With the criminalization of abortion firmly established, the medical profession experienced substantial growth during the first two decades of the twentieth century. The number of hospitals grew alongside escalating specialization, and physicians grew increasingly dependent on one another in order to succeed in business and the profession consolidated as a result (Starr 111, 145). Medical education also became more selective and expensive, and medical schools enforced discriminatory policies designed to stop women and people of color from joining the profession, and the profession quickly became “more uniform in its social composition” (Starr 124). And as the profession became more homogenous, it also made significant gains in prestige and income, making it a more desirable career choice and therefore even more difficult to enter (Starr 143). By 1931, it seemed that the medical profession had also overcome the problem of competition, as “irregular” practitioners were treating only 5.1 percent of illnesses at that time (Starr 127).

In the midst of these professional gains, medicine’s role in the practice of abortion began to change. As mentioned previously, women still sought out abortions despite its illegality, and many resorted to self-abortion or enlisted the help of the remaining irregulars and midwives willing to perform this service. When these attempts failed or a woman was injured or killed she would often be

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16 Approximately 1900 to 1973
17 Prior to the twentieth century, hospitals were mainly religious and charitable institutions for “tending the sick” but had little to do with medical treatment (Starr 145).
taken to the hospital, which had become not only a medical facility but also an extension of the state in some respects. In clear-cut criminal abortion cases, physicians often assisted law enforcement—which primarily “prosecuted abortionists after a woman died as a result of an illegal abortion”—by questioning dying women (Reagan 114, 131). Though physicians could legally perform abortions to save a woman’s life, and some certainly did regularly perform abortions for other reasons, many doctors still feared becoming a suspect in an abortion case and therefore sought to ally themselves with the state’s investigations (Reagan 131). In these early decades of criminalized abortion, organized medicine acted as an extension of the state by helping to prosecute illegal abortion cases, and their alliance with law enforcement was beneficial for the development of their social capital.

Physicians continued to help police illegal abortion until the Great Depression took hold in the 1930s. During this period, the need for and incidence of abortion skyrocketed, and as physicians had established themselves as the primary healthcare providers throughout the country, women began to pressure their doctors to perform abortions in these dire circumstances (Reagan 132). Informally, the medical profession’s acceptance and practice of abortion expanded during the Depression era, giving way to a new system. Many physicians engaged in “private consultation,” or an informal agreement between two doctors that stated that an abortion was medically indicated (even if it may not have been), in order to perform legal, therapeutic abortions in hospitals (Davis 66). This system of informal agreements was, at this time, fairly relaxed
and was used as a buffer to protect individual doctors from investigation about their abortion practices.

As the demand for abortions increased dramatically during the Great Depression, and for the first time physicians began to recognize social indications as a legitimate cause for therapeutic abortion, acknowledging “that social conditions were an essential component of medical judgment in therapeutic abortion cases” (Reagan 132). This time of economic crisis resulted in expanded abortion care that “became more concentrated in the hands of physicians in both hospitals and private offices,” and this was practiced across all medical specialties as the need for abortions was so widespread (Reagan 132). However, access to these physician abortions was limited primarily to affluent white women, while most poor women and women of color still self-induced or found less qualified providers (Reagan 137).

Public opinion began to shift during these times of trouble, and American society began to accept contraceptives and birth control as morally permissible during the 1930s (Reagan 134). In fact, a small group of radical physicians even talked about reforming the anti-abortion laws, and while the profession as a whole was not receptive to this change, it represents a notable shift in medical thought (Reagan 139). Moreover, the Great Depression was the first time that the practice of illegal abortion gained visibility as a public health issue. It became clear to many physicians, upon seeing women entering hospital wards after illegal

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18 A part of the reason that abortion law reform was not well tolerated among the relatively socially conservative medical profession is that such reform was associated at that time, as now, with radicalism and feminism, and most physicians did not want to be allied with these groups (Reagan 139).
abortions, that these abortions were contributing to maternal mortality (Reagan 138). The unprecedented visibility of illegal abortion complications in hospitals also helped to convince many doctors to help women who came to them seeking abortions (Reagan 146). Underscoring medicine’s growing acceptance of abortion during this time, a 1939 poll of the nation’s medical students found that “68 percent were willing to perform abortions if they were legal” (Reagan 143).

The expansion of abortion provision during the Depression era gave rise to “professional abortionists,” or physicians who informally specialized in abortion (Reagan 133). Only a few of these had obtained advanced abortion training, but by performing abortions exclusively most became very skilled at this simple procedure (Reagan 147). These physicians provided safe abortions in offices like any other doctor, and took referrals from entire networks of physicians in order to create a thriving abortion practice—in some ways, this was the precursor to the modern abortion clinic (Reagan 148). Though their work occupied a legal grey area, prosecuting these physicians was a low priority (Reagan 133). Additionally, with increasing demand for abortion services in the face of intense financial hardship, more physicians became interested in abortion practice (Reagan 147). Financial woes, however, were not the only factor motivating some doctors to perform abortions—others were affected by personal stories of their patients. One famous professional abortionist who practiced in the late 1930s, Dr. Keemer, once refused to perform an abortion on a woman who later committed suicide, and “after this tragedy, Keemer resolved to make amends by performing an abortion for someone else” (Reagan 156).
Similar to the cycle of visibility and then repression of abortion that occurred in the nineteenth century, as the practice of therapeutic abortion expanded during the Great Depression and professional abortionists flourished, it became increasingly obvious that some criminal abortion laws were being broken (Reagan 162). Much changed, politically and socially, as America moved out of the Depression. The 1940s were defined by World War II and the start of the Cold War, and these war-filled years marked a sort of transition into the socially conservative 1950s. American society changed dramatically during these years: the political environment became one dominated by paranoia and the desire for power and control, Americans moved to the cities in droves, McCarthyism flourished, and gender and race relations became increasingly strained. All of these deeply affected the practice of medicine and, specifically, abortion.

In the 1940s the state and the medical profession began to change their ways and cracked down on the enforcement of criminal abortion laws (Reagan 160). Rather than looking only for abortionists who had killed or harmed a woman, law enforcement began to focus on shutting down established, trusted abortionists as well (Reagan 161). In addition to doctors, police and prosecutors increased their interrogations of female abortion patients, often going so far as to raid known abortion clinics and asking the women inside to testify against their doctors (Reagan 161). “The state’s surveillance of abortion in this period is another aspect of the political and cultural attack on critical thought and behavior,” writes Reagan, connecting the rise of McCarthyism with efforts to destroy a number of “radical” movements at the time (Reagan 163).
Medicine, despite having the same legal loophole as they had before, also moved to halt the trends in abortion provision from the Depression era by introducing new rules to regulate therapeutic abortion (Reagan 173). Physicians and hospital administrators instituted “therapeutic abortion committees” in the early 1940s, and these committees, which would operate in hospitals across America for the next 30 years, were designed to limit the number of abortions performed at hospitals (Reagan 176). Physicians, hospital lawyers, and other administrators staffed these committees and would collectively review all requests for hospital abortions, often denying a substantial proportion of requests (N. Davis 67). Often, therapeutic abortion committees would also include sterilization requirements for the few therapeutic abortions granted to poor women or those with multiple pregnancies, effectively punishing these women and deterring others from asking (N. Davis 69).

These committees served a number of protective and regulatory functions for the medical profession. In a time of increasing state interest in policing criminal abortion laws, therapeutic abortion committees could protect physicians and hospitals from prosecution\(^\text{19}\) by providing a significant amount of evidence that the abortion was medically necessary, as well as a diffusion of responsibility for any one procedure (Reagan 176). These committees also created a venue in which some anti-abortion physicians could impose their views on colleagues who felt less strongly by discouraging physicians from seeking approval for abortions, particularly in cases of social, rather than medical, indications (Reagan 178).

\(^{19}\) It must be noted here that while fear of legal prosecution was widespread, at this time there had never been a physician arrested for therapeutic abortion, so the fear may have been disproportionate with the reality (Reagan, 175).
Additionally, public opinion had turned against the practice of abortion once more—partially due to a backlash against the freedom some white women had obtained by leaving the home to work during the Depression and World War II—and physicians benefited from having a committee with which to share the potential moral blame from the public or their colleagues (Reagan 176).

In the socially conservative climate that took hold of the 1940s and 1950s, a low therapeutic abortion rate quickly became a status symbol for hospitals, and “hospital administrators felt pressed by both colleagues and state officials to keep there level of therapeutic abortions down” (Reagan 180). The desire for low abortion rates then moved the vast majority of abortions out of hospitals during this time. Unfortunately for women with unwanted pregnancies, medical practice had become concentrated in hospitals, and it became increasingly difficult to find any physician willing to risk performing abortions either in a hospital or a private office (Reagan 180).

The result of the medical profession and the state’s joint efforts to put a stop to elective abortion was that women seeking this care resorted to dangerous alternatives. By the 1950s and 1960s, it was common for women to be blindfolded and taken to unknown locations for extremely expensive illegal abortions (Reagan 193). Moreover, “since abortionists provided an illegal service, anyone could enter the trade,” describes Leslie Reagan, continuing that “the crackdown on abortion coupled with the growing demand inevitably attracted more people to this lucrative business that required no specific training” (Reagan 199). Women’s accounts of their abortions during this time often told of
incompetent, drunk, and sexually inappropriate abortionists ("History of Abortion"). After a botched, incomplete, or unsanitary abortion, women would frequently end up in the hospital emergency ward with infections or irreparable damage to their reproductive organs ("History of Abortion"). Some estimate that in the 1950s, about a million illegal abortions were performed each year, with over a thousand deaths per year ("History of Abortion"). These trends continued throughout the 1960s and until abortion laws were liberalized, and sadly women of color and poor women bore the brunt of the cost: in 1969, 75 percent of the women who died from abortions, mostly illegal, were women of color, whereas 90 percent of all legal, therapeutic abortions that year were performed on white private patients ("History of Abortion").

While millions of women suffered during the decades of increased repression of abortion in America, the tides began to shift once more in the medical field in the 1960s. Some doctors, still staunchly anti-abortion, sat on therapeutic abortion committees and continued their attempts to stop women from having legal abortions. In a marked shift, however, other doctors, especially psychiatrists, began to publicly denounce the country’s abortion laws after seeing countless women filling up hospital emergency rooms (Reagan 218). Still other physicians actively participated in, and benefited financially from, the illegal abortion process by performing secretive abortions with the help of intermediaries. Perhaps more common, however, was the physician who would

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20 Sometimes, these same doctors who denounced “filthy abortionists” would later be searching for a safe and reliable provider of illegal abortion to whom they could send their own patients, wives, or daughters (Joffe 38).
occasionally provide abortions for their personal patients or friends’ wives in private offices, when they felt the circumstances were right (Joffe 71).

Physician involvement in the practice of abortion during the 1960s had become complicated once more, with no real professional consensus in place and abortion rights activism on the rise. Though laws in some states, like New York and Washington, slowly became more liberalized, law enforcement’s presence was still widely felt throughout most of the country’s hospitals (Reagan 241). This legal involvement, coupled with intense hospital restrictions on therapeutic abortion, began to “generate resentment among physicians who…felt shackled by the law” (Reagan 218). As such, many physicians who vocally supported liberalized abortion laws did so because they had both seen the consequences of illegal abortion and also wished to free their medical practice from legal interference (Joffe 38).

By the early 1970s, a vocal broad-based movement in favor of legalizing abortion had emerged after decades in the making. Composed of women of all social classes, members of the legal and medical professions, and even churches and clergy members, this movement brought together a diverse group of career and first-time activists (Reagan 244). The support of physicians, especially, helped to bring additional weight to the cause. Two major physician-centered conferences, held in 1955 and 1968, focused on the issues surrounding abortion and then presented recommendations for instituting legal abortion, and these conferences came to symbolize a degree of professional support for legal change (Joffe 39). Though consensus had certainly not been achieved within the
profession, many physicians came to see legalization as not only desirable, but also inevitable (Joffe 42). In a critical turning point, the AMA adopted a resolution endorsing liberalized abortion laws in 1970 (Joffe 46).

Shortly after, in 1973 the U.S. Supreme Court handed down two groundbreaking decisions, *Roe v. Wade* and *Doe v. Bolton*, which found the nation’s criminal abortion laws and restrictive therapeutic abortion committees unconstitutional, and together these decisions legalized abortion (Reagan 244). The rulings incorporated elements of both a woman’s right to privacy to decide whether or not to terminate a pregnancy and a physician’s right to practice without “undue interference” (Reagan 244). *Roe v. Wade* specifically validated the medical profession’s authority by placing the practice of abortion under the jurisdiction of medicine, stating that “the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated” (Reagan 244).

Chapter Two has traced the provision of abortion, by physicians, women themselves, and other practitioners, from the period before criminalization to the decisions that legalized the practice once more. It has demonstrated how the medical profession rose to power in part by exploiting social fears about abortion and launching a campaign to criminalize the practice. Furthermore, it has established that abortion was widely practiced, and often safely, long before the medical profession gained control of the procedure—highlighting the fact that it was not necessarily inevitable or expected that the practice of abortion would
come to be associated with regular medical practice. Later, during the years when abortion was outlawed in America, we saw that the medical profession as a whole took little responsibility for the procedure or the women who were harmed by its criminalization. This ambivalent reaction to abortion on the part of the medical profession set a dangerous precedent that, as we will see in the following two chapters, directly contributed to the marginalized status of abortion medicine in America today.
Chapter Two:

The Promise and Reality of Abortion Practice in Post-1973 America

This chapter will bring the previous chapter into focus by exploring responses to legalized abortion from the medical profession, politicians, and anti-abortion activists in the 1970s, 1980s, and 1990s, and will consider these reactions in relation to the development of the current abortion provider shortage. It will then delve into the practice of abortion in America today, keeping the issue of access in mind. After exploring the dire need for more physicians willing to perform abortions, I will address the issue of physician conscience and obligation to patients. This chapter’s exploration of the social, medical, and political context of legalized abortion that prompted the development of the provider shortage will then be complemented in Chapter Three by a more proximate-level analysis of events in medicine during this same period.

Changes in the Medical and Political Landscape After Roe v. Wade

The Roe v. Wade and Doe v. Bolton decisions of 1973 opened up a world of potential for changes in abortion practice. Finally in control of the procedure once more, the medical profession could have integrated abortion care into gynecological practices or hospitals, developed research for new techniques and drugs, and worked to reverse the shameful abortion practices that had previously
been so widespread. Just as childbirth and periods had become medicalized\(^{21}\), so could abortion care have potentially become a standardized part of medical discourse. Under the assumption that abortion care would become normalized, many of the women and physicians who had fought for this victory quickly “discarded their picket signs, believing the struggle was over” due to the promise of legal abortion (CARASA 13).

Relief on the part of physician-abortionists was tremendous, as they could finally rest assured that their work did not occupy a legal “gray area” and they were no longer at risk for legal prosecution (Joffe 144). Similarly, a number of primarily white, middle-class feminist organizations that had advocated for legalized abortion saw that fight as over, and then moved on to other concerns like fighting discrimination in the workplace (Craig 43). The broad based movement for legalization that had assembled in the early 1970s disbanded quickly after the 1973 victories.

What followed throughout the 1970s was a period where abortion rights groups splintered apart, the medical profession adopted a reluctant if not negligent attitude about abortion, and the anti-abortion movement experienced enormous social and political gains. Within abortion rights activism, many women who had focused on the issue of legalization failed to see that women of color, poor women, rural women, and young women had faced additional problems with regards to abortion and reproductive health in general—such as sterilization abuse, inadequate access, and prohibitive costs (Silliman 2). These

\(^{21}\) Which is not to say that this is necessarily desirable.
groups within the reproductive rights movement, such as the National Black Women’s Health Project, continued to fight against these issues after the *Roe v. Wade* decision (Silliman 4). Unfortunately, as will be demonstrated later in this chapter, the first restrictions passed with regards to abortion primarily affected poor women, prisoners, and young women rather than many of the more affluent white feminist activists, and as the major “pro-choice” organizations failed to incorporate these issues into their activism right away, a rift formed between the various groups that had once worked together for abortion legalization (Baehr, 5).

The medical profession as a whole, on the other hand, remained overwhelmingly silent on the issue of abortion after legalization. Rather than making dramatic changes in abortion practice and policy, as they could have with the law once more on their side, medical leaders instead adopted an “equivocal” stance on abortion (Joffe 52). A 1976 survey found that of the major national health-related organizations, “twenty-two out of thirty-six responding organizations reported taking no actions of the type that would normally be expected after such a major policy change” (Joffe 49). Surely, not all physicians were or had been in agreement about abortion rights—doctors had lobbied both for and against legalization—and it seemed that rather than risk dividing the profession, medical professional organizations instead chose to avoid the issue.

Some went beyond a silent reception and instead chose to adopt a more negative approach, and in fact, many hospitals restricted abortion practice in the period immediately following *Roe v. Wade*. In 1973, more than 50 percent of
abortions were performed in hospitals, but this changed quickly (Maynard). As Carole Joffe describes, “one of the most striking features of the period immediately after Roe was the failure of the majority of U.S. hospitals to establish abortion services: by 1977, only 31 percent of all non-Catholic hospitals provided any abortion services” (Joffe 47). While some hospitals simply failed to incorporate abortion services into their repertoires, others actively tried to prevent abortion practices—hospital administrators in some hospitals did this by leaving pre-1973 regulations on their books and continuing to enforce them, and others used intimidation to stop individual physicians from performing abortions (Joffe 146). After seeing the high numbers of women who had filled up their emergency rooms during the criminalized abortion era, some within medicine feared that their hospitals would become “abortion mills” if the service were provided too readily (Joffe 146).

Perhaps the primary reason for medicine’s failure to integrate abortion care into hospitals and mainstream practice was the intense stigma that remained connected to both the procedure itself and the physicians who performed it. By virtue of how abortion existed within medicine prior to 1973, those physicians most knowledgeable about the procedure—and thus those who could teach it to others—were also those who had routinely performed illegal abortions, and though many of these practitioners were very skilled, they were still lumped together with the incompetent “back alley butcher” abortionists (Joffe 50). When abortion was legalized and, theoretically, a new group of physicians could begin performing abortions, the more experienced physician-abortionists found it
difficult to share their knowledge and expertise with their colleagues without facing judgment (Joffe 158). As physicians who had not previously performed abortions were not encouraged by their colleagues or professional organizations to obtain additional training or to begin performing abortions, most of them simply did not. Even after legalization, a small and dedicated group of physicians—mainly those who had already been performing abortions regularly—provided the majority of all hospital and non-hospital abortions, and still “the rest of the staff regarded these doctors with esteem not markedly higher than that previously reserved for the back street abortionist” (Joffe 49).

With hospitals neglecting to provide abortion care, these services had to move outside of the hospital. Women’s health clinics, which had existed prior to 1973 in conjunction with the women’s health movement, seemed a natural place to concentrate abortion care after legalization (Morgen 70). By 1976, there were about 50 women-controlled health clinics across the U.S., most of which provided abortion services (Morgen 71). Many of these encouraged a different sort of medical care that encouraged self-help, political activism, and patient control (Rosser 118). Most physicians within the field of women’s health at that time, some of whom had performed abortions prior to legalization, were excited by this new model of care, believing that specialized outpatient surgical centers could be a place where skilled practitioners would provide compassionate care and counseling in a pro-woman environment, in contrast to the hostile hospital care seen in the pre-Roe v. Wade days (Joffe 146). Quickly, hospitals came to have “an increasing dependence on the freestanding clinic as the major site for both
abortion services and training” (Joffe 51). The relative ease of this transition, as it was seen so favorably at the time, set an important precedent for the years that would follow, in which hospitals would decrease their share of abortions more quickly than the clinics could take over this care.

Medicine, more generally, was undergoing enormous change and expansion during the 1960s and early 1970s. Teaching hospitals experienced dramatic financial growth—for instance, in 1940 Massachusetts General Hospital had an operating income of $2,084,000, compared to $23,163,000 in 1964—as medical care “came to be regarded as a basic right,” and the “demand for more doctors and medical services grew accordingly” (Ludmerer 210). Additionally, as a part of expanded social welfare initiatives in the 1960s, the federal government instituted Medicare and Medicaid health assistance programs in 1965, further increasing the growth of the medical field (Ludmerer 221, 223). For a short time, women receiving federal health assistance had access to federally funded reproductive services. In medical schools, clinical activities came to surpass academic research in importance, and the government was increasing its funding of medical schools at the same time as it began to exercise some degree of control over these institutions (Ludmerer 271). Slowly, the practice of medicine was becoming increasingly entangled with business and the government, and the continuation of these policies in the decades that followed would present complications for abortion care.

Though legalization had done little to incite action on the part of major “pro-choice” organizations or the medical profession as a whole, it presented a
new opportunity for activism within anti-abortion groups. With *Roe v. Wade* in place, these groups' cause—re-criminalization—became more concrete, and many who were personally opposed to abortion became activists for this cause for the first time. As historian Dallas Blanchard writes in his book *The Anti-Abortion Movement and the Rise of the Religious Right*, “the primary anti-abortion organizations existing prior to the Supreme Court decisions of 1973 were Catholic, so the earliest reactions to those decisions were primarily Catholic” (Blanchard 32). The Catholic groups which held anti-abortion views quickly began to organize “right-to-life” events and protests across the nation (Blanchard 32). These groups, like the National Right to Life Committee (NRLC) consisted primarily of male professionals both inside and outside of medicine (Blanchard 52). Their first organizing efforts throughout the 1970s included what might today be called “polite” measures, such as peaceful protests, funding the National Right to Life Association, writing letters of protest to the Supreme Court, and attempting to introduce anti-abortion legislation (Blanchard 32, 52). Most of their political work at this time occurred at the national level (Blanchard 52).

Anti-abortion legislative organizing was effective, and a number of legal victories were won in the years immediately following the passage of *Roe v. Wade*. The most far-reaching of these was what is commonly referred to as the Hyde Amendment, passed in 1976, which prohibited the use of federal funds to pay for elective abortions and has remained in place ever since (Beckman 6). The main effect of this legislation was to cut off the use of any federal Medicaid funds that would help pay for abortions for poor women (Silliman 26). A number of similar
financing restrictions were also passed at the state level, marking the beginning of a shift in tactics that would have serious consequences for abortion access (Craig 47). One of the primary goals of anti-abortion groups at this time was to pass a constitutional amendment that would reverse the effects of the *Roe v. Wade* decision and outlaw abortion (Beckman 4). These amendments fell into two categories, human life amendments based on defining the fetus as a person, and states’ rights amendments that would give states the options of setting their own abortion laws (Beckman 4). Though many such amendments were and have been introduced throughout the 1970s and after, anti-abortion activists found it difficult to achieve the supermajority necessary for the passage of a constitutional amendment (Beckman 5). A number of Supreme Court decisions during the 1970s also affected the practice of abortion, such as *Connecticut v. Menillo* in 1975, which determined that states could allow only physicians to perform abortions, and *Poelker v. Doe* in 1977 which held that government entities could refuse to perform or fund elective abortions in public hospitals (Blanchard 35).

Overall, the period from 1973 to 1980 saw the emergence of strategies and public health policies that would present a foundation for the development of more extreme approaches to abortion in the two decades that followed. Just as the pre-*Roe v. Wade* days had set an important precedence for the occurrences in this section, so did the immediate reactions to legalization play a key role in shaping the future of legal abortion provision.
The Reagan Era, Corporate Medicine, and the Rise of Clinic Violence

The 1980s and 1990s saw abortion become an even more politicized, divisive social issue in America. Violent anti-abortion extremism became a common threat to abortion clinics and physicians, and even political activism became more intense during this time. Trends outlined in the previous section—a push toward centering abortion care in the clinic and not the hospital, moving legal debates to the state, rather than national level, and the growth of corporate medicine—continued, and set the stage for major changes in abortion provision.

By the end of the 1970s, anti-abortion activists had recognized that they did not at that time have the amount of public support that would have been necessary to push forth a constitutional amendment banning abortion, so they began to change tactics (Blanchard 53). Two new strategies emerged. First, the majority of anti-abortion activists moved their lobbying efforts to the state level, choosing to focus on restricting abortion practice and access through consent and notification laws, funding laws, reporting laws, and others related to regulating clinic and hospital practices (Craig 80). Second, some of the more radical anti-abortion groups resorted to on-the-ground activism. This included establishing their own “counseling” clinics (the precursors to today’s “crisis pregnancy centers”) that attempted to convince pregnant women not to have abortions all around the country (Blanchard 53). Furthermore, these groups began picketing and protesting at abortion clinics and abortion providers’ offices (Blanchard 53). Each of these new strategies was of great consequence, and activists would find
that they were not only effective, but also brought great visibility to their cause. As such, they continued to become a regular fixture of abortion practice in America.

The newer and more radical anti-abortion groups also changed in composition. In contrast to the groups of professional Catholics who continued to engage in legislative work, many of those who preferred to protest at clinics were more likely to be fundamentalist Protestant working-class white males (Blanchard 54). When their protests were ineffective at stopping abortions from taking place, the more radical of this set of activists began to adopt ever more radical tactics. The 1980s saw, for the first time, the emergence of violent anti-abortion activity in the form of bombings, arsons, vandalism, blockades, invasions of abortion clinics, and threats against abortion providers and clinic staff (Blanchard 55). To a degree, their strategies worked, and resulted in the closure of some clinics and the intimidation of a number of women patients and clinic workers. Though some feminist and abortion rights groups attempted to counteract this harassment by establishing clinic escort services, the violence continued to escalate and law enforcement agencies took little action—even the Federal Bureau of Investigation (FBI) refused to get involved, “claiming each is an isolated incident and not organized terrorism” (CARASA 58). The failure to effectively stop the most extreme wing of anti-abortion violence would later have unfortunate consequences.

The politics surrounding abortion also changed dramatically during this time, moving from a fringe issue to be catapulted into public view by President
Ronald Reagan. In office from 1981 to 1989, President Reagan was supported by and brought visibility to the “New Right,” and he “gave presidential legitimacy to the legal enforcement of the antiabortion movement’s moral views” through his passionate defense of the cause (Craig 169). Known to be anti-abortion and highly religious, Reagan brought these issues to the forefront of presidential politics for the first time, and therefore further into the minds of most American voters (Craig 169). Suddenly, as a political issue in what is effectively a dual-party system, abortion also became superficially two-sided, and the American public may have developed its views about abortion in this context. Hereafter, abortion would be a litmus test of a president’s personal views and politics and a regular fixture in political debates.

Around 1987, Reagan and his staff decided to frame the abortion issue in a new way, developing a strategy that would have long-lasting consequences for women seeking this care. Because there was a general consensus that abortion was undesirable, even among those who supported its legality, the Reagan administration thought to frame abortion like the smoking issue—rather than outlawing it, they would develop legislation that aimed to financially and medically attack abortion (Beckman 8). This approach included laws that transferred funds to focus on adoption, ending medical tax deductions associated with abortion, asking the Surgeon General to warn the public of the hazards of abortion, and vetoing every bill allowing federal dollars to be spent on abortion.

22 Reagan’s administration did ask the Surgeon General at this time, C. Everett Koop, to release a statement on the harms of abortion. Koop, despite being “an outspoken right-to-life advocate,” concluded that the “physical risks associated with abortion were insignificant” and that other studies demonstrating mental health consequences were
The Reagan administration’s anti-abortion activity also instituted limits on scientific research involving fetal tissue, and changed the regulations for Title X family planning grants to ensure that funds would “be denied to any organization promoting, encouraging, or advocating abortions, even with their own funds” (Beckman 9). This move toward president-oriented abortion politics and legislation made the topic larger than ever, catapulting it even further into public view.

The anti-abortion crowd had another political win in 1989, when the Supreme Court handed down the *Webster v. Reproductive Health Services* decision which “significantly expanded the state’s ability to place restrictions on a woman’s access to abortion” by determining that such restrictions were not unconstitutional (Beckman 7). This decision spurred a resurgence of political activity from both abortion rights supporters and opponents (Craig 59). Specifically, anti-abortion activists increased their state-level lobbying for abortion restrictions with this newfound government sanctioning, while abortion rights groups—particularly the mainstream pro-choice movement that had been somewhat neglectful of the issue of access—found themselves on the defensive (Craig 279). The director of one abortion clinic from this time remarked that “until the Supreme Court announced the decision to hear the *Webster* case, we had difficulty communicating to pro-choice people that we were at risk” (Craig 63). After this loss, abortion rights groups attempted to regain public support and poorly constructed. Thus, the Surgeon General’s report did not present a substantial outcry about abortion and was therefore never widely disseminated by the Reagan administration (Beckman 8).
organized marches across the country, enlisting the support of celebrities and other notable public figures (Craig 67).

The medical field, which had been expanding during the 1960s and early 1970s, also experienced dramatic change during the Reagan Administration. As Kenneth M. Ludmerer describes in his book *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*, “by the mid-1970s, the era of “cost containment” had begun—the result of soaring medical costs in a nation suffering from the severe recession of 1973-1974 and the economic stagnation and runaway inflation that followed” (Ludmerer 277). This cost containment came to dominate the health care debate during the Reagan era, and federal reimbursement of medical care, especially for Medicare and Medicaid, was dramatically reduced (Ludmerer 349). In place of this system, “a competitive marketplace for medical care emerged—one that focused on prospective payment, lower prices, and the restricted use of hospitals and specialized services” (Ludmerer 349). That is, during this time, a system of external oversight of medical costs by large corporations and for-profit health maintenance organizations (HMOs) grew more powerful and more popular (Ludmerer 353).

The consequences of the move to corporation-controlled, price-competitive medicine were serious for abortion, which had been vilified politically throughout the 1980s. The sole legal responsibility of the for-profit corporations that controlled much of healthcare “was to increase share-holder value,” meaning that “money spent on education and research that would benefit
society as a whole without bringing immediate benefits to investors or their own panel of patients was not in their best interest” (Ludmerer 356). With abortion occupying a new place in public politics, the introduction of this care into business became a risky move and hospitals run by such corporations were even less likely to incorporate abortion care during this area due to the potential to attract unwanted attention from protestors or anti-abortion investors. Abortion care, then, continued to move out of hospitals and into freestanding clinics, which had themselves undergone a change during this era. Damaged by the profit-oriented economy and the expenses associated with increasing clinic violence, many of the feminist health centers that had provided low-cost abortions during the 1970s and early 1980s collapsed during the Reagan years (“History of Abortion”). In their place, clinics run by individual physicians and larger advocacy organizations took over in some places, while other locations were left without local abortion care (“History of Abortion”).

In the 1990s, after the Reagan years, many of these same trends in healthcare and anti-abortion activism continued. Clinic violence and harassment reached an all time high during this period, when several abortion providers and other abortion clinic staff members were murdered by militant anti-abortion activists (“Anti-Choice Violence”). Likewise, the number of bombings and arsons against clinics increased dramatically, as did vandalism and invasion of clinics and death threats against individual providers (Blanchard 57, 59). These incidents helped to keep abortion in the news and in political debate, and abortion remained a popular political “wedge” issue in presidential and
gubernatorial elections across the country (Costa 50). Laws, constitutional amendments, and other bills pertaining to the practice of abortion continued to be introduced at both the national and state level, and many resulted in restrictions on abortion care and practice (Costa 56). In 1992, the Supreme Court decision in *Planned Parenthood v. Casey* upheld a woman’s right to obtain an abortion, but also ruled that restrictions like notification clauses and mandatory delays are constitutional (Solinger xv). As we will see in greater detail in Chapter Three, anti-abortion violence, corporate medicine, and the move of abortion care out of hospitals and into clinics were all important contributors to the falling number of abortion providers as well as a lack of medical training in abortion, both of which experienced dramatic declines during the late 1980s and early 1990s.

Corporate medicine continued its ascent into power, with for-profit organizations owning eight of the ten largest HMOs by the mid-1990s (Ludmerer 356). Profit-oriented medicine also led to a number of other changes that were relevant for abortion care, such as an increase in Catholic hospital mergers. In 1996 alone, over 600 hospitals merged with Catholic institutions in 19 states, often out of financial necessity (Dinsmore). Typically, these partnerships require that the formerly secular hospitals adopt restrictions on reproductive health care after merging, resulting in decreased access to these hospital-based services across the country (Dinsmore). During this same period in the 1980s and 1990s, the Catholic Church had become more involved in abortion politics and increasingly sought to remove abortion care and birth control out of their affiliated hospitals, and in doing so, reduced the access that many women had to these services.
The composition of the medical profession also underwent changes during the late 1980s and 1990s, with the percentage of female and minority medical students slowly increasing. Though only 11.6 percent of physicians were female in 1980, 24 percent were female in 2000 (“Statistics and History”). Similarly, the proportion of non-white physicians had been increasing slowly since the 1970s, and the AMA recommended the use of affirmative action policies for medical school late in the 1990s (“Race and the AMA”). With cost-containment strategies in place, some hospitals also began to rely more heavily on non-physician practitioners, such as nurse practitioners and physician assistants, to provide some primary care (Samora 472). The prevalence of these providers increased significantly in the 1990s and after, thereby changing the composition of medical care providers even further (Samora 472). Though the medical profession opened its borders, to some extent, during this time, these changes were only very slowly reflected by significant medical policy changes—like the rise of culturally competent medical care or the sharing of primary care responsibilities.

The enormous changes that had occurred in the decades after legalization, in politics, medicine, law, and activism all simultaneously, though not always intentionally, created dramatic changes in abortion practice in America. Referring back to the idea of intersectionality put forth in the introduction, I suggest that the interactions of each of these events and institutions was critical for the shaping of the abortion provider shortage and the development of marginalized abortion care. As the next section will demonstrate more clearly,
these historical events were reflected in abortion practice and had a causal role in changing conceptions of abortion both within and outside of medicine.

*The Practice of Abortion in America Today*

Each year in America today well over one million abortions are performed, making this one of the most commonly occurring surgical procedures in the U.S. (Koyama 157). In fact, the procedure is so common that up to 40 percent of women will have had an abortion by the time that they are 45 (Koyama 157). Fortunately, this procedure is also a very safe and simple one, with less than 0.3 percent of patients experiencing a complication that requires hospitalization, and a miniscule death rate ("Facts on Induced Abortion"). The vast majority of these abortions occur during the first 12 weeks of pregnancy, the safest time to undergo such a procedure, and the women who abort do so for many reasons ("Facts on Induced Abortion"). Though women who have abortions come from all races, classes, locations, religions, and more, some groups—such as poor women, women of color, and women under age 25—are disproportionately more likely to have abortions than others, in part because of poor sex education, a lack of access to birth control and emergency contraception, and other social factors ("About Access"). A high percentage of women obtaining abortions identify as Protestant and Catholic, a majority of aborting women have one or more children, and two-thirds have never married
(“Facts on Induced Abortion”). Clearly, there is no one typical abortion patient, and this care is needed across social boundaries.

These abortions are performed primarily by physicians, as just a few states allow advanced practice clinicians\(^{23}\) to provide any abortion services (Samora 473). As of 2005, there were 1,787\(^{24}\) physicians in the United States willing to perform abortions, a number that has been declining since the 1980s (Jones 12). In fact, between 1982 and 2000, the number of abortion providers declined by about 38 percent, from a high of 2,900 to 1,800, and since 2000 the number of providers has dropped even further (Jones 6). One of the most trusted sources for information and statistics about abortion worldwide, Guttmacher Institute, has compiled decades of information about abortion providers as follows:

\(^{23}\) This refers to nurse practitioners, certified nurse-midwives, and physician assistants.

\(^{24}\) The study authors cite some limitations of their survey, so this number may be a close approximation.
As shown here, an increasingly small number of physicians, those deemed “large nonhospital providers,” are now being relied on to provide the majority of the nation’s abortions. Providers working in hospitals, on the other hand, typically provide abortions “only in cases of fetal anomaly or serious risk to the woman’s health,” and most of these providers performed fewer than 30 abortions in 2005 (Jones 13). “Small nonhospital providers,” which are typically physicians who perform some abortions in their personal offices or nonspecialized clinics, accounted for just two percent of all abortions performed in 2005 (Jones 13). In this graph, we can see the effects of the events and social changes described in the previous section, as the number of providers first began to drop during the Reagan years, and then experienced dramatic declines between 1988 and 2000, around the height of abortion clinic violence.

In 2005, 71 percent of all abortions occurred in abortion clinics, while just over 20 percent were performed in other health clinics providing mixed services, and less than five percent occurred in hospitals (“Trends in Abortion”). Despite the heavy reliance of abortion clinics, the number of these clinics declined by 15 percent between 2000 and 2005, making this care even less accessible for the nation’s women (Jones 12). Part of this decline may be related to the fact that specialized abortion clinics are easily targeted by anti-abortion activists, evidenced by the high percentage of abortion clinics that experienced some sort of violent harassment (“Anti-Choice Violence and Intimidation”). Hospitals, which

25 Sites where over 400 abortions per year are performed—often abortion clinics.
once performed up to 50 percent of the nation’s abortions, are now a minimal part of this care (“Facts on Induced Abortion”). As will be expanded upon in the next chapter, the lack of hospital providers exacerbates the abortion provider shortage as this is where the majority of medical students and residents obtain their training, and the likelihood of being exposed to abortion care in hospitals is low unless this exposure is expressly sought out.

The shortage of available abortion providers is exacerbated by the fact that a majority of high volume providers currently in practice are at least 65 years old (Hitt). Demonstrating this phenomenon, a 1995 survey of practicing obstetricians—the specialty seen as most responsible for abortion care—found that nearly 60 percent of physicians aged 65 and older performed terminations, while only 28 percent of those under age 50 did the same (Eastwood 303). This trend has continued since then, and this so-called “graying” of abortion providers is troubling on many levels. First, most of these older physicians are motivated to perform abortions because they saw the consequences of illegal abortion first-hand by training or practicing when it was criminalized (Joffe 183). Many recall seeing women die, or wind up irreparably injured, from botched abortions and are therefore much more likely than their younger counterparts to see this simple procedure as lifesaving and important to provide (Hitt). Younger doctors who have grown up in an age of legalized abortion may not see the procedure in this light, and are prone to assuming that this service is already “taken care of,” thereby diminishing feelings of personal responsibility for this care (Burns). Additionally, many of these older abortion providers are putting off retirement
because “they know there is no new class of doctors waiting to replace them,” and when they do retire the consequences could be severe, especially because they are more likely than younger physicians to do this work on a full-time basis (Maynard).

Women seeking an abortion later in pregnancy may have an even more difficult time finding a provider, as the shortage of practicing abortion providers increases with gestational age. While 96 percent of providers offer their services at eight weeks gestation, 67 percent offer some abortions after 13 weeks, while just 20 percent offer abortion after 20 weeks (“Facts on Induced Abortion”). By 24 weeks gestation, only 8 percent of providers will perform an abortion, so women in need of these services must often travel great distances to see a doctor (“Facts on Induced Abortion”). Moreover, the cost and length of an abortion procedure increases with gestational age, and patients may end up paying thousands of dollars in total (Jones 14).

Abortion procedure techniques have also changed over time, and available techniques do have some effect on provision. Currently, the majority of abortions that take place within the first twelve weeks of pregnancy are performed surgically (“Facts on Induced Abortion”). The most popular surgical abortion techniques in use today for these early abortions are manual suction or vacuum aspiration (Terrell). Both of these techniques involve cervical dilation and the use of a paracervical block to numb the area, followed by the removal of the contents of the uterus using either a hand-held suction device or a cannula.

\[\text{26 The vast majority of abortions performed this late in pregnancy are medically indicated due to serious fetal problems, to save the life of the mother, or under other extreme circumstances ("Facts on Induced Abortion").}\]
attached to a vacuum aspirator machine (Terrell). From beginning to end, this process typically takes no longer than ten minutes, and most doctors describe the procedure as an easy one to perform—perhaps even boring (Hitt). As we will see later in this chapter, concentrating these “easy” procedures all in one place may make abortion work even less desirable for physicians, exacerbating the shortage.

In 2000, after years of debate, the Food and Drug Administration approved a new abortion method for use in the U.S. that did not involve surgery (“Facts on Induced Abortion”). The drug, mifepristone\(^{27}\), can be used before nine weeks gestation to produce what is referred to as a “medical” abortion (Terrell). The protocol for medical abortion procedures involves taking a dose of mifepristone, which will stop the development of the pregnancy, under the supervision of a physician, then taking misoprostol, which will expel the contents of the uterus, up to two days later (Terrell). Around two weeks after the first doctors visit the patient is expected to return for a follow-up appointment to confirm that the pregnancy has been aborted (Terrell). While only 13 percent of all abortions—and 22 percent of all abortions before nine weeks—in 2005 were performed this way, research suggests that its use is on the rise as its safety is repeatedly demonstrated and physicians become more comfortable prescribing it (“Facts on Induced Abortion”). Medical abortion has helped to slow the decline of abortion providers in the U.S., as some physicians are more willing to offer this service than surgical abortion, and have begun providing medical abortions only (Jones 12). At this point, medical abortion has an enormous amount of

\(^{27}\) Also known as RU-486 and Mifeprex
potential for expanding abortion provision not just in the number of physicians providing this service, but also in the types of these providers and their locations, as will be discussed further later in this chapter.

Abortions that occur later in pregnancy, during the second or third trimester, are always performed surgically. These procedures carry a higher risk of complications and are more technically difficult to perform, but they also occur less frequently—in fact less than two percent of all abortions occur at or past 21 weeks gestation (“Facts on Induced Abortion”). The most common technique used to abort a later pregnancy is referred to as a “D & E,” or, dilation and extraction, in which a dose of medication is taken (or the physician may inject the fetus directly) to stop fetal development, then the cervix is dilated wider than in earlier abortions, and forceps are used to extract the fetus (Terell). Dilating the cervix can take several days, as it is done gradually using laminaria\(^{28}\), and the procedure itself is typically performed under general anesthesia (Terell).

Another, less common method of later-term abortion uses induced labor, rather than dilation and extraction, to remove the fetus (Terell). Some doctors may find these procedures emotionally difficult to perform\(^{29}\), which might be an additional contributing factor to the extreme shortage of later-term abortion providers.

All of these abortion services have become increasingly difficult to access since legalization. As discussed in the introduction, there are a number of barriers in place that prevent women from obtaining the abortion care that they

\(^{28}\) Thin, sterile seaweed sticks which swell slowly after being inserted into the cervix.

\(^{29}\) This will be discussed in greater detail later in this chapter.
need. Young women, women living in rural areas, and poor women, who are disproportionately of color, face the most opposition when seeking abortion care. Legal barriers are numerous, and may include parental consent and notification laws that violate patient confidentiality for women under age 18, mandatory waiting periods which require women to wait a period of time between a state mandated counseling appointment and their abortion, and “biased counseling” laws which require health care workers to tell patients specific information about abortion and childbearing—often this information contains medical inaccuracies and is designed to dissuade women from aborting (“About Access”).

Many of these restrictions, when coupled with travel costs and time away from work or home, result in dramatically increased costs for the woman. Moreover, the Hyde Amendment prohibits the use of federal funds to pay for abortion care, so low income women on Medicaid are not eligible for assistance with their abortions and must often pay the sum out of pocket (“About Access”). Additionally, most private health insurance companies provide no, or only minimal coverage for abortion care (Burns). The cost of an abortion varies by gestation, location, and facility type, and an abortion\(^{30}\) at ten weeks can range from $90 to $1,800, while an abortion at 20 weeks can cost between $350 and $4,520 (Jones 14). On average, abortion clinics reported the lowest median charge and private physicians’ offices reported the highest (Jones 14).

Long distance travel costs may also increase the financial burden placed on abortion-seeking women. As 88 percent of U.S. counties are without an

\(^{30}\) Note that medical and surgical abortions are comparable in price.
abortion provider—and nearly 100 percent of rural counties—many women must travel long distances to reach the nearest provider of abortion services (“Facts on Induced Abortion”). In one survey, nonhospital abortion providers estimated that eight percent of their clients traveled more than 100 miles to receive care, and 19 percent traveled between 50 and 100 miles (Jones 14). Furthermore, women attempting to access abortion services may also be faced with harassment from friends, family, activists, and even health care workers who hold anti-abortion views. “Crisis pregnancy centers,” schools, and doctors may provide women with inaccurate information that is designed to prevent them from having abortions (“About Access”). When actually at an abortion clinic or other office, these women face additional harassment from picketers and protestors.

The shortage of practicing abortion providers is well established as one of the primary causes for reduced access to abortion services, partly because the lack of available local abortion services drastically increases the cost and effort required for women to obtain abortions. As such, in order to improve access to abortion services and to improve the quality of this care, it is imperative to work toward reversing this shortage and producing more physicians willing and able to provide this care. In the face of a provider shortage that is so severe that women in some areas are attempting unsafe self-abortions, there exists some professional responsibility for physicians to provide this care—an argument that will be further developed in the next section (Joffe, “Reproductive Regression”). The remainder of this thesis will then bring together the historical accounts explored earlier, past and contemporary research on the issue, and anecdotal evidence that
points not only to the causes of this shortage, but also to potential solutions for its reversal.

*Professional Obligation and the Conscience Argument*

The severity of the abortion provider shortage described in the last section, and its consequences for women seeking abortion care, beg the question—do physicians have an obligation to provide this care, and if so, to what extent? These questions are currently very controversial in medicine, and have been the subject of intense debate and even legal action. While some professional organizations, such as the Accreditation Council for Graduate Medical Education (ACGME) and American College of Obstetricians and Gynecologists (ACOG), have regulations in place that encourage physician training programs to include information and education about abortion, legislation also exists at the state and federal level to protect healthcare workers with religious or personal objections to abortion from participating in this service (Hitt; Committee on Ethics).

Physicians and students who are personally opposed to abortion or identify as “pro-life,” tend to believe that induced abortion represents the immoral taking of a life (that of the fetus, which is awarded the status of a person), and argue that participation in this care at any level is a violation of conscience (“Right of Conscience”). Groups such as the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) assert that the practice of abortion has no place in medicine and that physicians have a personal right to
refuse involvement in abortion care by way of conscientious objection ("Right of Conscience"). Many “conscientious objectors” argue their position based on an individual practitioner’s right to freedom (of speech, religion, et cetera), and the American Medical Association acknowledges this freedom in its principles of medical ethics, which state that “a physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care” ("Principles of Medical Ethics"). Particularly within the American system of capitalist medicine, physicians must be awarded a degree of free choice regarding what services to provide and to whom.

While AAPLOG and similar groups oppose participation in abortion\(^\text{31}\) training, provision, and referral out of the desire to preserve their moral integrity, the majority of their arguments are related to the nature of abortion itself. AAPLOG, for example, alleges that the abortion services themselves are dangerous to patients both physically and psychologically ("Right of Conscience"). Using studies and data that have been discredited by respected organizations like the American Psychological Association and the Guttmacher Institute, this group argues that abortion results in long-term mental and psychological problems for patients, that the drugs used in medical abortions and emergency contraception are dangerous, and that the safety and complication rates of surgical abortions are unknown because freestanding clinics are not

\(^{31}\) And often forms of birth control like emergency contraception, or Plan B.
always required to report their activity, and because patient follow-up is low and so complications may not be identified (“Right of Conscience”).

Though their arguments about the safety of abortion are scientifically dubious and have been widely discredited, conscientious objectors’ claims about a practitioner’s right to refuse to participate in that which they find immoral hold more substance. The issue brings up a number of questions related to abortion training and practice. To what degree are these individuals exempt from participation and training, and what professional obligations do they have to be involved and to learn the procedure? What is a physician’s responsibility with regards to abortion care, and how do professional ethics come into play? How about emergency abortion services? And what does all of this mean for patient care—is it beneficial to either party to have unsupportive physicians participating in abortion care? When do obligations to the patient override obligations to the self, and vice versa?

Considering these questions on a practical, rather than purely abstract, level helps to shed light on how to evaluate professional obligation. Historically, and in practice, the physician-patient relationship is one of unequal power distribution, so the decisions of individual physicians must be made with the consideration of the potential magnitude of their choices versus those of their patient. A young, poor, or rural patient, for instance, might be more negatively affected by a physician’s refusal to provide emergency contraception than the physician would be by writing out a script. Even in the case of abortion, physicians must be held to a standard of professional conduct that is consistent
with that of all other medical care. “Do no harm,” for example, has been used to support arguments on both sides of the debate, and aside from this there seems to be no real consensus about which other professional obligations physicians have to their patients and society as a whole. To evaluate additional obligations, I will refer to the models put forth by Dr. Karen E. Adams in her article titled “Moral Diversity Among Physicians and Conscientious Refusal of Care in the Provision of Abortion Services,” and the ACOG Committee on Ethics’ position in their article, “The Limits of Conscientious Refusal in Reproductive Medicine.”

Both of these articles identify additional, informal professional responsibilities that physicians have to their patients and society as a whole. In describing from where these obligations derive, Adams argues that because physicians receive extraordinary social benefits (including partially tax-payer-funded schooling) by virtue of their training, and because they have a monopoly on most serious medical care, physicians are obligated to weigh the potential social harms that may result from decisions they make to withhold care (Adams 224). Here, social harms might be interpreted by opposing sides in different ways, with some physicians viewing abortion itself as a social harm, and others identifying more concrete issues like an increase in deaths from attempts at self-abortion. The Committee on Ethics also argues that certain moral obligations may outweigh the respect for conscience, stating that “with professional privileges come professional responsibilities to patients, which must precede a provider’s personal interests” (Committee on Ethics 3). These informal professional responsibilities include respecting patient autonomy, maintaining
scientific integrity, and promoting nondiscrimination (Committee on Ethics 4; Adams 224). Likewise, physicians are expected to provide the services and information that are consistent with the standards of their field, and to supply patients with accurate information so that they might make informed decisions about their own care (Committee on Ethics 3).

In the context of abortion, a physician’s refusal to provide services or information may violate these obligations in a variety of ways, or not at all. Though many physicians describe their anti-abortion views as a part of a commitment to “do no harm,” refusing to provide abortion-related care or referrals may in fact cause substantial harm to the patient (who is, in this situation, the pregnant woman and not the fetus), particularly when this referral occurs in an emergency situation or in a rural area where the ability to find alternative opinions or care is seriously limited. Moreover, refusals may, depending on how they are handled, cause harm to the patient by disrespecting her personal autonomy. This can result from the imposition of a physician’s own personal moral or religious beliefs onto the patient, or from providing the patient with scientifically discredited information (or withholding scientifically relevant information) that affects her decisions regarding care (Committee on Ethics 3).

The dissemination of information or advice about treatment that is at odds with professional or specialty standards also jeopardizes the physician-patient relationship by placing the physician in the position of moral or religious guide, rather than medical consultant. National laws giving physicians control over abortion care did so on the assumption that a woman’s decision to abort was
made in accordance with a physician’s medical judgment, and when this advice is provided based on the physician’s personal, rather than medical, judgment, this is not only an unethical use of the physician-patient relationship, but it verges on the unlawful. A physician’s refusal to provide care, information, or referrals also has the potential to reinforce social inequalities by, for example, “placing a disproportionate burden on disenfranchised women in resource-poor areas,” or by encouraging “the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally” (Committee on Ethics 4). As each of these suggest, the potential for violating professional responsibility is related to the degree and manner of refusal, the patient’s status, and the physician’s location.

Emergency care is another important consideration of professional responsibility, both in general and in the case of abortion. As mentioned in the AMA standards of medical ethics, physicians, by nature of their association with the profession, are expected to provide appropriate care in emergencies to the best of their abilities, and this is generally considered true even when off the clock ("Principles of Medical Ethics"). Additionally, the vast majority of physicians who state that they are opposed to induced abortion also believe the procedure is morally acceptable in some emergency situations, such as the save the life of the mother. It follows, then, that even physicians who do not personally approve of abortion may still be professionally obligated to provide this care in emergency

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Responsibility here may be associated with specialty as well. Primary and emergency care physicians, such as those in family practice and obstetrics and gynecology, would in this case be expected to have some knowledge of this care, whereas a pediatrician or ophthalmologist would not.
situations when a life may be at risk\textsuperscript{33}. In order to do this, relevant physicians must know how to perform a medically indicated abortion, and may therefore be obligated to obtain abortion training when it is offered.

A physician’s choice of specialty also bears on their professional obligations to become involved with abortion care. Those with personal objections to abortion should consider these views before entering a specialty for which abortion is a professionally recognized topic of importance, such as obstetrics and gynecology. In this specialty it is reasonable to expect to be faced with patients seeking advice about abortions, or requiring other abortion-related care, such as treatment for complications. Physicians who know that they would not be willing to provide the care or information that their specialty asks of them, or whose personal beliefs might influence the care given in a negative manner, should be expected to seriously evaluate the obligations that come with being a women’s health care provider (Committee on Ethics 4). As specialty choice is determined entirely by individual physicians, it is reasonable to expect that those who object to a specialty’s core values and treatments be discouraged from entering that specialty.

Of note here is the fact that some physicians who are strongly anti-abortion may in fact choose to enter the obstetrics and gynecology specialty in an effort to move the field away from what they believe to be immoral care. Undertaken as a form of activism, choosing this specialty out of a desire to stop or prevent abortions from occurring may be in line with the physicians own

\textsuperscript{33} This is particularly prudent in rural areas, where another physician familiar with abortion may not be immediately available.
personal standards, and such a physician may honestly believe that they are providing better health care by doing so. However, as this sort of decision is made in direct opposition to existing specialty standards, it can be seen as professionally irresponsible.

Situations certainly do exist in which a physician’s conscientious refusal to provide abortion-related care can occur in line with these professional standards. This may include an urban family physician who will not perform an abortion on a patient, but who provides the patient with accurate information about all of her options and makes a referral to another nearby physician willing to perform an abortion if needed. On the basis of the professional obligations discussed above, however, physicians may be morally and professionally obligated to provide medically accurate, unbiased scientific information about abortion and contraception to their patients, as well as referrals to alternative sources of care, though they need not perform the procedure itself. Furthermore, in order to have the skills necessary to provide emergency care and the knowledge base to offer respectful pregnancy options counseling, physicians likely to come into contact with abortion-seeking patients are obligated to participate in an appropriate degree of abortion training—including and beyond lectures about abortion techniques and complications—when and if it is offered. The availability of such training, and its connection to the abortion provider shortage, will be evaluated further in Chapter Three.
Chapter Three:

Barriers to Abortion Provision: Where Have All the Doctors Gone?

The previous two chapters have demonstrated not only the existence of the abortion provider shortage, but also the political, social, and legal history that enabled it. Furthermore, we have seen that in the face of such an extreme shortage of providers, physicians do have some professional obligations when it comes to training and providing services. This chapter will serve as an exploration of the primary direct cause of the provider shortage—a lack of training at both the medical school and residency level—as well as the many other barriers that practicing physicians face when attempting to incorporate abortion care into their work. Most of these barriers grew out of the events and political and social changes that were discussed in Chapter Two, and will here be discussed from the point of view of individuals, rather than American society as a whole. While the last two chapters have set up the societal context for the abortion provider shortage, this chapter will analyze the immediate obstacles to abortion provision that exist for healthcare providers, and will illustrate the importance of comprehensive abortion training.

Abortion Education in Medical School and Residency
With professional obligations and the provider shortage in mind, it becomes necessary to examine how and to what extent future physicians learn about abortion. We will begin with medical school education, the first portion of a doctor’s medical career. During the four years of intensive instruction at allopathic or osteopathic medical schools, students typically take two years of required preclinical coursework, which focuses on the basic medical sciences and health models, followed by two years of training that includes elective coursework and clinical clerkships in core medical specialties. Though each institution uses a different pedagogical approach and offers different required and elective courses, all medical students will complete their degrees with similar knowledge about the basics of treatment and disease in most specialties.

In order to evaluate abortion education at the medical school level, a number of questions must be answered. How and where, for example, is abortion introduced into the curriculum? Is the topic given its own lecture, is it mentioned in a lecture about another topic, or is it not mentioned at all? If abortion is included alongside other material, what other material? Is it discussed as a political and ethical issue, a medical procedure, a public health issue? What kind of exposure to students get to the clinical aspects of abortion, and does this include medical abortion and first- and second-trimester surgical abortions? Are students expected to participate, or must they pursue this training on their own? What effect does this training have on the students’ attitudes about abortion and abortion provision?
Proponents of abortion education in medical school argue that this training is necessary and ought to be a routine part of medical education, particularly in the face of a severe abortion provider shortage. The need to encourage interest in abortion provision is perhaps the most pressing issue, and widespread exposure to the subject across medical disciplines is one way to work toward this goal. Equally important is the fact that abortion remains one of the most commonly performed medical procedures in the U.S., and physicians of all specialties are likely to come into contact with a patient who has had or will have an abortion. At the very least, the nation’s primary care doctors need to know how to identify and treat complications of medical and surgical abortions just as they would for any other frequently occurring procedure. Furthermore, in the face of increased medical specialization, medical school is the only point in some physicians’ careers where they will be exposed to the basics about major health issues across a wide range of fields and advanced medical training cannot be relied on to provide this information. Those supporting abortion training in medical schools also highlight the fact that abortion is heavily politicized and hotly debated medical issues in the U.S. today, and those representing the medical profession have a responsibility to be educated about the medicine behind abortion, and not simply the ethics or politics.

Those who oppose training in abortion at the medical school level argue that the subject is too controversial, and inappropriate for medical school curricula. Some make this argument based on personal beliefs about the immorality of abortion in general, while others, such as medical school
administrators, may fear the political ramifications of exposing a broad range of students to information about abortion. Medical students opposed to abortion, for example, may protest the administration to remove this content, and anti-abortion activists have been known to harass medical students undergoing abortion training, or to publicize the school's inclusion of this training (Burns). Avoiding such controversy may seem to be, at least in the short run, in the school's best interest despite the fact that a lack of trained abortion providers may be damaging for patients.

Unfortunately, very little research has been done studying exactly what medical schools teach their students about abortion, and what percentage of medical schools include abortion training in their curriculum. The studies that do exist on the topic have been conducted primarily by physicians who favor the inclusion of this education in medical school, and while no scientific research exists to counter this belief, most of these studies have included addressed both sides. At present, the premiere study on the topic is “Abortion Education in Medical Schools: A National Survey,” which was conducted by Dr. Eve Espey and colleagues in 2005. Funded privately and based out of the Department of Obstetrics and Gynecology at the University of New Mexico, Albuquerque, Dr. Espey has a medical degree and a Masters in Public Health, and specializes in reproductive health care.

Dr. Espey and colleagues sent a survey designed to assess abortion training to the directors of the Obstetrics and Gynecology (henceforth, Ob/Gyn) clinical clerkships at all 126 accredited allopathic medical schools (Espey,
“National Survey” 641). In an attempt to determine the extent to which abortion information is included in medical schools during both the preclinical and clinical years, what sort of training is provided, and whether or not this training is well-integrated into the curriculum, confidential respondents were asked to answer questions about their specific programs. Seventy-eight clerkship directors responded, generating a response rate of 62 percent, and because of the survey method, it is unknown if this was a representative sample, although some response bias was expected (Espey, “National Survey” 641).

The results of this survey indicated that both information about abortion and exposure to actual abortion procedures was limited or nonexistent in the majority of American medical schools34 (Espey, “National Survey” 641). Based on the responses of Ob/Gyn clerkship directors, abortion education is offered in medical schools in the following ways:

<table>
<thead>
<tr>
<th>Education Components</th>
<th>Preclinical Years</th>
<th>Third-year OB-GYN clerkship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture on abortion</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Lecture, abortion mentioned</td>
<td>22%</td>
<td>37%</td>
</tr>
<tr>
<td>Small group</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>Clinical experience</td>
<td>6%</td>
<td>45%</td>
</tr>
<tr>
<td>No formal education</td>
<td>44%</td>
<td>23%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>23%</td>
<td>0</td>
</tr>
</tbody>
</table>

*Numbers in columns do not sum to 100% because some programs included more than one education component (Espey, “National Survey” 641)

34 As this was true for responding schools, and nonrespondents were more likely not to offer this training, this is a safe extrapolation.
The data presented here suggests that discussion about abortion in the preclinical years of medical school is especially limited, and while nearly half of the schools report offering a clinical experience in the third year, this says little about what percentage of students participate in such an experience. To address the issue of participation, the researchers also asked those schools offering a clinical experience to evaluate how well such an experience was integrated into the overall curriculum. Typically, this refers to whether this training was “opt in,” meaning that interested students could ask to participate but it is not routinely offered, or “opt out,” indicating a routine training option in which students could choose not to participate. Clerkship directors reported that 74 percent of these experiences were “at least partially integrated into the curriculum,” and their responses indicated that a significantly higher number of students participated in the well-integrated experiences than in the non-integrated experiences (Espey, “National Survey” 642). And though the difference between the two approaches is significant, still only 30 percent of clerkship directors reported that “most” of their students participated in the third-year clinical abortion experience when it was well integrated (whereas no clerkship directors reported that “most” or “half” of students participated in the non-integrated experiences) (Espey, “National Survey” 642). The finding that routine and well-integrated abortion training garners higher participation rates than “opt-in” training has been replicated many times.

Overall, this study found that 17 percent of responding medical schools offered no abortion training at all, a number which is probably higher when
considering that nearly 40 percent of schools did not respond, and those were less likely to offer this training (Espey, “National Survey” 641). This is a surprisingly high number given the frequency and visibility of abortion in America. Ultimately, Dr. Espey and colleagues also concluded that abortion training might be even more limited than this data suggests. When calculating that nearly one fifth of medical schools included no training in abortion, the researchers counted “Lecture on another topic in which abortion is mentioned” as education about abortion, but they acknowledge that the true value of such lectures may be limited (Espey, “National Survey” 641). Elsewhere, medical students have described this sort of lecture as one that reiterates well-known “pro-choice” and “pro-life” viewpoints, focusing on the ethics of abortion or including inaccurate information rather than offering legitimate technical instruction (Burns). One medical student commented that “perhaps in passing, I had limited exposure to some combination of the ethical questions of abortion, and remember hearing about misoprostol,” and a Medical Students for Choice member recalls learning “that abortion is legal in most states” (Burns).

Abortion education could also be included in a reproductive health elective, and this survey found that 52 percent of responding schools offered such an elective (Espey, “National Survey” 641). Unfortunately, clerkship directors also indicated that over in over 90 percent of these programs, fewer than ten percent of students in the class participated in these electives (Espey, “National Survey” 641). This led the authors to conclude that though these electives “are valuable in reaching the small number of students who are particularly motivated
to gain expertise in reproductive health, they do not fulfill the need for the kind of
general education that reaches all students in the preclinical years or clinical
clerkships” (Espey, “National Survey” 642).

The authors of this study, upon examination of their findings, concluded
that abortion education in U.S. medical schools is deficient, and that this
deficiency has likely contributed to the declining number of practicing abortion
providers (Espey, “National Survey” 642). Asserting that “while many
physicians choose not to offer abortion services in their practices…they should
understand abortion procedures and complications because of the high
prevalence of abortion,” Dr. Espey and colleagues argue that “abortion education
deserves a place in the curricula of all medical schools” (Espey, “National
Survey” 642).

An additional exploration of the issue of abortion training in medical
school takes place in a 2004 study by Solmaz Shotorbani and colleagues titled
“Attitudes and Intentions of Future Health Care Providers Toward Abortion
Provision.” Rather than focusing just on the inclusion of training, this study
examined the views of medical students themselves in an effort to determine the
acceptability of and interest in abortion among medical students. Published in
the Perspectives on Sexual and Reproductive Health journal with the Guttmacher
Institute, this small-scale study was conducted by staff at the University of
Washington, Seattle35, and it surveyed 147 second-year medical students36 at the

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35 It was funded in part by government agencies like the Maternal and Child Health
Bureau, Health Resources and Services Administration, and the U.S. Department of
Health and Human Services (Shotorbani 63).
affiliated medical school, with a response rate of 86 percent (Shotorbani 59). The University of Washington School of Medicine places a strong emphasis on primary care and rural health, and a majority of the medical students surveyed intended to enter a primary care specialty like family practice or internal medicine (Shotorbani 58). Though this article’s findings may not be generalizable to medical schools across the nation, it provides a useful glimpse into the way that medical students think about abortion provision, as well as their interest in the topic.

Overall, medical students surveyed indicated a high degree of support for legal and accessible abortion, higher than that of the general public. Seventy-two percent of those surveyed agreed that “elective abortion should be legal and accessible under any circumstances,” while 70 percent agreed that “it’s acceptable for a woman to choose abortion because of a fetal anomaly or congenital disorder” (Shotorbani 60). When asked to respond to the statement “every program that addresses women’s health should include abortion training,” the majority, 63.6 percent of students agreed, while 26.6 percent disagreed, and a remaining 9.8 percent neither agreed nor disagreed (Shotorbani 60). These findings indicate responding medical students’ favorable attitudes toward abortion at this early juncture in their training, though the study authors did not indicate whether or not these students had been previously exposed to information about abortion in medical school.

36 Though I am not discussing this here, this study also surveyed and assessed the views of students in the affiliated physician assistant and nursing schools.
Medical students were also asked to assess their willingness to provide abortion services later in their careers, with somewhat surprising results. Demonstrating substantial interest in abortion provision, responding students indicated the following:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>Undecided</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I plan to incorporate medical abortion into my practice</td>
<td>32.9%</td>
<td>21.9%</td>
<td>45.2%</td>
</tr>
<tr>
<td>I plan to incorporate surgical abortion into my practice</td>
<td>19.2%</td>
<td>26.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>I plan to perform abortion for my patients regardless of their reasons for terminating a pregnancy</td>
<td>30.8%</td>
<td>19.2%</td>
<td>50.0%</td>
</tr>
<tr>
<td>I would be willing to refer patients inquiring about an abortion to other clinics or providers if necessary</td>
<td>91.8%</td>
<td>3.4%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

(Shotorbani 60)

These results show a high level of interest in abortion provision among second-year medical students at this institution. Considering that less than one percent of all physicians perform abortions, it seems difficult to believe that such a substantial portion of students planned to incorporate this service into their later career plans. It is also interesting that, at this early juncture in training, over half of those surveyed expressed with certainty that they would not offer surgical abortions.

Those students who indicated that they would not provide abortion services at all were also asked to cite reasons for their refusal. The most prevalent reasons listed were: “It will be outside the scope of my practice,” “It’s against my
religious beliefs,” and “It's against my personal values,” with 35, 24, and 32 percent of students listing these reasons, respectively (Shotorbani 61). Cited far less often, at less than five percent each, were: “I will not have the opportunity to be trained in abortion techniques,” “I may be ostracized by my colleagues and/or discriminated against in my profession,” and “I fear that either I or my family may be harassed and/or threatened by others” (Shotorbani 61). What is troubling here is the high percentage of these students who, despite a plan to choose a primary care specialty, believed abortion care was irrelevant to their field. With the abortion rate in the U.S. in mind, it is likely that these students would treat a patient who has had or will have an abortion, and it may be necessary for them to know about the procedure in order to treat complications or concerns.

Though over 70 percent of medical students surveyed believed that abortion services should be legal and accessible, only 69.4 percent responded that they were willing to attend a program that requires abortion training in the curriculum—begging the question, how will abortion services remain accessible if physicians do not know how to provide them (Shotorbani 62)? Moreover, one third of those surveyed indicated that they were not willing to take elective courses in abortion training (Shotorbani 62). This finding underscores the value of routine training and sheds additional light on similar findings from Dr. Espey and colleagues, in which medical students were more likely to participate in training when it was routine or required than if it was optional.
Still, Shotorbani and colleagues were able to conclude that a majority of the medical students at the University of Washington believed that “abortion should be legal, accessible, and a standard part of clinical training” (Shotorbani 62). While this study only represents students at one medical school, it does indicate that medical students may have a high level of interest in learning about and providing abortions. Furthermore, this finding suggests that interest on the part of practitioners may not be the cause of the abortion provider shortage.

Dr. Espey of the University of New Mexico, Albuquerque conducted another study about abortion education in medical schools in 2007 titled “Abortion Education in the Medical Curriculum: A Survey of Student Attitudes”. This time, she and colleagues aimed to evaluate medical students’ attitudes about the inclusion of abortion education in both the preclinical and clinical years of medical school by surveying third-year medical students after their Ob/Gyn clerkship rotation. At the time of the study the University of New Mexico School of Medicine routinely included lectures on “the public health impact of abortion and on techniques and complications of medical and surgical abortion,” in addition to small-group problem-based discussions during the preclinical years, and also offered an optional clinical experience at a local Planned Parenthood site along with a comprehensive two-week reproductive health experience during the third-year Ob/Gyn clerkship (Espey “Student Attitudes” 206). Such a high amount of available abortion training for medical students is rare, as evidenced by Dr. Espey’s previous study, so this survey aimed
to assess how students felt about this instruction and what effect it had on their views about abortion.

Of the 118 students who did the Ob/Gyn clerkship during the study period, 100 responded to the survey, giving a response rate of 85 percent (Espey “Student Attitudes” 206). All of the survey respondents had taken part in the routine preclinical abortion lectures, and slightly more than half of the students surveyed had elected to participate in the clinical abortion care experiences—those who chose to “opt out” cited scheduling conflicts, moral objections, and lack of interest as reasons for abstaining (Espey “Student Attitudes” 207). The attitudes of both participants and nonparticipants were evaluated based on their responses to a number of survey questions, such as “Abortion is an appropriate topic for education in medical school” and “Overall, UNM has adequate, appropriate education about abortion” (Espey “Student Attitudes” 206). Those who answered “somewhat” or “strongly agree” were grouped together, and the results showed that an overwhelming 96 percent of medical students surveyed—including those who did not participate in the clinical abortion care experience—saw abortion education as an appropriate topic for education in medical school (Espey “Student Attitudes” 206). Similarly, 69 percent of participants and 64 percent of nonparticipants agreed that their university had adequate and appropriate education about abortion—what some might consider a surprisingly high approval rating given the substantial extent of the training (Espey “Student Attitudes” 206).
The survey also found similar attitudes between participants and nonparticipants about which aspects of abortion training students with moral objections should be excused from. Over two-thirds of both groups of students believed it was appropriate for those with objections to be excused from clinical experiences in abortion care, while less than one-third of either group agreed that these students should be excused from lectures about the public health impact of abortion (Espey “Student Attitudes” 206). The largest discrepancy found between the two groups was whether or not they believed that students opposed to abortion should be excused from attending lectures about the techniques of abortion, with 32 percent of clinical experience participants agreeing and 54 percent of nonparticipants agreeing (Espey “Student Attitudes” 206). This points to a common debate about what degree of training ought to be required of those who are morally opposed to abortion, which was addressed in the previous chapter.

Students who had participated in the clinical abortion care experience were also asked to evaluate the value of this training. Of those surveyed, 84 percent agreed that “the abortion care experience was worthwhile to my education,” and 73 percent indicated that they would recommend the experience to a fellow student (Espey “Student Attitudes” 207). Though there was no follow up with those who disagreed, the vast majority of students indicated that the clinical experience was valuable and worthwhile to their overall medical education (Espey “Student Attitudes” 207).
This study also evaluated the attitudes of medical students who intended
to pursue careers in family medicine or Ob/Gyn specialties about the training
they had received with respect to their future intentions about abortion provision:

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Percent responding “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you consider offering abortion in your future practice?</td>
<td>71</td>
</tr>
<tr>
<td>If yes, would you consider offering both medical and surgical abortion?</td>
<td>79</td>
</tr>
<tr>
<td>I prefer that abortion training is integrated into the residency curriculum and requires active opt-out.</td>
<td>74</td>
</tr>
<tr>
<td>I prefer that abortion training is an elective and requires active opt-in.</td>
<td>21</td>
</tr>
<tr>
<td>I prefer that abortion training is not included as part of residency training.</td>
<td>3</td>
</tr>
<tr>
<td>I feel more likely to offer medical abortion in my future practice than I felt at the beginning of medical school.</td>
<td>68</td>
</tr>
<tr>
<td>I feel more likely to offer surgical abortion in my future practice than I felt at the beginning of medical school.</td>
<td>38</td>
</tr>
</tbody>
</table>

(Espey “Student Attitudes” 207)

These results demonstrate that a program with significant abortion training
experiences in both the preclinical and clinical elements of medical school can
increase student interest in abortion provision. Third-year medical students
indicated not only that the education they received increased their likelihood of
offering abortion services, but also that they saw a program requiring active “opt-
out” as preferable to one requiring active “opt-in.”

Dr. Espey and colleagues have demonstrated an overwhelmingly positive
reaction to extensive abortion training at the University of New Mexico School of
Medicine. As another small-scale, localized study, these results may not be
generalizable, but they do underscore the importance, acceptability of, and
interest in abortion training at the medical school level. It is especially significant
that even students who were opposed to abortion personally, or who chose to
“opt out” of clinical training, saw abortion as an appropriate topic for medical education. This presents an important counterpoint to those medical school administrators who cite the possibility of opposition from anti-abortion students as grounds for keeping the issue out of the classroom.

The research discussed in this section, though useful, does have some limitations. Dr. Espey’s national survey of medical schools in 2005, for instance, chose to survey Ob/Gyn clerkship directors. These clerkship directors may not have had accurate information about which topics were included, and how many students participated, at educational components that were outside of their jurisdiction. Moreover, if the clerkship directors were relying on course syllabi when making their assessments, it is possible that the actual information discussed in courses differed from what was expected. A survey of medical students might provide more useful qualitative information about this, and I will discuss additional directions for future research and advocacy in Chapter Four.

As already mentioned, the studies about medical student attitudes each occurred at a single institution, so their findings may not be generalizable to all medical students. Neither of these studies assessed how much medical students knew about abortion or abortion technique at the time of their responses. Particularly with the study by Shotorbani and colleagues, it is difficult to determine what information was informing the opinions of second-year medical students, and whether or not all of it was accurate. An additional issue that comes with surveying medical students so early in their careers about their future
intentions with respect to abortion provision is the fact that the students “may not
have a realistic picture of what they will actually be able to do in the real world of
practice” (Rosenblatt 197). Similarly, student responses were based on a
student’s willingness to provide abortion services in their own future practices,
but the percentage of physicians practicing on their own or in privately owned
group practices has been declining, and today primary care physicians are more
likely to work in a hospital setting than on their own (Burns; Terrell). As I will
discuss further in later in this chapter, such changes in physician practice are
likely to have a large effect on ability to provide abortion services.

Despite these limitations, when considered together the three studies
outlined here present a strong argument in favor of the routine inclusion of
abortion education in medical school. Medical students are not only supportive
of legal and accessible abortion, in general, but they are also interested in
obtaining this training, see it as an appropriate component of medical school
education, those who participate in clinical experiences see it as a worthwhile,
and students are most likely to participate when this training is offered as a
routine or expected part of training. In addition to the benefit to future-
physicians, the inclusion of abortion training in medical schools is likely to be
beneficial to patients, as their doctors will be better equipped to sensitively discuss
abortion options and complications, and because a higher number of abortion
providers will help to alleviate barriers in accessing services that are associated
with the provider shortage.
Abortion Training at the Residency Level

After graduating from medical school, students pursue residency training in their chosen specialty field. In the first year of this training, students are referred to as interns, and in the years that follow, they are residents (or resident physicians). These programs are likely to take place at or in conjunction with a hospital, which might be a public, private secular, or private Catholic hospital. During residency, students work long hours for a low salary, and they begin to treat patients under the supervision of experienced physicians. Residencies prepare physicians to provide patient care on their own, and this is the time when students can move beyond learning about procedures by watching, and can actually begin to perform these procedures on their own. It is also the time when individuals can make decisions about the kinds of medicine they would like to practice. Finally, after the completion of residency training, students become fully licensed to practice medicine.37

While arguments about the importance of including abortion training in medical school education have emerged primarily over the past two decades, the more specialized residency has been a well-established location for this training for some time. Specifically, the most obvious focus for abortion training has been on obstetrics and gynecology residency programs, which typically take four years to complete and include extensive clinical training in a wide range of medical and surgical conditions and interventions related to gynecologic and obstetric care.

37 Note: Some physicians will go on to fellowships for subspecialty training.
Though abortion providers have hailed from a wide variety of specialties, obstetrician-gynecologists hold the primary responsibility for abortion care because it is so directly relevant to their field. In fact, professional organizations in the Ob/Gyn field have identified abortion as an important skill to be learned by Ob/Gyn residents since as early as 1978\textsuperscript{38} (Lindheim 24).

Those who express opposition to abortion training in Ob/Gyn residencies typically do so not because they believe the topic is inappropriate for the specialty, but because they are morally opposed to abortion as a part of health care in general. Individual residents who are anti-abortion, for example, are not required to participate in clinical abortion training (Almeling 268). Additionally, anti-abortion institutions, such as Catholic hospitals and residency programs, typically reject abortion training in residency on the basis of religious opposition\textsuperscript{39}. Proponents of routine abortion training in Ob/Gyn residency programs, on the other hand, point to the relevance of the procedure and its techniques to the specialty and these physicians’ obligations to know about abortion care in order to properly serve their patients. Supporters also cite the direct link between a lack of trained Ob/Gyn residents and physicians and the continuing decline in the number of practicing abortion providers.

Some in the field of abortion provision have estimated that in order to become a competent provider by the end of residency, and to be eligible for work at most abortion clinics, a physician ought to have performed between 25 and

\textsuperscript{38} As will be discussed later in this chapter, abortion is also an appropriate topic for family medicine and internal medicine specialists to learn about in residency.

\textsuperscript{39} But, as I will discuss later in this chapter, a regulation passed in 1995 attempted to require Catholic Ob/Gyn residency programs to offer their residents a venue in which to obtain this training.
100 surgical abortions\(^40\) (Burns; Terrell). Thus, if residency programs seek to produce physicians capable of alleviating the provider shortage and actively performing abortions, they must include relatively extensive training in this area, just as they would for pelvic exam technique and childbirth. In order to determine whether or not Ob/Gyn residents are receiving the expected training in abortion, physicians, researchers, and activists have been studying Ob/Gyn residency programs intermittently since 1978, just a few years after legalization. I will consider the findings from the major studies in this body of research in order to investigate how abortion training in Ob/Gyn residency programs has changed over time, and what factors have influenced these changes.

The first three major studies I will examine were published in 1978, 1987, and 1995 in the journal *Family Planning Perspectives*, with support from the Guttmacher Institute. These were authored by Barbara L. Lindheim and Maureen A. Cotterill, Phillip D. Darney and colleagues, and H. Trent MacKay and Andrea Phillips MacKawy, respectively. Using slightly different questions but similar methodology, each of these studies surveyed the program directors of Ob/Gyn residencies across the U.S. regarding the training their residents had received in a number of abortion care areas. The surveys sought information regarding what sort of first- and second-trimester surgical abortion instruction was given, whether this training was routine, optional, or not available, and whether the program was affiliated with a public, private non-religious, or

\(^{40}\) Certainly a wide range, but it seems to depend on the type of abortion one wishes to perform, and the potential location of employment or provision and the potential for on-the-job training that exists.
private-Catholic hospital. Each of these also assessed resident participation using varying measures and estimates.

A comparison of the results of these three studies shows that there have been notable changes in Ob/Gyn resident abortion training over the years. I have compiled some of the key findings from each survey in the following chart:

As this data shows, routine instruction in first- and second-trimester abortion declined dramatically over time, and optional training in both methods experienced a sharp decline in the 1980s, and then rose again, but remained less common than it had once been. Additionally, the number of programs that

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41 As I will discuss later, response rates for each of these studies varied, so this data represents survey respondents and not necessarily all Ob/Gyn residency programs.
42 Note that even in programs with routine instruction, not all residents are likely to be trained, as some choose to opt-out.
simply did not offer second-trimester abortion instruction had risen substantially and remained above 30 percent throughout the 1980s and 1990s.

In 1978, Lindheim and Cotterill found that of the 213 responding hospitals, over 80 percent required Ob/Gyn residents to learn to treat complications of abortion procedures, including 55 percent of private, Catholic hospitals (Lindheim 25). Additionally, 40 percent of Catholic hospitals offered training in first trimester abortion, and 35 percent offered this training for second-trimester abortion, compared to the 76.2 and 75.5 percent of public hospitals that offered the same training (Lindheim 25). Based on information about each program, the study authors were able to conclude that between 71 and 95 percent of all Ob/Gyn residents at the time of the study were trained to treat abortion complications, and between 56 and 79 percent could perform first-trimester abortions, while between 48 and 70 percent could perform second-trimester abortions (Lindheim 26). Despite these numbers, which will later seem very high, Lindheim and Cotterill concluded that the majority of U.S. Ob/Gyn residency programs at that time were not fully complying with the professional standards laid out by the Council on Resident Education in Obstetrics and Gynecology (CREOG), which had listed abortion as an obstetrical skill that residents should learn (Lindheim 24). Predicting trends that would continue for decades after the study was published, the authors stated that “to the extent that physicians do not learn how to perform abortions, or are forced to get on-the-job training at non-hospital clinics or in the course of their practice after specialization, the incorporation of abortion into the mainstream of health care
over time will be adversely affected” (Lindheim 27). When the study was implemented in 1976, 30 percent of U.S. hospitals had reported performing at least one abortion, in contrast to 5 percent in 2005 (Lindheim 27; Jones 12).

The follow-up to this study, authored by Darney and colleagues, was conducted in 1985\(^43\). At this time, only 13 percent of all abortions were performed in hospitals (Darney 162). Unfortunately, they found that instead of improvements, there had been declines in the number of programs with both routine and optional training in first- and second-trimester abortions. The sharpest declines occurred for optional training, which translated into a fourfold increase in the percentage of residency programs that offered no abortion training at all (Darney 160). One of the primary causes for the decline in training was the substantially smaller percentage of private Catholic and non-Catholic hospitals that offered abortion training: by the 1985 survey, 73 percent of Catholic hospitals offered no first-trimester abortion training (Darney 160). As mentioned in Chapter Two, the Catholic Church had become increasingly involved in abortion politics during this time, and exerted a stronger push on its member hospitals to exclude such care. Overall, the percentage of all programs offering no first-trimester abortion training rose from 7.5 percent go 27.8 percent, and the percentage offering optional training declined from 66.2 percent go 49.6 percent (Darney 160). Referring back to the graph on page 59, we can see that the number of abortion providers practicing around that time had already begun to

\(^{43}\) The response rate for this study was high at 87 percent (Darney 159).
drop, and it would experience another significant drop by 1991 (“Trends in Abortion”).

The next study in this group of three, conducted in 1991 to 1992 but published in 1995, found that abortion training had continued to decline at U.S. Ob/Gyn residency programs. Routine training in first and second trimester abortion procedures dropped the most significantly, reaching a mere 12.4 percent for first-trimester abortion, and 6.9 percent for second-trimester abortion (MacKay 113). This was partially offset by a slight increase in optional or offered training, which jumped to around 60 percent\(^44\) for both procedures, but as optional programs have significantly less resident participation, a lower number of Ob/Gyn residents would receive this training (MacKay 113). Again, optional abortion training declined in Catholic hospital-based programs, with three percent of these programs offering any training, compared to over 20 percent in the 1985 survey (MacKay 114). Non-Catholic private programs and public programs increased their optional training during this period, however, such that around 70 percent of each offered some degree of training (MacKay 114).

At the time of this study, fewer than ten percent of all abortions were performed in hospitals, making it more difficult for residency programs to offer in-house training (MacKay 115). As such, in those hospitals that did not offer abortion training, residents were unlikely to gain any exposure to this procedure over the course of their medical education. This study was also conducted in the midst of rising abortion clinic violence, Catholic hospital mergers, HMOs, and

\(^{44}\) Which is still lower than it was in the 1976 study.
increasing legal restrictions on abortion practice, and the authors pointed to a shifting attitude among practicing obstetrician-gynecologists and other program administrators, saying that “abortion is not uniformly seen as an important part of the skills that obstetricians and gynecologists should possess” (MacKay 115). By the time that this study was released, it was becoming clear that the decrease in the number of abortion providers nationwide had not been merely a phase in the 1980s, but was becoming a dangerous trend.

In response to this study’s findings and the growing shortage of abortion providers, the Accreditation Council for Graduate Medical Education (ACGME) “instituted explicit requirements for the inclusion of abortion training as a standard part of obstetrics and gynecology residency education” (Almeling 268). These regulations would become a key turning point in Ob/Gyn residency training. Though the ACGME is a private group that cannot enforce compliance with such guidelines, it is supported by influential organizations like the AMA and is considered an authority within the field of obstetrics and gynecology. These 1995 guidelines, which intended to require Ob/Gyn residency programs to include abortion training if they were to receive accreditation, were aimed specifically at public teaching hospitals on the grounds that these hospitals have moral or religious objections to a medical procedure that is protected by law without compromising separation of church and state (MacKay 112). An exception, however, was included to release programs with religious or moral objections to abortion from this obligation, stating instead that these programs need only release their students to obtain the training elsewhere if they so choose.
Moreover, legal and regulatory protections were already in place at the national level to ensure that individuals who did not wish to participate in abortion training would not be obligated to do so (Burns).

Despite these “moral exception” clauses, the ACGME guidelines were widely opposed by a number of anti-abortion groups. The Federal Government also voiced its opposition to the regulations by passing the Coats Amendment in 1996, which made it illegal for an accrediting agency to deny a physician training program accreditation “due to its failure to be involved with one or more of those abortion-related activities” (“Abortion Training of Doctors”). Though the ACGME regulations had explicitly made room for moral opposition from individuals and religion-based programs, the Coats Amendment stated that the federal government itself would grant accreditation to programs refusing to comply with the 1995 guidelines (“Abortion Training of Doctors”). With the Coats Amendment in place, and anti-abortion groups paying close attention to the matter, many who had supported the regulations feared that nothing would come of them.

To test whether or not the 1995 ACGME regulations had any effect, Rene Almeling and colleagues conducted an additional survey on abortion training in Ob/Gyn residency programs in 1998, which was published in 2000. In conjunction with the National Abortion Federation (NAF), Almeling and company surveyed program directors at all 267 accredited allopathic Ob/Gyn
residency programs, receiving a response rate of 69 percent\(^{45}\) (Almeling 269). The authors found what appeared to be an increase in the number of programs offering routine first- and second-trimester abortion training, as responses indicated that over 40 percent of programs offered routine first- and second-trimester abortion instruction (Almeling 270). Optional abortion training, on the other hand, was measured differently in this study than it had been previously—in this study, authors distinguished between abortion training that was offered routinely, that which was offered within the program “electively” (opt-in), and programs which reported having “a system in place” for residents to obtain abortion training off-site if desired (Almeling 269). Using these measures, 34 percent of programs reported offering elective, in-program first-trimester abortion training and 12 percent of programs made this training available for their residents elsewhere, whereas 7 percent offered no first-trimester abortion training at all (Almeling 269). Second-trimester abortion training was an elective part of 29 percent of programs, offered outside of the institution in 14 percent of programs, and not offered at all in 10 percent of programs (Almeling 269).

When comparing this data to that presented in previous studies, it appears that routine abortion training had increased significantly after the 1995 ACGME regulations, while optional training and the proportion of programs not offering second-trimester instruction have both decreased. However, the inclusion of a new category—training available outside of the institution—and a lower response rate may change the interpretation of this data. Previously, respondents may

\(^{45}\) Slightly lower than in previous studies, probably in part because of the controversy that had come to surround the issue.
have included out-of-house training as a part of “offered” training, or it might represent new training opportunities in programs that previously did not offer any avenue for residents to obtain abortion training. By the first analysis, it would seem that the number of programs offering some kind of training had risen, whereas by the second interpretation, optional training had decreased substantially by moving out of resident training hospitals.

The authors of the 1998 study have also explained additional ways of interpreting their data. Because they received a lower response rate than in previous years, and there were demonstrated differences between the early and late responders, Almeling and colleagues believe that their results contain a response bias (Almeling 271). Thus, they offered two different scenarios. First, if nonrespondents offered abortion training in the same proportions as respondents did, then the percentage of Ob/Gyn residency programs offering routine first-trimester abortion training could be as high as 46 percent (Almeling 271). However, if under the more likely assumption, nonresponding programs did not offer abortion training, this percentage drops to 31 percent, and the percentage of programs not offering any first-trimester abortion training rises from 19 percent to 44 percent—a number that is substantially higher than estimates from the study by MacKay and MacKay in 1995 (Almeling 271). Either interpretation would, nonetheless, signal an increase in the number of programs offering routine training after the 1995 ACGME regulations.
Fortunately, the moderate improvements demonstrated by Almeling and colleagues seem to be sticking\textsuperscript{46}. In 2006, Dr. Katherine L. Eastwood and colleagues authored the most recent of this set of studies on abortion training in Ob/Gyn residency programs with the help of the American College of Obstetricians and Gynecologists. They found that the shift from optional to routine training was continuing as residency programs were beginning to re-integrate abortion training into their curriculums. Though they, too, had a relatively low response rate at only 73 percent, their findings were promising (Eastwood 304). Only ten percent of all responding residency programs failed to offer any abortion training at all to their residents, and 51 percent reported offering routine abortion training, with the remaining 39 percent offering optional abortion training (Eastwood 305). As the authors note, “this shift in training is significant, because routine status clearly leads to training in a greater variety of abortion techniques” (Eastwood 307).

Expanding on these findings, Eastwood and colleagues evaluated whether the training that residents received was adequate, which they describe as performing “at least 10 procedures per gestational age category” (Eastwood 305). They found that, based on the responses of the residency program directors, in programs that offer routine abortion training, the majority of residents performed more than 10 first-trimester abortions, whereas nearly half of residents in programs with optional training had performed less than 10 first-trimester

\textsuperscript{46} Of course, this did not happen in a vacuum, and was certainly helped by the fact that abortion clinic violence was no longer at its height, and student groups like Medical Students for Choice had increased their presence and influence at medical schools and residency programs.
abortions (Eastwood 307). Similarly, residents in programs with routine training in medication and second-trimester abortions were significantly more likely to have performed these procedures than residents in programs with optional training (Eastwood 307). Citing an earlier study’s findings that the likelihood of future abortion provision is clearly associated with two factors—training within the hospital setting and performing more than 25 abortions in residency—the authors concluded that routine abortion training was more likely to produce capable abortion providers than was optional training, so the move toward routine training was a step in the right direction (Eastwood 307).

As abortion training in residency became more available after the 1995 ACGME regulations were passed, the decline in the number of practicing abortion providers has slowed. Between 2000 and 2003, for instance, the number of providers dropped 2 percent—a vast improvement over the 11 percent decline seen between 1996 and 1999 ("Trends in Abortion"). This demonstrates the effectiveness of an increase in abortion training at the residency level at producing more abortion providers, as older providers continued to retire after 2000, but were beginning to be replaced by younger providers. The finding that extensive abortion training in residency leads to the production of new abortion providers has also been supported by research. One study conducted by Jody Steinauer in 2001 found that practicing Ob/Gyns who had recently graduated from California residency programs were much more likely to perform abortions if they had received comprehensive abortion training during their residency (Steinauer. "The Effect of Training," 1162). Three variables were independently, positively
correlated with abortion provision in this group: the number of abortions performed during residency, the gestational age limit of abortion training, and practicing in an urban area (Steinauer, “The Effect of Training,” 1162). Variables that were negatively correlated with abortion provision, on the other hand, were membership in a restrictive practice and having participated in training outside of the teaching hospital setting (Steinauer, “The Effect of Training, 1162).

These results point not only to the importance of extensive, in-house abortion training during residency, but also to the fact that the social environment of both training and later medical practice play a role in preventing physicians from performing abortions. The attitudes of a physician’s colleagues and professors may be just as critical to participation in abortion work as are the individual physician’s own beliefs and skill sets. As I will discuss in the next section, there are a number of logistical and social forces that affect a physician’s decision to provide abortions after residency, and these must also be considered when evaluating the causes of the provider shortage.

However, limited research also suggests that adequate training that is coupled with strong social support systems can dramatically increase an individual physician’s likelihood of performing abortions later on. A case study of residents at the University of Minnesota Obstetrics and Gynecology Residency Program, completed by the Abortion Provider Expansion Project (APEP), examined resident thought processes about abortion at a large midwestern
teaching hospital (Baram 2). More than half of those surveyed had not been exposed to abortion education during medical school, so most were getting their first exposure to the procedure during residency (Baram 5). Over two-thirds of those surveyed said that their ideas about abortion and abortion provision had changed over the course of their medical education, and many indicated that the clinical training they had received in residency was a positive “catalyst for change” in their beliefs (Baram 6). Additionally, almost half said that they had made a decision about whether or not they would later provide abortions while still in residency, with two-thirds reporting that they planned to include medical and/or surgical abortion in their future practices if possible (Baram 7). Providing additional clues about what might prevent physicians from providing abortions, many of those who planned to perform abortions later on expressed a concern about harassment issues, and “commented that they would feel more comfortable providing abortions in a hospital setting rather than in an independent clinic where harassment is more likely” (Baram 13).

Resident comments about how their clinical experiences affected their ideas about abortion varied, but all suggested that exposure to real abortion patients helped to destigmatize the procedure. “I saw a 16-year-old girl who was pregnant and didn’t even know how to become pregnant,” one resident wrote, adding “I decided I would be a provider at that point” (Baram 6). Another resident stated that she “realized that the procedures are not technically difficult” and that she felt comfortable performing on that level (Baram 6). One responding

47 This was a very small scale study and these numbers are not representative, but they do provide interesting qualitative information about resident though processes.
resident who did not plan to provide abortions indicated that the clinical rotation “opened my mind about abortion and now I realized it’s a necessary, safe, legal procedure and although I will not provide abortions myself, I am willing to refer my patients to a doctor who can help them,” demonstrating that abortion training can help make the need for the procedure more apparent to some who are morally opposed (Baram 6).

For those who stated that they would not be performing abortions, the most common reasons listed as influencing their decisions were as follows: pragmatic issues such as time pressures during residency, competency in the procedure itself, and ideas about the demand for services; fear of harassment; personal experiences religion, and “moral beliefs”; ideas about women’s autonomy and choice; and their desired career setting (Baram 10). Overwhelmingly, 96 percent of those who did not plan to provide abortions expressed that their reasons for abstaining were related to the influence of “political issues” (Baram 10). This staggering figure shows that the political visibility of abortion has become paramount to clinical judgment in some physicians’ minds, overshadowing the effect of any medical training or indications that might occur.

However, political views on the other end of the spectrum may be encouraging some physicians to get involved with abortion care. Particularly for younger generations of physicians whose exposure to the topic has been colored by the prevalence of political debate, the decision to provide abortions and obtain training may have its roots in social and political activism. In an interview, one
medical student described her interest in abortion provision as follows: “I don’t have a gut drive, it’s more like an intellectual drive…A woman’s control over her body is representative of her freedom, I feel the obligation to make sure that service is available and not stigmatized” (Meisol). Whereas many physicians trained before 1973 first encountered abortion in emergency situations, and may therefore describe the work as life saving or life-preserving, many younger physicians and those currently in training may want to provide for different reasons. Some such physicians may even see the work itself as unrewarding, but “see their choice to perform abortions as a political one” (Hitt). The move toward abortion provision as a political statement is described more later in this chapter.

Another issue that many researchers have pointed out is related to time. Residents are notoriously busy, working long hours under extreme stress. When abortion training is made optional, or it is clear that educators do not expect their residents to obtain this training, there is little reason for those who do not feel a strong conviction about the topic one way or another to spend additional time on this training (Lazarus 1419). Knowing that it is acceptable to claim exemption from this training on the grounds of moral objection, some will profess anti-abortion views simply to get out of the extra work (Lazarus 1422). Limited research on this has demonstrated that the number of residents claiming to have moral objections to abortion decreases dramatically when it is made clear that abortion training is expected, rather than optional (Lindheim 28). These findings
present yet another reason that routine, well-integrated abortion training in residency is important.

This body of research on abortion training in Ob/Gyn residency programs, stretching from the 1970s to the present, shows that a chronic lack of training for U.S. obstetrician-gynecologists has been a significant causal factor in the abortion provider shortage. Moreover, it demonstrates that abortion training is both appropriate and useful for these physicians, and that extensive, well-integrated, routine training is useful for generating positive feelings about abortion while also increasing the number of practicing abortion providers. Increasing routine training in this area, therefore, is likely to have a strong positive effect on alleviating the abortion provider shortage, while also helping to normalize abortion care within the field.

A discussion about abortion training in medical residency programs would be incomplete without a discussion of family medicine and internal medicine specialists and abortion provision, as Ob/Gyns are not the only physicians capable of providing abortions. In fact, the National Abortion Federation has reported that 32 percent of its member-providers are not Ob/Gyn specialists (Meisol). Many within and outside of medicine have highlighted family medicine physicians and other internists as a source of potential abortion providers due to their focus on comprehensive, lifelong patient care. These primary care physicians, who are expected to have close relationships to their patients, are more likely to practice in rural areas where the provider shortage is
most severe (Steinauer, “Training Family Practice Residents,” 222). Indeed, family physicians are often the only source of health care for millions of rural women and the only providers of affordable health care for many poor women nationwide (Steinauer, “Training Family Practice Residents,” 222).

In addition to their distribution, family physicians and internists may help to solve the abortion provider crisis for other reasons. The predominance of the clinic setting is problematic in part because it separates abortion care from the rest of medical care, and makes patients and care-providers more vulnerable to harassment. If family physicians, who often work within private practices that serve a variety of clients, were to perform the occasional abortion within their practices, they could help to reduce the visibility and controversial nature of the procedure in addition to the risk of violence to the patient. Abortion care in such a setting could be dramatically improved, as the patient would be in a more relaxed setting with a physician she is likely to know well and trust, therefore decreasing the stress of the encounter and promoting comfortable care. Additionally, medical abortion patients are more likely to attend the necessary follow-up appointments with their family physicians than they are with clinic physicians who may be distantly located (Snyder).

While many ambivalent and anti-abortion physicians argue that abortion is an inappropriate topic for internal and family medicine specialties, research suggests that abortion care remains well within the aims of these specialties. Family medicine, for example, involves a commitment to providing continuity of care within a primary care setting across a patient’s lifetime. An abortion may be
an event of much significance in a woman’s life and health, and it is beneficial for both doctor and patient to keep this care continuous (Brahmi 403). Family physicians and internists also provide family planning counsel and other gynecological services, and abortion care represents a natural extension of these services.

Several scholars have investigated abortion training in family medicine residency programs over the past decade. With only 11 of the 480 allopathic family medicine residencies in the country willing to be identified as offering abortion training as a routine part of the curriculum, there is a clear deficit in these residents’ exposure to this information (Brahmi, 399). This scarcity of training also reflects the hesitancy of family medicine physicians in general and training programs in particular to become associated with abortion care, despite the fact that early abortion care is consistent with the purpose of this primary care specialty. Moreover, it is symptomatic of the marginalized nature of abortion care within medicine more generally.

Much of the research that has been conducted on family medicine residencies and abortion training has centered on demonstrating the acceptability and value of this training for family medicine specialists, with very positive results. First, research has shown that family medicine residents are interested in learning about and performing abortions, and that the majority see first-trimester abortions (both medical and surgical) as appropriate for the specialty (Lerner 144). Despite the considerable interest, however, few residents actually perform abortions (Lerner 144). Particularly in the case of medical abortion, family
physicians and internists see this as a positive and acceptable procedure to include in their practices, yet few feel comfortable enough with their skills and training in surgical abortion back-up to actually provide medical abortions (Schwarz, 43). In fact, “the training-related factors were most predictive of whether an internist was willing to provide medication for abortion” in a multivariable analysis (Schwarz, 42).

Research has also demonstrated that residents’ beliefs about the appropriateness of abortion training within family medicine, and their subsequent desire for further training, was strongly affected by whether or not they had been offered this training to begin with (Lerner 144). Routine abortion training, in addition to imparting residents with a valuable skill set, had the effect of beginning to normalize the procedure in the minds of those who may have learned to vilify it. What is more, for residents who are still in the process of learning a specialty field and its conventions, a superior's encouragement to participate in abortion training helps to emphasize that this is an acceptable part of family medicine (Burns). A lack of exposure even to information about abortion seems to color family medicine residents against learning more. One study, concerned with this problem, found that a simple educational intervention in the form of a lecture about abortion was sufficient to increase interest in and support for abortion training (Wu 616). Residents with the least knowledge about the procedure and its public health consequences were the most likely to oppose its inclusion, and evidence suggests that mere exposure is enough to reverse this trend and generate interest (Wu 616). It is clear then, that including
abortion training as a routine part of family medicine residency programs may help to generate more interest in abortion provision among this group of physicians.

Moreover, several studies have shown that when family medicine physicians are trained in abortion techniques, they tend to see it as rewarding and beneficial to their overall practice. One study of both resident and patient experiences in a clinical abortion rotation found that “residents’ satisfaction with training and patients’ satisfaction with the care they received were overwhelmingly positive” (Paul 124). Satisfaction with abortion training was also significantly higher for residents who had on-site medical abortion training than those who trained off-site in a clinic, again demonstrating practitioner preference for hospital-integrated abortion care (Brahmi 401). But the volume of patients seen is also an important factor in practitioner confidence, so until abortions are more routinely practiced in a hospital setting, participation in clinic-based training can enhance residents’ skills by offering a high-volume experience (Paul 125).

Additionally, even for those who did not plan to utilize their abortion training later on, many reported that “their general procedural skills in gynecology improved,” as abortion training gives these residents more in-depth exposure to gynecological techniques, in addition to providing experience in pregnancy options counseling (Brahmi 402). Residents also reported that participation in abortion training increased the likelihood that they would perform abortions later in their career, and some found that “the exposure to
abortion training and the idea that it was possible to include abortion in primary care clinics was empowering” (Brahmi 403). Many younger physicians have come to believe that abortion care exists solely in the clinic setting, and without encouragement from others in the field, might never realize the option of integrating abortion care into a private practice exists. One resident commented about the training experience as follows: “Prior to residency I really had absolutely no plans of ever learning abortion—but I think it was just learning about this whole first-trimester abortion and especially the medication abortions…it just seemed like such an easy thing to do for people in the office” (Brahmi 403).

Much of the more recent research on this topic has focused primarily on family medicine physicians and medical abortion. While internists and family medicine specialists are capable of performing early vacuum aspiration surgical abortions, research has indicated that these specialists may be more comfortable with medical abortion, and they may be more likely to see this as consistent with the services they provide (Snyder). It is also critical on a practical level to consider that “the time and resources required to train a health-care provider to dispense mifepristone are significantly less than to train an aspiration abortion provider” (Schwarz 40). There are other barriers to training and institution abortion care within these specialties, many of them related to the opposition of colleagues and potentially even patients. Furthermore, these physicians may not have malpractice insurance that includes coverage for these procedures—this and similar barriers will be discussed in the next section.
The provision of medical abortion by family medicine physicians has the potential to transform the practice of abortion in America by making the service more accessible, increasing the types and number of providers, improving the experiences of abortion women, and increasing the proportion of abortions that occur earlier in pregnancy, thereby making the procedure even safer. If this training were to be modeled after that in Ob/Gyn residency programs in which training routinely occurs but individuals are permitted to opt-out, it seems that it would be well-received if coupled with information describing its relevance to family medicine patients and practice in general. All of the research on the topic has suggested that early abortion training in family medicine and internal medicine residency training programs is beneficial for both patients and physicians, and points to the inclusion of this training as an additional way to combat the shortage of abortion providers.

*Medical Training and Socialization*

In order to understand the full impact that including or excluding abortion training can have on future-physicians over the course of their medical careers, it is important to recognize that the function of medical training is multifaceted. The entire process of training to become a doctor is quite significant, taking many years and requiring considerable financial resources, educational preparation, and commitment. In its entirety, this process goes beyond the acquisition of knowledge to include an elaborate network of social roles, contracts, and
experiences that help to shape the character of the modern physician and the practice of medicine more generally. The information and roles acquired during training allow these individuals to perform the role of physician. Thus, the research on abortion training presented in the previous two sections must be considered within both contexts—the information and clinical skills instruction that physicians do and do not receive in addition to the attitudes and judgments that may come along with this training.

Physicians may even be socially primed before they reach medical school, as a plethora of pre-medical coursework and experiences are required for medical school entrance. These requirements, such as coursework in biology, chemistry, and organic chemistry, coupled with clinical or research experiences, help to ensure that students are capable of handling the workload a doctor faces. They also act as powerful screening tools that help admissions committees to select candidates who they believe will “fall in line” with the attitudes of the admitting institution (Stein 179). The stringent requirements for medical school are a part of the reason that only a limited pool of individuals have the opportunity to enter the medical profession, and those who do may not be demographically representative of the general public as they tend to be disproportionately white, financially well-off, and broadly educated (“Statistics and History”).

Those who do enter U.S. medical schools, either allopathic or osteopathic, can expect four years of intensive instruction, followed by several more years of clinical experiences during residency. This extensive preparation serves several functions. As posited by sociologist Howard F. Stein in American Medicine as
Medical training works to impart the knowledge and skills of doctoring onto students and, while doing so, it transforms a layperson into the social role and status of a physician (Stein 179). Medical school in particular is designed to provide students with the set of attitudes and beliefs that are seen as necessary to play the professional role properly (Friedson 17). That is, in addition to learning textbooks full of medical science and pharmacology, students learn to adopt the language, conventions, and values of the medical profession. Later, in residency, students spend virtually all of their time learning to put the values and techniques of a particular specialty into practice with real patients.

How is it that medical students and residents learn to think about patients and their bodies, and what is valued in terms of patient care? For most non-integrative medical models, the physical body and its constituent parts are referenced as “units of clinical discourse,” rather than as components of an embodied individual (Stein 13). Treatment of these parts is emphasized over treatment of the whole person, and students are taught from the very beginning of training to view the human body in a detached matter. As observed by author Wendy Simonds in her book *Abortion at Work: Ideology and Practice in a Feminist Clinic*:

> The first “patients” medical students encounter are, after all, dead...The medical language students learn reinforces the notion that “one dissects anatomic material; one does not look backward to the person once invested in this body.” For medical students, then, the humanity embodied in the human body becomes a secondary, if not a dangerous, concern. (Simonds 44)

Though clinical detachment does serve the important purpose of preventing emotion from interfering with clinical judgment, this norm often works against
physicians providing abortion care who tend to see their work as most rewarding when they can engage with their patients. In some ways, abortion care is inherently holistic as it is concerned with the patient’s thought process as well as body. Furthermore, those physicians who choose to adopt a more involved method of practice may be ill equipped to do so, and are prone to suffering burnout.\footnote{48 More on “burnout” later in this chapter.}

Also engrained in American medical culture, and thus present in medical training, is the importance of control. “The highest virtue,” writes Stein, “is to be able to bring patients’ pathologies under control,” and it seems that the very definition of medical treatment echoes the desire to fix what is “broken” (Stein 48). Related to this is the oft-cited model of the “sick role” in which illness represents a form of deviance from what is normal and healthy, and ill individuals may adopt a particular social role as a part of this condition that allows them to be unproductive members of society during sickness (Freidson 13). This is permitted when the patient participates in healing and seeks outside help, and in the hands of the medical profession treatment becomes a “rite of social control” (Stein 35). Another extension of this idea is Stein’s model of the good versus the bad patient, in which the bad patient “may or may not have a bona fide biomedical diagnosis and is held responsible for the control of his or her disease,” and “seeks to control the physician,” in contrast to the good patient who is compliant and defers to the physician’s expertise (Stein 98).
To the degree that physicians learn to internalize these health care models, their clinical judgment and choice of treatment plans may be affected. This becomes particularly relevant for abortion care, which presents a challenge to these established norms in several ways. First and foremost, as an elective procedure where the patient herself has made the diagnosis and treatment plan, the degree of control a physician has in this situation is low. For some physicians, this is seen as a “de-skilling” of medical ability, “in which a healthy woman makes the “diagnosis” of an unwanted pregnancy and the abortion-providing doctor then serves as a mere technician” (Solinger 322). In fact, the “mere technician” idea has been a frequently offered concern by physicians, particularly right after the legalization of abortion, as a part of the physician’s social role involves the ability to have control over the determination of treatment (Hitt). At present, this concern may seem especially relevant for physicians who do not get to participate in pre-abortion counseling, like in the busy clinic setting where other workers do the counseling and doctors provide just the abortion itself (Burns).

Abortion care also violates the conception of the “sick role,” as abortion-seeking women are typically in otherwise good health and are seeking medical assistance for what many would hesitate to call a cure. This is directly related to ideas of sexual purity for women that are so prevalent in mainstream culture, and rather than an unwanted pregnancy being viewed as a malady deserving treatment, it is seen as a punishment for impurity. In this scenario, the woman with an unwanted pregnancy represents a “bad patient,” as she is concerned with
a health matter that is not always considered legitimate, and she may in fact be partially responsible for. Moreover, she has a large role in determining the course of treatment, which is in opposition to the “good patient” who relies on the physician's judgment.

These models for viewing patients may be learned subtly, through the culture of medicine rather than through textbooks or direct instruction. What medical students and residents do or do not learn directly about abortion may also deeply affect their views about the procedure. For example, we have seen that abortion information is often left out of medical school education entirely. The absence of this training may then lead some future-doctors to conclude that this care is unimportant or unaccepted in the medical community, supporting the marginalization of abortion care within medicine. In a vicious cycle, if these physicians later go on to teach or run their own training programs, they may be unlikely to recognize the importance of abortion care as a topic for instruction. Similarly, Ob/Gyn residents who spend their time learning what are considered the most important procedures and skills for their specialty may deduce that abortion is not a valued part of this care within that community, and may in turn devalue it in their own practices later on.

Socialization, however, works in multiple ways, so if abortion care is given a spot of importance in medical school and residency education, students may be more likely to see this care as a natural and significant part of medicine, thereby normalizing it. Particularly when growing up in an environment in which the visibility of abortion politics is emphasized over that of abortion health
care, students may enter medical school with specific preconceived notions about abortion that have little to do with its health consequences. The failure to counteract the primacy of the political aspect of abortions with medical information is a critical because it encourages the belief among medical professionals—who hold the sole responsibility for this care—that abortion is “too controversial” for mainstream medicine.

Abortion training at both the medical school and residency level must then be considered for its effect on physicians’ technical abilities as well as their thought processes. It is not enough that doctors learn the techniques for surgical abortion or the potential complications of a medical abortion, they must also understand why abortion care is a public health issue and why access to this care is important and how it is currently limited. Without the sort of comprehensive education that can work to counteract the views about abortion that are presented in political media, physicians will be responding to abortion not through the context of medicine, but through that of personal opinion.

*Putting Abortion to Work*

“The training itself is easy, and the complication rates are low…it’s the political stuff that’s hard” –Dr. Terrell

Abortion rights activists both in and outside of medicine have been pleased to note that abortion training in medical school and residency has been
on the rise over the past decade. They have also been dismayed to learn that the increase in number of trained physicians has not translated into parallel increases in the number of physicians actually providing abortions—instead, the number of abortion providers continues to decline (albeit at a slower rate than before) (“Trends in Abortion”).

The gap between receiving abortion training and actually providing abortions later on has only recently become clear to those in the field, and has yet to be researched in depth. At this point, the reasons for this gap vary greatly, and most often the decision not to pursue a career that includes abortion provision results from a combination of personal factors and professional obstacles. Based on discussions with abortion providers and activists, as well as other anecdotal evidence in the forms of memoirs and news articles, I have identified some of the most common issues that seem to be influencing physicians’ decisions about whether or not to provide abortions. These range from the personal to the institutional in origin, and may vary greatly for different individuals working in different contexts. Some of these reasons speak to the specific nature of abortion work, while others demonstrate the far-reaching results of the political and social climate surrounding abortion, and the history described in Chapter Two.

This chapter thus far has demonstrated that comprehensive abortion training in residency is one of the most critical factors predicting later abortion work, and this remains one of the most important issues to focus on in order to produce more physicians willing and able to provide abortions. On an institutional level, however, there are a number of additional practical concerns
that can present barriers to abortion provision in a physicians’ career. Many of these barriers, as we will see, grew out of the social and political changes that surrounded the abortion issue after legalization. Beginning and established physicians may find it difficult to find work in which abortion provision is included, or where it is permitted on the side. Considering the shortage of physicians, this might sound surprising, but in fact physicians may experience a number of hurdles when attempting to find a way to incorporate abortion provision into their work.

First, there is the common perception that doctors who perform abortions do only that, and that they always work in clinics (Joffe 152). Abortion provision has been conceptualized in this manner in part because of the primacy of the clinic setting for abortion provision, and because of the separation of abortion care from the rest of medicine. However, the majority of abortion-providing physicians work in a practice or hospital all or most of the time, and then “moonlight” at clinics to provide abortions on their off days (Terrell; Lotke). It is, in fact, the physicians who include abortion provision as just a part of their general practice who report the most job satisfaction (Joffe 172). Some physicians, then, may not realize they can incorporate abortion work into their careers this way, or do not wish to work in the clinic setting and become discouraged. Even those who are deeply committed to abortion provision, but who may not be ready to start their own clinic or practice, may avoid doing the work because they do not wish to work for larger organizations like Planned

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49 Though there certainly are some physicians who provide abortions full-time, such as Dr. Mildred Hansen, who travels around the Midwest as the primary abortion provider at several clinics (Maynard).
Parenthood, and other options may not be available, especially in rural areas (Lotke). One provider I spoke with emphasized that abortion provision was “just a part of [her] job,” and commented that she had been reluctant to get more involved with abortion work because “this field could soon all be illegal, and I’d hate to be in this specialty then,” reflecting the unease many physicians feel about increasing their involvement with abortion work (Lotke). In a national symposium of organizations that work with issues related to abortion provision, it was found that many of those who wanted to provide abortions but were not doing so expressed that they “did not know how to integrate abortion provision into their medical practices” (“Bridging the Gap” 18).

Those who do wish to work in abortion clinics on a part-time basis, in addition to full-time work elsewhere, may face additional complications. Younger physicians tend to find jobs working HMOs, hospitals, or other larger organizations that typically restrict abortion provision in a number of ways (Burns; Terrell). This is partly because, as described in Chapter Two, profit-oriented corporations run many of these HMOs and hospitals and wish to avoid political upset. First, these organizations often have regulations that prevent their employees from practicing elsewhere, and these “non-compete” clauses make it impossible for physicians to moonlight at clinics (Burns). Additionally, though some established physicians may be able to renegotiate the terms of their employment, younger physicians typically do not have the necessary clout to make such demands (Burns). In socially conservative or religiously affiliated organizations in particular, physicians with a demonstrated interest in abortion
provision may also find that this interest comes up in job interviews, and in the event that these individuals are hired, they may be discouraged from getting involved with abortion work (Terrell).

This highlights another issue that young and established physicians alike may face with regards to abortion provision—the opinions of colleagues. In one of the few studies that exists on this part of abortion work, Jody Steinauer and colleagues found that “discomfort among office staff” and “practice group restrictions” are among the most common factors that stop physicians from providing abortions (Steinauer “Predictors of Abortion Provision” 5). Similarly, to succeed in including abortion into an existing private practice, a physician really needs the approval and support of other physicians, something that may be difficult to do in rural areas (Burns). In addition to the stigma that surrounds the issue of abortion in general, there remains enormous prejudice against abortion providers within medicine that stems back to before legalization. In an article about this topic written by Jack Hitt, one doctor is quoted as saying that abortion provision is “seen as the dirty work of our field,” and believes these doctors do the work not out of commitment but “because they can’t find steady work,” saying that they are “grade-B doctors” (Hitt). These attitudes persist despite the fact that most physicians who incorporate clinic work into their other practices are doing so primarily because they want to, in addition to full-time jobs in family medicine or obstetrics (Terrell).

A part of this prejudice against abortion providers is also connected to the fact that first-trimester surgical abortion procedures are typically very simple to
learn and perform. As Carole Joffe describes in *Doctors of Conscience*, “for most practitioners there is little professional challenge in it once the basic technique of suction curettage has been mastered,” describing the proliferation of a single procedural technique as contributing “to abortion provision’s relative lack of status in the larger medical community” (Joffe 151). Because early abortions are seen as “unchallenging,” “easy work,” and “boring” surgeries, they have been termed “scut work” by some within medicine (Lazarus 1423).

This is not merely a problem of prestige and popularity. Some abortion providers may also find themselves bored by the first-trimester procedure, particularly if they work at clinics frequently or full-time and perform the same uncomplicated surgery again and again (Joffe 148). The ease of this procedure presents another reason that practitioners most satisfied with their abortion work have typically incorporated it, somehow, into a broader scope of practice. Moreover, as most physicians value professional challenge, they tend to prefer abortion practice when it is well-integrated into other hospital or private practice care, and this issue points to an additional reason to push abortion practice into mainstream medicine.

Other practical reasons that may prevent interested physicians from pursuing abortion work include low remuneration and high malpractice insurance. The cost of an abortion, though seemingly high for most patients, has remained largely stable despite inflation (Korn 111). While the cost of an abortion may be prohibitively high for patients because it is rarely covered by insurance, it still results in low pay for the doctor involved (Korn 111). This, of
course, varies by location, type of procedure, and method of payment (per-procedure or salaried), but typically compensation levels for abortion providers are low relative to other possible areas of practice (Burns). Contributing to this is the high malpractice insurance that physicians may need to purchase, in addition to their standard malpractice insurance (which is often very high for Ob/Gyns to begin with), and it may not make financial sense to provide abortions (Burns; Terrell).

Personal concerns may also greatly affect a physician’s decision to become an abortion provider (or to continue providing abortions, in some cases). Perhaps most prominent among these is a physician’s convictions about abortion, one way or another. Obviously, those who do not approve of abortion for religious or other reasons do not enter the field. Most of those who do provide abortions, on the other hand, are activists deeply committed to the cause, and this commitment comes from a variety of places. In her memoir *This Common Secret*, Dr. Susan Wicklund describes how her own abortion as a young woman, which was performed hastily and with no communication, “hardened [her] resolve” to go on to provide quality abortion services to her own patients (Wicklund 21). This is not an uncommon motivation to enter the field. Some doctors also report that a specific case during medical school or residency has motivated them to perform abortions, whether it is older physicians who saw the effects of criminalized abortion, or, like Dr. Wicklund, encountering a patient who was unable to get an abortion for other reasons and suffered horrible consequences. For those who work in rural or underserved areas, seeing patient need
demonstrated, in a hospital or clinic or private practice, may also serve as an impetus to provide abortions (“Why I Provide Abortions” 5).

Though some doctors describe “falling into” abortion work circumstantially, it seems as though abortion provision for most is very much a matter of intention (Lotke). Particularly with younger doctors, those who undergo training with the intention of going on to provide abortions are most likely to do so, whereas some of those who train never actually intend to use that knowledge (Burns; Terrell). Dr. Terrell, an abortion provider practicing in Minneapolis, always knew she wanted to include abortion provision as a part of her Ob/Gyn work, and she describes it as “a natural piece of taking care of women” (Terrell). Commenting on the gap between abortion training and abortion provision, she acknowledged that some students “train just because it’s a part of the curriculum and they want to do well, but they don’t plan to provide abortions,” and believes that in order to produce more abortion doctors, “we need to focus on those who want to provide, then get them where they need to be” (Terrell).

Many younger physicians cite political and personal commitments to abortion rights and access as the driving forces behind the decision to provide abortions. Medical Students for Choice members, for example, are likely to consider abortion provision as an additional form of “pro-choice” activism. Whether or not they enjoy the work itself, some who do abortions approach it with the following attitude: “I think it’s a necessary evil, no, unpleasant service, we have to provide for the sake of women’s lives and health” (Meisol).
Describing the importance of a political commitment to being a compassionate abortion provider, one physician stated that “it's very important that all the people who are working in the clinics are doing it because of their strong belief that women must have freedom of choice,” continuing that “anyone who comes to those organizations or clinics simply because it's a job treats it very differently, and treats women very differently” (Loeb). Similarly, many working at feminist abortion clinics believe that having a staff that cares about aborting women on both a political and personal level are going to provide the best care.

Abortion work as activism has become the norm in some ways, especially given the intense harassment that some doctors undergo just to get to work. As one clinic owner commented, “finding doctors who are willing to risk everything…to provide abortion care is difficult,” and those who do this work must be deeply committed (“The Last Abortion Clinic”). Due to the highly politicized nature of abortion in America today, and the constant harassment that many clinics experience, many doctors are wary of putting themselves and their families at risk. One provider, while counseling medical students interested in abortion provision, posed a number of questions related to abortion work: “If you are going to perform abortions, how is your family going to think about it? How will you tell your kids? What are you going to do if your church doesn’t want you to come anymore?” (Meisol). Another provider commented that “as the controversy surrounding abortion grows and anti-choice rhetoric becomes louder and more violent, it would be effortless to eliminate abortion from my comprehensive services and continue to practice in anonymity” (“Why I Provide
Abortions” 6). Some young physicians may not want to deal with what is a reality for many abortion providers—wearing bullet-proof vests to work, carrying a gun, keeping your profession a secret at dinner parties—and choose not to incorporate abortion care into their careers.

Others may negotiate their involvement with abortion work in relation to family—one young provider “made a deal with her husband that she would not be an activist or be quoted by the media until their toddler is in college” (Meisol). In fact, one study found that having children was negatively correlated with involvement in abortion work for physicians, and this may be true in part because potential abortion providers fear that their children will be harassed (Steinauer, “Predictions of Abortion Provision” 15). Even if a physician does choose to get involved in abortion work, they may feel the need to take precautions with their family members, such as having a different last name than the rest of the family.

For others, the prospect of harassment is not as frightening, and this may depend on a physician’s location. Two of the physicians I spoke with, Dr. Terrell and Dr. Lotke, described how harassment from anti-abortion activists actually encouraged them to continue their work by underscoring the importance of it. Still, Dr. Lotke also discussed how she was careful to make sure that her daughter’s name wasn’t written on her car seat when she went to work, and Dr. Terrell advised young providers to “put personal safety first” (Terrell; Lotke). This fear speaks partially to the need for enhanced security at abortion clinics and harsher punishment for violent anti-abortion activists, but also to the fact that abortion provision as a career can be especially difficult because, in the words of
Carole Joffe, “abortion work has the potential to spill over into virtually all aspects of the providers’ lives” (Joffe 172). Nonetheless, many doctors who provide abortions do find their work incredibly rewarding. One Seattle provider reflected that “the reason I continue to go to work every day is that I love the work I do…there is nothing I would rather be doing,” and a Milwaukee doctor described receiving “more heartfelt thank-you notes from patients who have undergone pregnancy terminations, often in crisis situations or with serious fetal or maternal complications, than from patients with healthy babies after uncomplicated deliveries,” continuing that “that is professionally rewarding” (“Why I Provide Abortions” 2, 4).

One oft-cited way that successful abortion doctors managed to negotiate abortion provision in relation to their personal lives was by having the support of a mentor (Burns). Typically, this mentor is an older physician who can provide emotional and practical advice about making it in the difficult world of abortion provision, and may offer contacts, apprenticeships, or even equipment toward this goal. This is particularly important because, as discussed earlier in this chapter, medical students and residents learn from their elders the conventions and values of their profession, and to have a mentor who believes abortion care is important and worthwhile can have an enormous effect as most of these students’ superiors are not involved in abortion work. In their memoirs about abortion work, Dr. Susan Wicklund and Dr. Suzanne Poppema both describe how the help of a mentor helped them further their careers (Wicklund 39; Poppema 77). Dr. Terrell, also described how her mentor helped her find a way to integrate
abortion training into her career in obstetrics, even helping her find a job (Terrell).

Oddly enough, for others, the proximity of another abortion provider may actually be a hindrance to engaging in abortion work. As political and personal conviction often play a part in becoming a provider, those who see the job as “done” in their community may feel no sense of moral obligation to provide abortions (Lazarus 1422). When attempting to hire doctors to provide abortions in the well-known abortion clinic Lovejoy in Portland, Oregon, one doctor found that because there were a number of clinics in the area, he was “battling a perception around town that there already are plenty of abortion providers,” making appeals to conscience “difficult at best” (Korn 293). Additionally, when a clinic opens up in an underserved, low-population area, anecdotal evidence suggests that the doctors who perform abortions privately will stop because they assume that “someone else has taken care of it” (Burns). Even for those who are interested in abortion provision or who are politically committed to abortion rights, there may be a sense of relief that there is no dire need for them to get involved. In the words of one provider: “There are lots of people who love us, but don’t want to do [abortions] themselves…They’re certainly happy that I’m well trained, but they don’t want to get their hands dirty” (Joffe 158).

Another topic that many who work in abortion care are loathe to discuss is that of the potential emotional impact that results from the act of performing abortions. The primacy of the “pro-choice” versus “pro-life” debate tends to inspire those on the abortion rights side to adopt a view of the procedure that
does not consider the fetus, or implies that an emotional attachment to the fetus as “a baby” as anti-choice. However, those involved in the actual work of terminating pregnancies may be faced with a different reality, especially those involved in later-term abortions. Many negotiate their work with abortion in complex ways, developing a view of the abortion issue that is more nuanced than most political debates.

In memoirs and interviews, abortion providers have discussed their reactions to and difficulties with second-trimester abortions. Whereas first-trimester abortions may produce so-called “products of conception” that are fairly benign, those for later-gestation abortions may be more difficult to see. One young provider describes her reaction to a second-trimester aborted fetus and her subsequent negotiation with this issue: “It’s hard, really really hard…it’s just—I mean it looks like a baby…and, you know, I saw this one, and it had its fingers in its mouth…it makes me really sad that that had to happen, you know, but it doesn’t change my mind” (Simonds 70). Though the shock of seeing a fetus that was further along may produce an emotional reaction, most involved in this work say that they remain committed to preserving abortion rights, but acknowledge that there is a loss of human life and that sadness is acceptable. In my discussion with her, Dr. Terrell described how she sees abortion as the taking of a life, but still believes that abortion is morally acceptable and can even be a positive thing for some of her patients (Terrell). Some health care workers involved with second-trimester abortions have also described their conscious
efforts to “recontextualize their work,” and have found that they were capable of seeing these late abortions as “interesting rather than disgusting” (Simonds 71).

For other doctors, emotional encounters with later-term abortions can help to determine where they, personally place the line between which abortions they are willing to perform and which they are not. Many abortion providers have a limit in place that determines the gestational age at which they are no longer comfortable performing an abortion. This may because of personal feelings about abortions after a certain point, or it may simply be the result of a physician’s own technical proficiency. The surgical abortion procedure also becomes more difficult as gestational age increases, and has a higher risk of complications, but some doctors enjoy performing a more technically difficult procedure, and prefer a second-trimester abortion to a first-trimester abortion (Hitt). In describing how she set her own limit, Dr. Wicklund recounts her first experience watching a second-trimester abortion: “Seeing an arm being pulled through the vaginal canal was shocking…not only was it a visceral shock, this was something I had to think deeply about…confronting a twenty-one week fetus is very different” (Wicklund 28). Ultimately, she decided that this “was not something [she] could be comfortable with,” and chose to limit her practice to abortions at fourteen weeks or less (Wicklund 28). Even among those who do perform second-trimester abortions there is an acknowledgement that the work can be emotionally challenging. One doctor described how “fetal destruction is a very different ball game” from the first-trimester vacuum aspiration procedures,

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50 This may occur during a second-trimester D & E operation, in which the fetal parts are separated inside the womb.
and allowed that “there's something emotionally upsetting about this” (Simonds 97). Unfortunately, few resources are available to help physicians deal with the emotional impact of this work, nor is discussion of these issues encouraged due to the fear that a physician’s words may be co-opted by anti-abortion forces (Burns).

Similarly, some physicians who perform abortions out of personal or political conviction may struggle to enjoy the work. Author Peter Korn, in his fascinating ethnography of the Lovejoy clinic, describes this phenomenon:

But after an abortion, there is usually little sense of great accomplishment. For starters, the vast majority of abortions are unchallenging surgery, easy work for an experienced surgeon. The deeper reason is the emotional and psychological impact that abortions can have on a surgeon. Except in a very few cases, performing an abortion does not feel like saving or healing a life. It might feel necessary and it may well feel like the right thing to do, but it rarely feels good. (Korn 20).

And in many modern abortion clinics, this problem is exacerbated because non-physician employees most frequently do the counseling work, and the physician’s only contact with the patient is during the abortion itself. This system has evolved because of its cost-effectiveness in the clinic setting, as abortion providing physicians are needed primarily to perform procedures and dispense medication at high volumes while other staff members may require less pay and can provide quality counseling. For those physicians who do abortion work because of their commitment to personal choice, it may be difficult to remain so far-removed from the reasons each patient has for aborting.

Many abortion providers find the counseling aspect of abortion care to be the most rewarding part, and this presents a double-edged sword for most of
today’s clinics. On the one hand, physicians tend to find their work unfulfilling when they are consistently removed from the counseling process. On the other hand, those who are routinely involved in counseling patients may suffer emotional burnout. Good counseling, especially in high-stress or very emotional environments, requires a certain amount of personal involvement on the part of the counselor. Physicians, who are trained to disengage emotionally from patients, may not be sufficiently prepared to deal with the consequences of this work, or may find themselves getting too involved. One counselor described acting as a “sponge” for the stress of emotional patients, and found that “there’s only so much of it you can take and be healthy” (Simonds 69). In addition to stress, the politics of the situation may also contribute to burnout, and at one clinic “several staff members said clients’ hypocritical attitudes about abortion” helped to cause frustrations, as it is not uncommon for a patient to express to a counselor or physician that she does not “believe in” abortion, despite being there to have one (Simonds 47). All of these stresses, when combined with the threat of harassment and violence from anti-abortion activists, may make it difficult for some doctors to be involved with abortion work long-term. The owner of a clinic in the South regrettably acknowledged that “being involved with abortion every day takes a toll, and so we’ve lost some of the really great folks that were pioneers for us to begin with because they’ve burned out and moved on” (“The Last Abortion Clinic”).
Abortion provision has become a form of medical activism since legalization, and this has both benefits and consequences for patients and doctors. Patient care, for one, is likely to be better when a physician cares deeply and has a lot of experience with the procedure. Furthermore, dedicated physicians are more likely to stay the course in response to the many obstacles that attempt to prevent them from doing abortion work. Abortion provision as activism, however, also serves to keep willing but middle-ground physicians from getting involved, and it continues the politicizing of abortion work. In order to normalize the procedure, its practice must also become more mainstream.

This chapter has traced how individual doctors make decisions about abortion provision throughout their careers, and how these decisions are affected by the availability and expectation of training, the social and political context of abortion care at any given moment, and their own personal convictions. For some, their decisions may in fact be made for them if training is never made available and abortion provision is never indicated as a career option. For others, even those who wish to provide abortion services to their patients, there are reasons to avoid doing so at every turn. Those who do manage to perform abortions in the face of so many obstacles are truly heroic.
Chapter Four:

Toward a Better Future

“Why do I perform abortions? Because it matters. It matters for the health of the women I help, it matters for the health of their families, it matters for the health of our society and, now, it matters for freedom” -Dr. Warren M. Hern (“Why I Provide Abortions” 6)

The number of physicians willing and able to perform pregnancy terminations has reached its lowest point since the procedure was legalized, making abortion care difficult to obtain for many women, and indicating that that the mere legalization of abortion in America may not have been enough to ensure that those in need of abortions can actually have them. Rather, the accessibility of abortion may rest in the hands of medical professionals. This shortage of abortion providers has, as I have demonstrated in this thesis, resulted from a multitude of factors—from the decisions of individual physicians made in relation to the state of abortion practice today, to the systemic failure of the medical profession to incorporate abortion care into its concept of standard health care.

By analyzing these many factors together, this thesis aimed to create a more complete picture of the current abortion provider shortage and its causes. First, in Chapter One we saw that abortion was not always politicized in America, and that the now-powerful medical profession played a significant part in changing this. We also saw how abortion practices shifted in the midst of
political involvement, and how criminalization became a tool that some physicians used to achieve greater medical authority. This historical precedent foreshadowed the events of legalization as well, when the medical doctors who advocated for liberalized abortion laws did so not just to improve the lives of their patients, but also to improve their own working conditions.

We then saw, in Chapter Two, how the medical profession as a whole failed to integrate abortion care into hospitals, training programs, or mainstream practice after taking legal control of abortion practice in 1973. The silence on the part of the medical profession was quickly overshadowed by the increasingly vocal and violent anti-abortion movement, which came to dominate political, legal, and medical discussions about abortion throughout the decades following Roe v. Wade. As abortion care was moved, literally and figuratively, from the heart of medical practice, women’s health care suffered. Access to these services diminished after legalization in large part due to the increasingly short supply of sympathetic doctors who would risk their careers, and maybe even their lives, to get involved with abortion care.

I next outlined the practice of abortion in medicine today, demonstrating the existence and severity of the provider shortage and its consequences for women. With this shortage and the medical profession’s legal monopoly on abortion in mind, I argued that physicians do in fact have some ethical obligations to participate in abortion training and care. By the end of the second chapter we began to see the abortion provider shortage within its larger social and
historical contexts, specifically in relation to the fields of medicine, law, and politics.

Chapter Three then moved on to a more proximate level of analysis regarding the causes of the provider shortage and the nature of abortion work. I presented research findings on the single most significant causal factor of this shortage—a lack of trained physicians. These sections demonstrated that abortion education at the medical school and residency levels has been deficient for some time and very clearly undervalued in mainstream medicine. This body of research presented strong evidence in favor of more extensive training by showing that students at all levels were interesting, saw the training as appropriate, and most found it to be worthwhile. Furthermore, we saw that comprehensive and routine training does indeed increase rates of abortion provision, so improving this training may be a key solution for the lack of available providers.

We also saw in Chapter Three that a lack of training is not the only barrier that physicians face to getting involved with abortion work. A number of other hurdles, most of which are related to the events in law, medicine, and anti-abortion activism described in Chapter Two, may stand in the way of providing abortion services to patients in need. These practical factors that influence the decisions of individuals are deeply connected to the historical context of abortion provision in America, and this section underscores the importance of an analysis of this issue that incorporates historical and contemporary elements.
An understanding of the historical and social context of the current abortion provider shortage can, and should, inform approaches to reversing it. It has become clear that the current system of abortion provision is flawed in a number of ways, and improvements in patient care and access as well as provider working conditions are deeply needed. First, as we have seen that the lack of trained medical professionals lies at the heart of this provider shortage, medical schools and residencies (in Ob/Gyn, family and internal medicine specialties) must increase and improve their educational resources in this area. The existing research on this topic outlined in Chapter Three pointed to several specific guidelines related to how to approach these improvements. At all stages of medical education, information about abortion must be presented routinely and with a primary focus on the medicine, rather than the politics, of pregnancy termination. While students with moral opposition may opt out of clinical training, it is imperative that they learn enough to identify and treat possible complications and to provide accurate medical information to abortion-seeking patients. Ob/Gyn specialists in particular bear the primary responsibility for abortion care, and thus have a stronger obligation to participate in training, but it is beneficial to both patients and other primary care physicians for this training to be available in family and internal medicine specialties as well. Furthermore, comprehensive and standardized abortion education for medical professionals serves several important purposes relevant to the reduction of the provider shortage, from increasing student interest in abortion provision and the likelihood of later getting involved with abortion work, to producing better-informed
medical professionals who recognize the validity of this care, to creating the potential for more normalized, integrated abortion care within mainstream medicine.

More research on abortion education at both the medical school and residency level is also needed. Though the existing research provides a wealth of useful information, it also has a number of flaws. First and foremost of these is that all of the national research that evaluated medical student and resident exposure to abortion information surveyed program and clerkship directors rather than the students themselves. There is reason to believe that in-class discussions about this controversial topic may not adhere to what is on the syllabus, or biased educators may present inaccurate information. Therefore, surveying medical students and residents directly could shed light on what these students actually learn and recall about their experiences, as well as providing more qualitative data such as the attitudes of their professors toward abortion or how well-attended lectures on the topic may be. Fortunately, at the medical school level, some of this sort of research may already be underway. The advocacy group Medical Students for Choice is currently in the process of conducting a national survey of abortion education that relies on the responses of students themselves.

There is also a need for longitudinal research that can assess student and physician thought processes about involvement with abortion work over time. Limited findings discussed earlier, such as David Baram’s survey of Ob/Gyn residents, suggest that exposure to different sorts of training experiences and information about abortion can deeply affect physicians’ long-term views about
abortion care and provision. This research, though certainly a large undertaking, could follow medical students throughout their pathway to becoming practicing physicians and determine which factors are likely to produce the most physicians willing to perform abortions, and which produce the fewest. A study that explores decision-making at a number of different locations in a given physician’s career might help activists to direct their work more specifically.

While a substantial amount of research exists about the training that physicians-in-training receive in abortion, very little research has been done to study the gap between obtaining training and actually performing abortions later in life. The trajectory toward becoming an abortion provider seems to be a “leaky pipeline,” and more information is needed to evaluate why otherwise willing doctors might not be getting involved with abortion work. Anecdotal evidence presented in Chapter Three suggests some potential focal points for this sort of research. Regulations about “moonlighting,” for example, might be a major force preventing some physicians from providing abortions, and the desire to work in a particular setting, such as a hospital or private office, may be deterring some from abortion work due to misconceptions about how abortion is and can be practiced. Additionally, psychological and professional supports must be made available to those involved in abortion practice to guard against burnout, and mentorship programs may go a long way toward increasing rates of abortion provision. These and many other issues outlined in Chapter Three deserve further investigation, as it does seem as though focusing on providing extra support to those doctors who are already interested and willing to provide
abortions is likely to have the greatest positive effect on reversing the current shortage.

The reduction of the abortion provider shortage might also be achieved by looking outside of the physician workforce. Several studies have indicated interest, willingness, and competency in abortion provision among advanced practice clinicians (Foster). Relaxing legal restrictions and increasing the training that these practitioners receive in medical and early surgical abortion might have a profound effect on the practice of abortion by increasing access to this procedure for low-income and rural women, and by releasing physicians from some of the responsibility for this care.

Those within the medical profession must also go beyond merely conducting research and take action based on their findings. For example, a number of the studies, memoirs, and articles discussed throughout this thesis have indicated that physicians and patients both prefer abortion care that is well integrated into a broader scope of medical care in the office or hospital setting. Despite these findings, abortion care continues to exist primarily in the clinic setting, and though there are certainly difficulties in incorporating abortion care into existing systems, it will not happen without a significant push from those within medicine. Physicians have also indicated a desire to be more involved with counseling sessions, yet most clinics continue to separate them from this process in order to reduce costs. Additionally, though it is clear that abortion care needs to be better integrated into mainstream medical care, there are benefits to the clinic setting, such as a very specialized staff and environment as well as
highly competent providers who are comfortable with the procedure. Thus, there is a need to include abortion care in hospitals and private offices while simultaneously improving clinic care by providing better protection against harassment and violence.

Many of these and other improvements must, I believe, be initiated by individuals and groups within the medical profession. This is true for several reasons. First, activists outside of medicine have repeatedly faced enormous barriers when trying to convince physicians and hospital administrators to change their ways, and their opinions may be discounted because they do not possess the same medical expertise (Burns). Second, the historical accounts presented in this thesis demonstrate that the medical profession bears a significant responsibility for the state of abortion care today, both legally and because its past actions were important for shaping the current provider shortage. Finally, we have seen that the politics of abortion have been overemphasized at the expense of discussions of the medical and public health aspects of this procedure, and the history of criminalized abortion presented in Chapter One illustrates one of the many reasons that the medical necessity of abortion must be remembered. The medical profession has become incredibly powerful in America, and it can use this power to come out in support of the need for safe, legal, and accessible abortion.

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