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The Marginalization of Abortion in Medicine

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The Marginalization of Abortion in Medicine

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Submitted in Partial Fulfillment
of the
Prerequisite for Honors
in Political Science
under the advisement of Professor Tom Burke

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INTRODUCTION

The consensus among medical professionals was that, once legal, abortion should be incorporated into obstetrics and gynecology practices, as it was a routine and very safe procedure. In the intervening years, however, abortion has become marginalized within medicine, resulting in a dwindling number of providers and facilities willing to perform the procedure.¹

Before 1973, legal abortions were available almost exclusively in hospitals. In certain medical situations, a patient could petition a hospital's therapeutic abortion committee to request an abortion. When they were originally established, these committees only permitted abortions under a narrow set of circumstances but, over time, these standards evolved and by the late 1960s, in hospitals with therapeutic abortion committees, the procedure was largely available to anyone with the means to access the hospital.²

Because some states had legalized abortion before *Roe*, the medical community had some idea of what the model of care could look like. In many of these states, as a result of both politics and practicality, abortion had moved from hospitals to non-hospital clinics. Some prominent physicians voiced criticism of this model, believing that it would marginalize abortion, and they hoped that nationwide legalization could allow for a model of care where abortion provision was shared among hospitals, non-hospital clinics, and physicians in private practice.³ This model never materialized; instead, the caricature of the "abortionist" motivated by greed persisted and

¹ Emily Bazelon, "The New Abortion Providers," *The New York Times Magazine*, July 14, 2010.

² Nancy Aries, "The American College of Obstetricians and Gynecologists and the Evolution of Abortion Policy, 1951-1973: The Politics of Science," *American Journal of Public Health* 93, no. 11 (2003): 1810-1819, JSTOR.

³ Drew Halfmann, *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain, and Canada* (Chicago: University of Chicago Press, 2011), 106.

OB-GYNs never incorporated the procedure into their standard practices as predicted immediately following the *Roe* decision.⁴

In addition to the shift from hospitals to clinics, in the decades since *Roe*, there has been a significant, consistent decline in the number of abortion providers in the United States. Currently, eighty-seven percent of U.S. counties, where thirty-eight percent of women of reproductive age live, lack an abortion provider.⁵ While there is some debate about whether lack of training in medical school contributes to the problem, even doctors already trained to perform abortions are abstaining from doing so. In a 2014 study, ninety-seven percent of practicing OB-GYNs reported seeing at least one patient who requested an abortion; however, only fourteen percent of OB-GYNs performed them.⁶

This thesis will interrogate how abortion came to be marginalized within the medical community and how that marginalization has contributed to decreased abortion access for patients. My interest in this topic has developed as a result of my current job. For the last two years, I have worked as a counselor at an independent abortion clinic in Brookline, Massachusetts. In my role as a counselor, I help patients understand their pregnancy options and support them through the abortion process.

Doing this work affords me a unique opportunity to understand some of the challenges patients face when accessing abortion care, even in a liberal state like Massachusetts. Working directly with patients seeking abortions, I see the very real impact of barriers like funding restrictions and certain types of informed consent policies. I believe that, from this vantage point,

⁴ Bazelon, "The New Abortion Providers."

⁵ Rachel K. Jones and Jenna Jeman, "Abortion Incidence and Service Availability, 2011," *Perspectives on Sexual and Reproductive Health* 46, no. 1 (2014): 3-14, Medline.

⁶ Debra B. Stulberg et al., "Abortion provision among practicing obstetrician-gynecologists," *Obstetrics and Gynecology* 118, no. 3 (2011): 609, Medline.

it may be more difficult to recognize and understand the ways in which larger systems, not just specific public policies, impact abortion access. This project is an opportunity to develop a broader understanding of these issues.

Each of the following chapters will investigate a division of the medical community that, since *Roe*, has marginalized abortion care and assess the ways in which marginalization within medicine has affected abortion access. The first chapter will look at medical schools. Do medical students and residency programs provide adequate abortion training? How is the provider shortage impacted by medical school training? The second chapter examines private practices. What prevented OB-GYNs from integrating abortion into their private practices, and why do their numbers continue to fall? In what ways does the medical establishment contribute to and perpetuate this shortage? The concluding chapter focuses on hospitals. What led abortion to shift from hospitals to clinics and what does hospital abortion provision look like today?

CHAPTER ONE: ABORTION AND MEDICAL SCHOOLS

In 1973, the United States Supreme Court Decision *Roe v. Wade* made abortion legal nationwide. There was a belief among many groups who had pushed for legalization that the Court's decision meant abortion would no longer be a political issue but strictly a medical one. In hindsight, this was wildly optimistic.

Although there has been variation on both sides, public opinion on the issue of abortion has mostly held steady over the last two decades, with Americans evenly split on the issue. According to a Pew Research Center poll conducted in 2017, support for abortion reached a twenty year high, with fifty-seven percent of Americans believe abortion should be legal in all or most cases; by contrast, forty percent believe it should be illegal in all or most cases.¹

Despite increased public support for abortion rights, the number of abortion providers has been declining. As of 2010, eighty-seven percent of counties in the United States, where more than one-third of women live, had no abortion provider.² One possible factor is lack of training in the procedure for medical students and residents has made for fewer available practitioners. This chapter will explore the evolution of abortion training in medical schools and residency programs and what this could mean for the future of abortion access.

History of Abortion in Medical Training

Beginning in the mid-1800s, the recently established American Medical Association (AMA) led a state-by-state campaign to make abortion illegal. Until this time, the procedure had not been legislated and most women were able to get an abortion from a midwife or physician

¹ "Public Opinion on Abortion 2017," Pew Research Center, accessed March 8, 2018, <http://www.pewforum.org/fact-sheet/public-opinion-on-abortion/>.

² Emily Bazelon, "The New Abortion Providers," *The New York Times Magazine*, July 14, 2010.

before “quickenings,” when the fetus begins moving, usually in the second trimester of pregnancy.³ The AMA was successful and, by 1880, every state in the country had criminalized abortion, although most states carved out exceptions to save the life of the pregnant woman.⁴ The drive to criminalize abortion was motivated by several factors, including the safety of the procedure and anxiety about declining birth rates among Anglo-Saxon women.⁵ However, the AMA’s Section on Obstetrics based its opposition on moral grounds. At their 1893 national meeting, the chairman of the Section on Obstetrics, J. Milton Duff, called abortion, “a pernicious crime against God,” and argued that it was the duty of the medical profession to, “educate the public up to a thorough appreciation of the pernicious results of this evil.”⁶

As a result of the AMA’s position, it would be decades before medical students were routinely taught how to perform abortions. Obstetrics students, however, were taught how to induce labor, and these induction techniques could be adapted to terminate a pregnancy as well.⁷ The most common methods of labor induction involved rupturing the amniotic sac or partially open the cervix manually to start the dilation process. In a full term pregnancy, these methods induced a patient’s labor; at an earlier gestation, the induced uterine contractions were strong enough to expel a fetus.⁸

As an abortion method, these techniques were more dangerous than when performed later in pregnancy. There was a significant risk of uterine rupture, which could lead a patient to

³ Leslie J. Reagan, *When Abortion Was a Crime: Women, Medicine, and the Law, 1867-1973* (Berkeley: University of California Press, 1997), 14.

⁴ *Ibid.*

⁵ Carole Joffe, “Portraits of Three Physicians of Conscience: Abortion Before Legalization in the United States,” *Journal of the History of Sexuality* 2, no. 1 (1991): 46-67, JSTOR.

⁶ Reagan, 82.

⁷ James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy* (London: Oxford University Press, 1979), 14.

⁸ *Ibid.*, 16.

hemorrhage to death. It was also extremely painful and could be a lengthy process.⁹ The introduction of dilation and curettage (commonly known as a D&C) led to the abandonment of these techniques among illegal abortion providers.¹⁰ In this method, the patient's cervix is opened by the insertion of small metal rods known as dilators. After the cervix is sufficiently opened, a small spoon shaped instrument called a curette is used to scrape fetal and placental tissue out of the uterus.¹¹ This method also became the most common way to treat a patient experiencing a spontaneous abortion, more commonly known today as a miscarriage.

While their clinical treatment was nearly identical, miscarriage management and abortion differed linguistically and contextually. The term "miscarriage" as we have come to think of it has not been in use very long.¹² Over the last forty years, what has come to commonly be called miscarriage was known as a "spontaneous abortion" while what is now referred to generally as "abortion" was known as an "induced abortion." This distinction in terminology developed, in part, as a result of ultrasounds becoming more commonplace in OB-GYN care in the second half of the twentieth century.¹³

Ultrasound technology made it easier to diagnose a miscarriage, even if a patient had not yet experienced physical symptoms. Although some medical textbooks prior to legalization claimed to give physicians some guidance on how to diagnose an illegal abortion, none of these methods was a reliable indicator and the distinction between spontaneous and induced abortion was mostly academic and legal.¹⁴ Medically, if a pregnant patient came to a doctor, there was

⁹ Ibid

¹⁰ Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Boston: Beacon Press, 1995), 33.

¹¹ Reagan, 72.

¹² Andrew Moscrop, "'Miscarriage or Abortion?' Understanding the medical language of pregnancy loss in Britain; a historical perspective," *Medical Humanities* 39, no. 2 (2013): 98-104 ProQuest.

¹³ Ibid., 98.

¹⁴ Ibid.

almost no reputable way for the doctor to determine if the patient was experiencing a spontaneous or an induced abortion and, regardless, the treatment to remove any remaining fetal or placental tissue was the same.¹⁵

Despite its use as a miscarriage management procedure, until the 1950s, medical students mainly learned about D&Cs from textbooks, with little to no access to practical training. Access to practical training was largely dependent on the policies of the particular institutions where the training and the institutional policies were often dependent on the region.¹⁶ In “Portraits of Three Physicians of Conscience: Abortion Before Legalization in the United States,” sociologist Carole Joffe documents significant regional variation in the availability of abortion training.¹⁷ For example, overall, students who trained at East Coast schools began receiving practical D&C training beginning in the 1920s. However, for students in the Midwest or Southwest, practical training in the technique did not become routinely available until the 1960s.¹⁸

Professional medical opinion regarding the legality of abortion first began to shift in the 1930s. In 1936, Dr. Frederick J. Taussig, a professor of obstetrics at Washington University, published a study on illegal abortion in 1930.¹⁹ In that year, abortion was listed as the official cause of death for almost 2,700 women, accounting for eighteen percent of all maternal deaths.²⁰ Some physicians pointed to Taussig’s study as evidence that denying women abortions did not decrease the demand and that to continue denying women the procedure was poor medical

¹⁵ Ibid., 99.

¹⁶ Joffe, “Portraits of Three Physicians of Conscience,” 48.

¹⁷ Ibid., 50.

¹⁸ Ibid., 51.

¹⁹ Ibid., 49.

²⁰ Rachel Benson Gold, “Lessons from Before *Roe*: Will Past Be Prologue?” *Guttmacher Report on Public Policy* 6, no. 1 (2003): 8-11, JSTOR.

practice.²¹ This led to division within organized medicine, between those who believed that abortion should remain illegal and those who were worried about the cost of criminalization.²²

In 1951, the American College of Obstetricians and Gynecologists (ACOG) was founded as the first professional organization exclusively for OB-GYNs.²³ At this time, it was the position of the ACOG that abortion should be permitted whenever a pregnancy was life threatening (known as therapeutic abortion). The definition of life-threatening was very narrow and only applied to certain agreed upon physiological conditions, such as Rheumatic Heart Disease.²⁴ By the mid-1950s, however, most of the conditions deemed acceptable were eliminated by advances in medicine.²⁵

Despite scientific advances, the ACOG did not alter its position on abortion. In 1959, the organization's *Manual of Standards in Obstetrical-Gynecologic Practice* recommended that hospitals establish therapeutic abortion committees.²⁶ These committees would review every physician request to perform an abortion. This way, the ACOG reasoned, they would not have to revise their position even with the advances in medicine. These committees could be counted upon to enforce strict guidelines for therapeutic abortion.²⁷

The first revision to the ACOG's abortion policy occurred in 1968. It made exceptions for the health, not just the life, of the pregnant woman. The new policy stated that, "In determining whether or not there is such a risk to health, account may be taken of the patient's

²¹ Joffe, "Portraits of Three Physicians of Conscience," 50.

²² Ibid.

²³ Aries, 1810.

²⁴ Ibid., 1812.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid., 1813.

total environment, actual or reasonably foreseeable.”²⁸ Coinciding with this policy change was the introduction of the suction aspiration method of abortion. This method, which used a small vacuum instead of a curette to remove the contents of the uterus, was both safer and less technically complex than a D&C. This meant that medical students could learn to safely perform abortions with minimal practical experience.²⁹

Most physicians who pushed for reform of abortion laws saw it as a matter of improving public health for women. But there was also a vocal contingent that believed repeal of abortion laws was necessary to protect the right of doctors to treat patients with their best medical judgement.³⁰ These doctors resented being told how to treat their patients as a matter of professional pride. By 1967, a survey from the journal *Modern Medicine* found that eighty-seven percent of practicing physicians believed abortion laws should be liberalized.³¹

Even with widespread support among their own for liberalization of abortion laws, most of the organized medical community was indifferent to the idea. While the ACOG developed policy recommendations beginning in the 1950s, the AMA took no position until 1967, even then, it did not articulate an official policy preference; the organization simply endorsed the idea that abortion laws should be reformed.³² Even after endorsing liberalization, developing an official policy was never a priority for the AMA state committees, leaving the ACOG as the only organized medical body pushing for reform. In 1970, at their national conference, the AMA

²⁸ Ibid., 1815.

²⁹ Joffe, “Portraits of Three Physicians of Conscience,” 53.

³⁰ Geoffrey R. Stone, “The Road to Roe,” *Litigation* 43, no. 1 (2016): 43-39, ProQuest Central.

³¹ Mohr, 258.

³² Drew Halfmann, *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain, and Canada* (Chicago: University of Chicago Press, 2011), 74.

finally issued an official statement, asserting that abortions could be performed when, “in the best interests of the patient,” but not, “mere acquiescence to the patient’s demand.”³³

During the decade preceding the legalization of abortion, it was not just the medical community agitating for changes to the existing laws. The American Law Institute (ALI) was an organization of law professors, lawyers, and judges who often developed and advocated for revisions to state laws.³⁴ In 1962, the ALI issued recommendation for revision of state abortion laws. They supported abortion laws allowing for therapeutic abortions, which included risks to the pregnant woman’s health as well as her life; their definition of health included mental, not just physical, health.³⁵ They endorsed the convening of therapeutic abortion committees, like those recommend three years earlier by the ACOG, wherein two doctors would be required to justify a patient’s need for an abortion. While the medical community’s advocacy for the legalization of abortion was a response to patient need, the ALI was focused on protecting doctors from legal liability.³⁶

In addition to the legal and medical communities, religious leaders also believed abortion laws should be changed. Founded in New York City by a group of ministers and rabbis in 1967, the Clergy Consultation Service on Abortion (CCSA) helped women with unwanted pregnancies access abortion.³⁷ They provided women with information on the procedure and helped them find doctors to perform illegal abortions safely. The CCSA also went a step further than ACOG and ALI by advocating not merely for the reform of abortion laws but for their abolition.

³³ Ibid.

³⁴ Linda Greenhouse and Reva B. Siegel, *Before Roe v. Wade: Voices that shaped the abortion debate before the Supreme Court’s ruling* (New York: Kaplan Publishing, 2012), 24.

³⁵ American Law Institute, *Abortion: Model Penal Code* (1962), accessed March 8, 2018, http://dla.library.upenn.edu/dla/pacscl/ead.pdf?id=PACSCL_UPENN_BIDDLE_WpennlawbllarchivesfindingaidsPULALI04005eadxmlUSPUL.

³⁶ Ibid.

³⁷ Greenhouse and Siegel, 29.

Confronting abortion as a public health issue, upon the group's founding they issued a statement explaining that, because of illegal and unsafe abortions endangering women's health "...we pledge ourselves as clergymen to a continuing effort to educate and inform the public to the end that a more liberal abortion law in this state and throughout the nation be enacted."³⁸ By 1970, the group had members working in 26 states who had helped more than 100,000 women access abortion care.

By 1970, abortion had been decriminalized in California, Colorado, Oregon, and North Carolina. That year, Hawaii, followed soon after by New York, legalized the procedure. Three months after legalization in New York, the ACOG revised their abortion policy once more. Within the organization the rationale was that it was necessary for the organization to keep up with changing laws, lest it become obsolete.³⁹ Reported in the September 1970 *ACOG Bulletin*, the new policy read, "It is recognized that abortion may be performed at a patient's request, or upon a physician's recommendation."⁴⁰

The gradual legalization of abortion in a handful of states gave the medical community some idea of the practical realities of legal abortion for the physician. The introduction of the vacuum aspiration method of abortion, along with improvements in anesthetic safety, made performing abortions outside of a hospital feasible.⁴¹ In the states that legalized abortion before *Roe*, hospitals continued to provide abortion care, sharing the patient load with a growing number of outpatient clinics. After 1973, the medical community assumed that this model of care, with hospitals and clinics as equal providers, would continue to be the norm.⁴²

³⁸ Clergy Consultation Service, *Papers of the Clergy Consultation Service, 1967-1979*, Manuscript Series CXXVIII, Charles Deering McCormack Library of Special Collections, Northwestern University Library.

³⁹ Aries, 1816.

⁴⁰ Ibid.

⁴¹ Halfmann, 106.

⁴² Ibid.

There was some physician pushback against this model of care. The most vocal critics were the doctors who felt strongly that, even with advances in medicine, the hospital was still the safest place to perform an abortion.⁴³ The other, much smaller, dissenting group were doctors who believed that if abortion was moved out of hospitals, it would be more difficult for medical students and residents to receive good training. Dr. Robert Hall, a physician at Columbia Presbyterian Hospital in New York City, agreed with this and went even further, arguing that a clinic based model would absolve doctors of their duty to provide abortions and would keep abortion from becoming standard gynecological practice.⁴⁴

Three years later, in their 1976 member bulletin, the ACOG declared that all OB-GYN residency programs should have three components: obstetrics, gynecology, and abortion procedures. The organization created an advisory board, the Council on Resident Education in Obstetrics and Gynecology (CREOG) to assist residency programs in the development of their curricula.⁴⁵ The council published detailed standards but declined to create any enforcement mechanisms to ensure compliance. This created wide variation in abortion training across residency programs.⁴⁶

Residency Programs After *Roe v. Wade*

The first major study on abortion training post-legalization was published in 1978.⁴⁷ The first major study on abortion training post-legalization was published in 1978. In their study,

⁴³ Halfmann, 107.

⁴⁴ David J. Garrow, "Abortion Before *Roe v. Wade*: An Historical Perspective," *Albany Law Review* 62, no. 3 (1999): 833-852, Gale.

⁴⁵ Barbara L. Lindheim and Maureen A. Cotterill, "Training in Induced Abortion by Obstetrics and Gynecology Residency Programs," *Family Planning Perspectives* 10, no. 1 (1978): 24-28, JSTOR.

⁴⁶ *Ibid.*, 24.

⁴⁷ *Ibid.*, 25.

authors Barbara L. Lindheim and Maureen A. Cotterill found that only twenty-six percent of residency programs made abortion training mandatory; sixty-six of programs allowed residents to opt-in to abortion training; and approximately eight percent of programs offered no abortion training at all.⁴⁸ The study also found that when abortion training was opt-in, fewer than half (forty-three percent) of residents chose to participate.⁴⁹

A survey of residency program directors, published in 1987, observed significant changes compared to the 1978 study. Programs that required abortion training decreased slightly, to twenty-three percent, and opt-in programs decreased to half of all programs.⁵⁰ Residency programs offering no abortion training, however, saw an almost fourfold increase, to twenty-eight percent.⁵¹

During this same period, abortion provision began to shift away from hospitals and towards independent clinics.⁵² Most of these clinics were staffed and equipped specifically to provide only abortions, as opposed to hospitals that provided comprehensive OB-GYN care. By the time of the 1987 study, only thirteen percent of all abortions were performed in hospitals.⁵³ Since residency programs are hospital based, this meant increasingly limited opportunities for resident training. The increase in programs with no abortion training may be attributable to this shift. Lack of official program standards from the CREOG, coupled with a decrease in available patients, meant that residency programs had no incentive to continue abortion training once it became inconvenient to do so.

⁴⁸ Ibid.

⁴⁹ Ibid.

⁵⁰ Phillip D. Darney et al., "Abortion Training in U.S. Obstetrics and Gynecology Residency Programs," *Family Planning Perspectives* 19, no. 4 (1987): 158-162, JSTOR.

⁵¹ Ibid., 158.

⁵² Ibid., 162.

⁵³ Ibid.

Another study, published in 1995, observed a similar pattern in the years 1991 and 1992. Although there was a moderate uptick in opt-in programs, the number of programs offering no abortion training increased, to thirty percent, while programs with mandatory training decreased, to twelve percent.⁵⁴ Also during this time, the number of abortions performed in hospitals once again decreased from thirteen percent to ten percent.⁵⁵ Just as with the 1987 study, it seems likely that these changes are the result of abortion moving from the hospital to freestanding clinics and disincentivizing programs from providing abortion training to their residents.

The continued decline of routine abortion training in residency programs led to a movement to reform residency programs, organized by medical students and professional organizations. This began in the spring of 1993, when thousands of medical students received an anonymous pamphlet in their mailboxes. The pamphlet read “Q: What would you do if you were in a room with Hitler, Mussolini, and an abortionist and you only had a gun with two bullets? A: Shoot the abortionist twice.”⁵⁶ After receiving this pamphlet, Jody Steinauer, then a medical student at the University of California San Francisco, founded Medical Students for Choice (MSFC) on her campus.⁵⁷ The organization’s first major act was to petition the Accreditation Council for Graduate Medical Education (ACGME), formerly the Council on Resident

⁵⁴ H. Trent McKay and Andrea Phillips McKay, “Abortion Training in Obstetrics and Gynecology Residency Programs in the United States, 1991-1992,” *Family Planning Perspectives* 27, no. 3 (1995): 112-115, JSTOR.

⁵⁵ *Ibid.*, 162.

⁵⁶ Megan L. Evans and Lois V. Backus, “Editorial: Medical students for choice: creating tomorrow’s abortion providers,” *Contraception* 83, no. 5 (2011): 391-393, ScienceDirect.

⁵⁷ Samantha Allen, “The Internet’s First Abortion Class,” *Daily Beast*, October 16, 2014, <https://www.thedailybeast.com/the-internets-first-abortion-class>.

Education in Obstetrics and Gynecology, to make abortion training mandatory in all OB-GYN residency programs.⁵⁸

As a result of the decline in abortion training opportunities in residency programs, in 1995, the ACGME revised their guidelines. The new guidelines required all programs to provide “access to experience,” for their residents, allowing individuals with religious or moral objections to opt-out.⁵⁹ The guidelines, however, did not require that abortion training be mandatory. They only required that students be given access to opportunities to learn, leaving whether it was mandatory or optional up to the institution. The ACGME reforms took effect on January 1, 1996.⁶⁰

Shortly after the implementation of the ACGME reforms politicians began to vocally oppose them. Representative Peter Hoekstra, a Republican from Michigan accused the ACGME of, “pushing a political agenda,” with the development of these regulations.⁶¹ In response, the Coats Amendment to the Omnibus Consolidated Rescissions and Appropriations Act of 1996 was passed. The amendment prevented residency programs from losing their accreditation if they do not provide access to abortion training to their residents.⁶²

The first study after the implementation of the ACGME reforms was published in 2000 and was designed to evaluate their effectiveness. The trends observed in the two prior studies continued, although at an accelerated pace. Programs with mandatory and opt-in training shot up to forty-six percent and thirty percent respectively, while programs with no abortion training

⁵⁸ Angel M. Foster, Jane van Dis, and Jody Steinauer, “Educational and Legislative Initiatives Affecting Residency Training in Abortion,” *Journal of the American Medical Association* 290, no. 13 (2003): 1777-1778, Medline.

⁵⁹ *Ibid.*, 1777.

⁶⁰ *Ibid.*

⁶¹ Dara Beth Arons, “Shoot the Abortionist Twice: the Crisis in Abortion Training in the United States,” (MD Thesis, Yale University, 2006).

⁶² *Ibid.*, 50.

dropped to nineteen percent, the lowest level since the 1980s.⁶³ This would indicate that reforms made by the ACGME had their intended effect; a significant majority of residents were able to access some abortion training. However, the authors temper their enthusiasm for the results, raising the possibility that the reforms led schools to feel pressured to report higher levels of abortion training than was actually offered.⁶⁴

The most recent study on this issue was published in 2014. This survey of fourth year residents found that a majority of residents (fifty-four percent) received routine training in abortion, with another thirty percent of programs offering opt-in training. Only sixteen percent of programs did not offer abortion training.⁶⁵ Given these findings, it appeared that the potential bias that worried the authors of the 2000 study were likely not a factor and that the reforms did genuinely lead to increased availability of abortion training.

Current Medical School Curricula

Despite increases in the availability of abortion training, the United States still has a provider shortage. In 2011, the number of providers had decreased by four percent over a three-year period. While that might seem like a small change, it meant that eighty-nine percent of U.S. counties, where thirty-eight percent of women of reproductive age live, lacked an abortion provider.⁶⁶ Because more than a third of women will have an abortion by the age of forty-five,

⁶³ Rene Almeling, Laureen Tews, and Susan Dudley, "Abortion Training in U.S. Obstetrics and Gynecology Residency Programs, 1998," *Family Planning Perspectives* 32, no. 6 (2000): 268-271, JSTOR

⁶⁴ *Ibid.*, 268.

⁶⁵ Jema K. Turk et al., "Availability and characteristics of abortion training U.S. ob-gyn residency programs: a national survey," *Contraception* 89, no. 4 (2014): 271-277, JSTOR.

⁶⁶ Rachel K. Jones and Jenna Jeman, "Abortion Incidence and Service Availability, 2011," *Perspectives on Sexual and Reproductive Health* 46, no. 1 (2014): 3-14, Medline.

this provider shortage creates a significant barrier to access.⁶⁷ If availability of abortion training in residency does not contribute to provider shortage, it is possible that it is not just access to training but the content of that training that matters.

Multiple studies conducted over the last decade have indicated that it is not just training during residency that affects an OB-GYN's decision to perform abortions; the decision is also influenced by instruction in abortion during medical school.⁶⁸ In a survey of medical students completing their OB-GYN rotation, ninety-six percent believed that including abortion in preclinical curricula was important. Students who intended to specialize in OB-GYN or Family Medicine were the ones most likely to support abortion in preclinical curricula.⁶⁹

In order to improve the quality of preclinical education, in 2005, the Association of Professors of Obstetrics and Gynecology (APOG) developed a set of competencies for the integration of women's health into medical school curricula.⁷⁰ To emphasize the appropriate level of competence in a particular skill, they created a scale: knows, knows how, shows how, does.⁷¹ According to the APOG, the most important skill for medical students to master was, "non-directive counseling to patients with unintended pregnancies," but they also encouraged knowledge of termination procedures as well.⁷²

In addition to the competencies developed by the APOG, fifty-three percent of medical students participated in opt-in clinical training.⁷³ Of the students who did not participate in

⁶⁷ Ibid., 3.

⁶⁸ Rebecca H. Allen et al., "Future abortion provision among U.S. graduating obstetrics and gynecology residents, 2004," *Contraception* 81, no. 6 (2010): 531-536, Medline.

⁶⁹ Eve Espey et al., "Abortion education in the medical curriculum: a survey of student attitudes," *Contraception* 77, no. 3 (2008): 205-208, ScienceDirect.

⁷⁰ APOG Women's Health Education Office, *Women's Health Care Competencies for Medical Students: Take Steps to Include Sex and Gender Differences in the Curriculum* (2005): 2-41.

⁷¹ Ibid., 6.

⁷² Ibid., 41.

⁷³ Espey et al., 207.

clinical training, those who declined for moral or religious reasons were the minority; only forty-two percent of students cited such objections when opting out. The majority of students opted out due to scheduling conflicts (sixty-four percent) or because they simply were not interested (eighteen percent).⁷⁴ There is strong evidence that residents who pursue abortion training do so because of a prior interest.⁷⁵ Since prior interest in abortion is likely developed as a medical student, mandatory clinical experience in medical school could encourage future residents to participate in abortion training.

Because it was clear that abortion training in residency was not increasing the number of providers, the American College of Obstetricians and Gynecologists (ACOG) issued a committee opinion on abortion training and education, outlining what the organization believed was necessary to increase the number of abortion providers.⁷⁶ They again encouraged residency programs to adopt the 1996 ACGME reforms and asked that abortion be part of every medical school's curriculum. Additionally, they urged their members to protest legal restrictions of public funding for abortion training.⁷⁷

In 1999, Uta Landy, the former executive director of the National Abortion Federation, and her husband, Philip Darney, an OB-GYN professor at U.C.S.F., established the Kenneth J. Ryan Residency Training Program. The program provides medical schools with up to three years of funding to provide comprehensive family planning training, with an emphasis on abortion care.⁷⁸ It was designed with the ACGME reforms in mind, as a way of incentivizing residency

⁷⁴ Ibid.

⁷⁵ Allen et al., 536.

⁷⁶ American College of Obstetricians and Gynecologists, "Committee Opinion: No. 612, November 2014," accessed October 29, 2017, <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co612.pdf?dmc=1&ts=20171028T1824308650>.

⁷⁷ Ibid., 1.

⁷⁸ Bazelon, "The New Abortion Providers."

programs to adopt the reforms as part of comprehensive family planning training. As of 2014, sixty-seven residency programs in the United States and Canada participate in the program.⁷⁹ While it is not clear if these institutions would have adopted the ACGME guidelines anyway, a recent survey indicates that residents at participating institutions have significantly higher competence in abortion and family planning, even among residents who opted out of some portions of the training.⁸⁰

Similar to clinical experience in medical school, mandatory abortion training in residency programs increases future abortion provision. Prior to their training, only thirty-three percent of residents' whose programs mandated abortion training intended to provide abortions after completing their residency; by the completion of their training, a full one hundred percent of residents in this group intended to provide abortions in the future.⁸¹

This increase in intended post-residency abortion provision was linked to higher levels of self-assessment of competency.⁸² Because mandatory abortion training necessarily increases opportunities to practice and improve skills, this may lead a resident to have more confidence in their abilities, which in turn, affects their decision to provide abortions in the future. Among programs with opt-in training, there was no change in residents' intent to provide abortions in the future.⁸³

⁷⁹ American College of Obstetricians and Gynecologists, 3.

⁸⁰ Jody E. Steinauer et al., "The benefits of family planning training: a 10-year review of the Ryan Residency Training Program," *Contraception* 88, no. 2 (2013): 275-280, Medline.

⁸¹ Laura MacIsaac and Zevidah Vickery, "Routine training is not enough: structured training in family planning and abortion improves residents' competency scores and intentions to provide abortion after graduation more than ad hoc training," *Contraception* 85, no. 3 (2012): 294-298, ScienceDirect.

⁸² *Ibid.*, 298.

⁸³ *Ibid.*, 297.

Legislative Barriers to Abortion Training

Student and resident training is not the only obstacle to increasing the number of abortion providers. Because many medical schools and residency programs are associated with public universities and hospitals, both the federal and state governments have the power to significantly impact those programs. Funding for abortion education has been a contested issue ever since 1973, the year abortion was legalized nationwide.⁸⁴

The first legislation to restrict public funding for abortion education did not come directly as a result of the decision in *Roe v. Wade* but from a ruling handed down by a federal district court. In the case, *Taylor v. St. Vincent's Hospital*, the court ruled that, because a Catholic affiliated hospital received some federal funds, it could not refuse to perform sterilizations or abortions.⁸⁵ The Church Amendment, named for Senator Frank Church, a Democrat from Idaho, said that receipt of federal funding could not compel a nurse or doctor, “to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such a procedure or abortion would be contrary to his religious beliefs or moral convictions.”⁸⁶ The amendment did not just protect individuals; it also protected hospitals who received federal funding from being compelled to “make its facilities available for the performance of any sterilization or abortion procedure if such performance is prohibited by the entity on the basis of religious beliefs or moral convictions.”⁸⁷

At the time the Church Amendment was passed, there was some concern, voiced mostly by Senator Russell Long, a Louisiana Democrat, that the law was too broad and that it could be

⁸⁴ Kristina Tocce and Britt Severson, “Funding for Abortion Training in OB-GYN Residency,” *American Medical Association Journal of Ethics* 14, no. 2 (2012): 112-117, Medline.

⁸⁵ Douglas Nejaime and Reva B. Siegel, “Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics,” *Yale Law Journal* 124, no. 7 (2015): 2516-2591, Gale.

⁸⁶ *Ibid.*, 2536.

⁸⁷ *Ibid.*, 2537.

invoked by anyone working in the hospital, not just the individuals directly involved with procedure. Senator Church, however, assured his colleague that the amendment did not include anyone without direct involvement in the matter.⁸⁸

Despite Church's assertion that the amendment's application was limited, it opened the floodgates for so-called "conscience clauses," to be enacted all over the country. By the end of 1974, twenty-seven states had laws allowing hospitals to refuse to provide abortions.⁸⁹ Many of these laws stipulated that physicians and hospitals that refused to perform abortions were not obligated to even provide patients referrals to another provider. This expansive interpretation was affirmed with the 1996 omnibus appropriations bill, which prohibited the federal government from denying funding to hospitals that refused to provide abortions.⁹⁰

That same year, after the approval of the Coats Amendment, which stipulated that refusal to perform abortions did not need to be contingent upon moral or religious belief, the Accreditation Council for Graduate Medical Education (ACGME) had clarified their recently issued reforms. They stated that, "residency programs with religious or moral objections must not impede residents who do not share those objections from receiving education and experience in performing abortions from another institution."⁹¹ The organization also required that programs with these policies publicize them to all residency applicants.

The most recent attempts to restrict funding for abortion training focus on funding systems. Medicare and Medicaid are the two largest federal funders of medical education, covering both direct payments (like salaries for residents) and indirect payments (like subsidies

⁸⁸ Ibid.

⁸⁹ Ibid., 2538.

⁹⁰ Ibid.

⁹¹ Tocce and Severson, 114.

to teaching hospitals).⁹² An amendment proposed by Representative Virginia Foxx of South Carolina in 2011 would prohibit these programs from providing funding for training for abortion providers. The amendment passed in the House of Representatives but stalled in the Senate.⁹³

Although the Foxx Amendment failed to become law, state governments have had more success. In 2011, the governor of Arizona signed a bill prohibiting the spending of “public monies, tax monies, federal funds passing through the state treasury, monies paid by students as part of tuition or fees to a state university or community college,” for abortion training.⁹⁴ By 2015, nine states had banned abortion training in publicly funded hospitals and state universities and subsequent bills have gone even further.⁹⁵

The Wisconsin state legislature is currently debating a bill that would ban students from its state university system from learning how to perform abortions. Because of this, the University of Wisconsin system has an agreement with Planned Parenthood that allows its professors to train students in Planned Parenthood clinics.⁹⁶ The new bill would prevent University of Wisconsin professors from teaching abortion anywhere other than a hospital. It’s a Catch-22 that effectively bans medical students in the state university system from receiving any abortion training.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Ibid., 115.

⁹⁵ Mara Gordon, “The Scarcity of Abortion Training in America’s Medical Schools,” *The Atlantic*, June 9, 2015, <https://www.theatlantic.com/health/archive/2015/06/learning-abortion-in-medical-school/395075/>.

⁹⁶ Sharmane Mills, “Medical Groups: Wisconsin Abortion Bill Would Jeopardize Doctor Training,” *Wisconsin Public Radio*, July 18, 2017, <https://www.wpr.org/medical-groups-wisconsin-abortion-bill-would-jeopardize-doctor-training>.

Conclusion

Even in the face of these obstacles, students and OB-GYN residents still believe that instruction in abortion procedures is a necessary part of medical instruction. Over the last decade, the number of residency programs with mandatory abortion training has increased to over fifty percent of programs.⁹⁷ We know that programs with mandatory training are more likely to produce doctors who intend to provide abortions.⁹⁸ But of students who intended to provide abortions, ultimately, only fifty-two percent of them did.⁹⁹ This indicates that it is not necessarily inadequate medical instruction contributing to provider shortage but obstacles encountered once they've completed their training.

⁹⁷ Turk et al., 276.

⁹⁸ MacIsaac and Vickery, 297.

⁹⁹ Lori Freedman, *Willing and Unable: Doctors' Constraints in Abortion Care* (Nashville: Vanderbilt University Press, 2010), 35.

CHAPTER TWO: ABORTION AND PRIVATE PRACTICE

As discussed in the previous chapter, the last two decades have seen a steady increase in the number of medical schools and residency programs offering at least some abortion training. However, despite the increase in available training, the number of abortion providers steadily declined during the same period: from 1992 to 1996, the number of providers fell by fourteen percent, eleven percent by 2000, and another two percent by 2005.¹

These numbers refer to the total number of abortion providers, and do not specify where abortions were performed (non-hospital clinic, hospital, or physician's office). During this timeframe, the number of all types of abortion facilities decreased, but the decrease was more pronounced in private practice. In 1996, forty-four percent of private practices offered abortion services and performed three percent of all abortions.² Twenty years later, only fifteen percent of physician offices offered abortion services, and they performed less than one percent of all abortions.³

Private OB-GYN practices have never been the primary sites for abortion care, even after *Roe v. Wade* legalized the procedure. However, they are often the first point of contact for patients dealing with unplanned pregnancies. After the legalization of abortion, what prevented OB-GYNs from integrating abortion into their private practices, and why do their numbers continue to fall? In what ways does the medical establishment contribute to and perpetuate this shortage? In this chapter, I will examine the historical and political factors that have contributed to the exclusion of abortion from private practice.

¹ Lori Freedman, *Willing and Unable: Doctors' Constraints in Abortion Care* (Nashville: Vanderbilt University Press, 2010), 35.

² Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Family Planning Perspectives* 30, no. 6 (1998): 263-270, JSTOR.

³ Rachel K. Jones and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2014," *Perspectives on Sexual and Reproductive Health* 49, no. 1 (2017): 17-27, Wiley Online.

History of Abortion in Private Practice

Before abortion was legalized across the United States with *Roe v. Wade*, hospitals were the most common facility for legal abortions. Starting in the 1950s, hospitals began establishing abortion committees, formally known as therapeutic abortion committees.⁴ Physicians would request the procedure on behalf of a patient and the committee, comprised of doctors across multiple specialties, reviewed the case and rendered a decision.⁵ When these committees were first established, they focused primarily on the physical health of the pregnant woman when considering approval. By the early 1960s however, eighty percent of committees considered the mental health of the pregnant woman, leading to an increase in the number of approved abortions.⁶

Rather than monitoring the health and safety of patients, abortion committees were established to protect the hospitals and doctors.⁷ While OB-GYNs were at the forefront of the movement to reform abortion laws, protecting their image from the stereotype of the dirty, illegal “abortionist,” was crucial. Adopting a strength in numbers approach, doctors believed that collaborating on the abortion decision-making process would protect an individual from being singled out for derision and any potential legal issues.⁸

The modern service delivery model for abortion and the role of the physician within it was largely developed before the *Roe* decision, after New York legalized abortion in 1970.⁹ Keeping abortion within hospitals and private OB-GYN practices seemed feasible but, almost

⁴ Rickie Solinger, “‘A Complete Disaster:’ Abortion and the Politics of Abortion Committees, 1950-1970,” *Feminist Studies* 19, no. 2 (1993): 240-268, JSTOR.

⁵ *Ibid.*, 249.

⁶ *Ibid.*, 261.

⁷ *Ibid.*, 249.

⁸ *Ibid.*

⁹ David J. Garrow, “Abortion Before *Roe v. Wade*: An Historical Perspective,” *Albany Law Review* 62, no. 3 (1999): 833-852, Gale.

immediately, the demand for abortion skyrocketed. The drastic increase in patient volume required abortion providers and facilities to reevaluate where abortions would be performed. The need to accommodate the high volume of patients is what initially led to the development of freestanding abortion clinics.¹⁰

One of the main advocates for the clinic model of abortion provision was the nascent feminist movement. Many second wave feminists had either had an illegal abortion or had helped others get them, and those experiences contributed to their passion for making the process of accessing an abortion as easy as possible for patients.¹¹ They hoped to establish clinics that provided more than abortion alone, offering a broad spectrum of sexual and reproductive health care to women.¹² Creating spaces that were, “woman-centric,” was important, not just for the comfort of patients, but as a political statement. These clinic founders wanted to assert some independence from a medical establishment they viewed as paternalistic.¹³

Feminist groups were not the only ones developing the clinic-centric model of abortion care. Driven more by medicine and, occasionally, profits than ideology, physicians established clinics of their own. Like the feminists who had experienced illegal abortion, many doctors had seen the damage done by illegal abortion and felt compelled to provide the procedure within the new legal landscape.¹⁴ Initially, these doctors partnered with the feminist clinics. However, upon the discovery that abortion provision could be fairly lucrative, a division occurred. Even doctors who believed in the cause were incentivized by the potential financial gain; some of the feminists

¹⁰ Ibid., 838.

¹¹ Johanna Schoen, *Abortion After Roe: Abortion After Legalization* (Chapel Hill: University of North Carolina Press, 2015), 24.

¹² Ibid., 46.

¹³ Ibid., 24.

¹⁴ Ibid.

felt any focus on the fiscal aspects of running a clinic led to a commodification of abortion that they found at odds with their values.¹⁵

While the number of abortions significantly increased after *Roe*, the number of physicians willing to provide abortions remained relatively low. A small number of doctors provided large numbers of abortions, many of them traveling to do so. With the grisly specter of illegal abortion still fresh in the medical establishment and public's minds, there were simply few doctors willing to invite potential marginalization within their profession.¹⁶

It was not fear of stigmatization alone that kept doctors from providing abortions but significant institutional barriers as well. Many hospitals, worried about being perceived as “abortion mills,” limited the number of abortions they would allow their physicians to perform.¹⁷ Local governments also made providing abortions challenging by instituting onerous zoning laws and building codes explicitly to keep clinics out of their cities and towns. By the mid 1970s, state lawmakers began passing laws restricting abortion access, including spousal consent laws and laws against certain types of abortion procedures.¹⁸

For some physicians, the main obstacle preventing them from integrating abortion care into their private practices was logistics. A single physician or even a small group practice believed they would be unable to keep up with demand for abortion while continuing to provide other aspects of OB-GYN care.¹⁹ Doctors who wanted to provide abortions within a private practice often had colleagues in the practice who were hostile to abortion or worried about the stigma of associating the practice with abortion provision. Outside of providing them for their

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid., 25.

¹⁸ Ibid.

¹⁹ Ibid., 37.

established patients, if a physician wanted to provide abortion care, they usually needed to do so outside the confines of their practice.²⁰ This contributed to the proliferation of the clinic model over one that centered on private practices.

Dr. Robert Hall, the New York City physician and a passionate supporter of reforming abortion laws, expressed skepticism about the clinic model of service delivery that has since come to dominate abortion care.²¹ Dr. Hall argued that the model would make it easy for organized medicine to abdicate its responsibility to provide abortions as a part of routine gynecological care. He believed that this would marginalize the procedure and, ultimately, decrease access for patients.²² Considering the steady decline of OB-GYNs including abortion in private practice, Dr. Hall's warning proved prescient.

Self-Policing within the Medical Community

Even before the *Roe v. Wade* decision, there was considerable debate among physicians regarding abortion within private practice. In a 1972 article in *Family Planning Perspectives*, an OB-GYN practicing in New York, where abortion was legal, advocated performing abortions in a private practice setting.²³ According to Dr. Selig Neubardt, there was no longer a valid medical reason to only perform abortions in hospitals. Up until this time, patients were usually given general anesthesia; now, physicians were increasingly using a para-cervical block (an injection to numb the patient's cervix while they remain awake) to ease patient discomfort. A para-cervical

²⁰ Ibid.

²¹ Garrow, 839.

²² Ibid., 40.

²³ Selig Neubardt and Harold M.M. Tovell, "Should Abortions Be Performed in Doctors' Offices?" *Family Planning Perspectives* 4, no. 3 (1972): 4-8, JSTOR.

block was preferable because it had fewer risks and potential complications compared to general anesthesia.²⁴

Neubardt only performed abortions for women to whom he already provided routine gynecological care in his practice. He and the two other doctors in the practice were providing approximately one hundred abortions a year to their patients. This was in line with a study published in 1971 that found that in the states with the most liberal abortion laws (New York, Washington, Hawaii, Alaska, and California), three-quarters of OB-GYNs were performing an estimated 120 abortions per year in private practice.²⁵ The same number agreed that providing abortion had not significantly increased patient load and would continue to provide them in their offices.²⁶

Not every OB-GYN was in favor of offering abortion in private practice. Dr. Harold M.M. Tovell, the head of Obstetrics and Gynecology at St. Luke's Hospital in New York City, argued that it simply was not possible to perform safe abortions anywhere but a hospital. He also asserted that he did not think it was necessary to have so many abortion providers, given that he had never had a patient in his practice request one.²⁷ However, these dissenting OB-GYNs were a minority, and most physicians intended to include legalized abortion in their practices.²⁸

As it turned out, the physicians who wanted to provide abortions in private practice were half right. They were correct that it was safe to perform abortions outside of a hospital. They were wrong, however, about post legalization patient volume.²⁹ It wasn't until legalization that it

²⁴ Neubardt and Tovell, 4.

²⁵ Ibid.

²⁶ R.E. Hall, "A Survey of Abortion Experience," *Ortho Pharmaceutical Corporation Ortho Panel 8*, (1971): 78-91, ScienceDirect.

²⁷ Neubardt and Tovell, 6.

²⁸ Ibid., 5.

²⁹ Garrow, 838.

became clear how many patients had received abortions illegally. It is estimated that approximately 750,000-1,200,000 illegal abortions were performed each year in United States before *Roe*.³⁰ These numbers surprised even physicians that had illegally provided abortions.³¹

Most physicians providing abortions pre-*Roe* were doing so illegally, outside the purview of professional medical organizations like the American College of Obstetricians and Gynecologists (ACOG). But unlike these doctors, ACOG had a better prediction about what was to come.³² Anticipating nationwide legalization, they issued a clinical opinion which stated that, assuming one million abortions each year, even if only half of their 20,000 member OB-GYNs in the United States offered abortion services, it would be more than enough, equaling one hundred abortion patients each.³³ At this volume, it was reasonable to assume performing abortions as part of an OB-GYN practice would not be an imposition.

Despite the endorsement of professional bodies like ACOG and AMA, a private practice centered model of abortion care never came to pass. This could be attributed in some part to lack of guidance from medical organizations. According to a 1976 study, twenty-two of the thirty-six major medical organizations, including the Association of American Medical Colleges and the Joint Commission on Accreditation of Hospitals, neglected to develop guidelines or best practices for abortion care.³⁴ This neglect signaled to the medical community that abortion was an aberration, not a procedure that could be performed safely in an office.

³⁰ Willard Cates, Jr., David A. Grimes, and Kenneth F. Schulz, "The Public Health Impact of Legal Abortion: 30 Years Later," *Perspectives on Sexual and Reproductive Health* 5, no. 31 (2007): 25-28, Wiley Online.

³¹ Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Boston: Beacon Press, 1995), 145.

³² American College of Obstetricians and Gynecologists, "A statement on abortion by one hundred professors of obstetrics," *American Journal of Obstetrics and Gynecology* 112, no. 7 (1972): 992-998, ScienceDirect.

³³ *Ibid.*, 992.

³⁴ Freedman, 23.

After *Roe*, patient demand exceeded even ACOG's predictions, with more than 1.2 million abortions being performed annually by the end of the decade.³⁵ With the heavy volume, the outpatient clinic model proliferated due to its time-and cost-effectiveness. Somewhat understandably, clinicians were prioritizing efficiency (within good medical practice). In the early years of legal abortion, this meant physicians who performed abortions likely did so at a clinic, in addition to having a regular private OB-GYN practice.³⁶ In this regard, expediency contributed to keeping abortion outside mainstream obstetric-gynecological care.

Thirty years later, another opportunity to integrate abortion care into private practice arose. On September 28, 2000, the U.S. Food and Drug Administration (FDA) approved a drug called RU-486, more commonly known as mifepristone, which many doctors believed would make it even easier for OB-GYNs to provide abortions for their patients outside a clinic setting.³⁷ Early pregnancy termination via medication is simple process. In a doctor's office, the patient takes a pill (the mifepristone) which interferes with progesterone, the hormone necessary to maintain a pregnancy. One to two days after she takes the mifepristone, the patient takes a second dose of medication, a drug known as misoprostol. The misoprostol induces uterine contractions which expel the pregnancy.³⁸

Despite the procedure's approval by the FDA, it could be difficult for doctors to access both mifepristone and misoprostol together. Misoprostol was easily accessible for physicians because it could be used to treat ulcers, could be used in labor induction, or treat postpartum uterine hemorrhage. Since misoprostol was already available, in anticipation of the approval

³⁵ "Abortion Surveillance, 1984-1985," Centers for Disease Control and Prevention, accessed March 12, 2018, <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001467.htm>.

³⁶ Garrow, 838.

³⁷ Elizabeth Pinho, "The Story of RU-486 in the United States" (Third Year Paper, Harvard Law School, 2001), 3.

³⁸ *Ibid.*, 5.

of RU-4861, congressional Republicans had passed several laws designed to strictly regulate physician access to mifepristone. Without both medications, a medical abortion would not be effective.³⁹

The eventual approval of mifepristone, which had been legal and available throughout Europe since the 1990s, was partly the result of advocacy by the medical profession. In 1993, the *New England Journal of Medicine* published an article which laid out the case for legalization.⁴⁰ Dr. Allan Rosenfeld, a doctor and professor at Columbia University School of Public Health, utilized data from studies done in Europe to demonstrate that, when used together, these drugs were safe and effective. He cautioned physicians to use care and detailed instructions when providing them but stated his belief that, under newly elected President Clinton, mifepristone would quickly be approved by the FDA.⁴¹

His optimism was not unfounded. In 1990, the American Medical Association (AMA), along with feminist organizations like the Feminist Majority Foundation, began lobbying both the French manufacturer of mifepristone to bring the drug to the U.S. and for the FDA to approve it.⁴² The AMA argued that medical pregnancy termination was less invasive than a surgical abortion and, when it is available, the less invasive method is always preferable. However, pressure from anti-abortion groups and Congressional Republicans kept the George H.W. Bush Administration from bringing the drug to the United States.⁴³

³⁹ Caroline De Costa, *RU-486: The Abortion Pill* (Salisbury: Boolarong Press, 2007), 42.

⁴⁰ Allan Rosenfeld, M.D., "Mifepristone (RU-486) in the United States -- What Does the Future Hold?" *New England Journal of Medicine* 328, no. 21 (1993): 1560-1562.

⁴¹ *Ibid.*, 1561.

⁴² Laura Fraser, "The Abortion Pill's Grim Progress," *Mother Jones*, January/February 1999, <https://www.motherjones.com/politics/1999/01/abortion-pills-grim-progress/>.

⁴³ *Ibid.*

Despite the election of a Democratic president, Rosenfeld's 1993 prediction of swift FDA approval did not come to pass, and it would be almost a decade before the drug was available. Around this time, the National Institutes of Health (NIH) completed several trials which confirmed what was known from other countries with access to the drugs: mifepristone and misoprostol used together were an effective way to end a pregnancy.⁴⁴

With mounting evidence of medical abortion's efficacy and safety, Rosenfeld was joined by a chorus of doctors advocating for the drug to be approved. In 1998, five physicians published the first literature review of the NIH trials.⁴⁵ These doctors emphasized not only the safety and efficacy of the medications but the ease with which they could be administered and the privacy afforded patients. Because access to abortion care had been decreasing in the 1990s, these doctors also felt that medical abortion could improve abortion access for women.⁴⁶ While individual physicians were advocating in journals, ACOG did not step into the fray until 2000, when they issued a committee opinion endorsing the FDA's decision to approve mifepristone.⁴⁷

News of the FDA's approval of mifepristone was greeted with optimism. "Now, Another Pill Promises Revolution," blared the *New York Times* headline the day after FDA approval. Coming on the heels of a 1995 attempt by Republicans to ban late term abortions (referred to as partial birth abortions), the paper suggested that medical abortion could be viewed as a compromise.⁴⁸ Because polling showed a majority of Americans believed that abortion should be

⁴⁴ De Costa, 33.

⁴⁵ Irving M. Spitz, M.D. et al., "Early Pregnancy Termination with Mifepristone and Misoprostol in the United States," *New England Journal of Medicine* 338, no. 18 (1998): 1241-1247.

⁴⁶ *Ibid.*, 1242.

⁴⁷ American College of Obstetricians and Gynecologists, "Committee Opinion No. 245: Mifepristone for medical pregnancy termination, 2000," accessed March 10, 2018.

⁴⁸ David A. Grimes, "Now, Another Pill Promises Revolution," *New York Times*, October 1, 2000, <https://search-proquest-com.ezproxy.wellesley.edu/docview/431581814/fulltext/3941F7CBC43343C7PQ/5?accountid=14953>.

legal early in pregnancy and because these medications would only be used during the first seven weeks of pregnancy, a happy medium could be achieved.⁴⁹ An article in the *Washington Post* predicted that the pill would increase access and could mean the end of clinic protests.⁵⁰

The popular media was not alone in their optimism. A study commissioned by the Kaiser Family Foundation (KFF) found that fifty-four percent of OB-GYNs who offered abortion services planned to incorporate medical abortion into their practice. Among physicians who did not previously perform abortions, forty-five percent said they intended to start offering medical abortion to their patients.⁵¹

The KFF study also revealed that among physicians who did not intend to provide medical abortions, personal opposition was not the primary reason. Of these OB-GYNs, fifty-one percent said they had continued concerns about protests or violence and forty-nine percent responded that they simply had no interest in providing abortions.⁵² Additionally, thirty-nine percent said that, “legal regulations associated with abortion,” were too onerous to include abortion in their practices.⁵³

After their committee opinion endorsing legalization of mifepristone, the ACOG issued a practice bulletin, laying out a protocol for medical abortion. In keeping with the FDA’s guidelines, OB-GYNs were advised that the drugs should only be used during the first seven weeks of a pregnancy, after which they become less effective and may fail to end the

⁴⁹ Ibid.

⁵⁰ Marc Kauffman, “FDA Approve Abortion Pill; Family Planning Groups Hail ‘Milestone,’” *Washington Post*, September 29, 2000, <https://search-proquest-com.ezproxy.wellesley.edu/docview/409004549/A3B0A3208C36422APQ/2?accountid=14953>.

⁵¹ Kaiser Family Foundation, “National Surveys of Women’s Health Care Providers and the Public: Views and Practices on Medical Abortion, 2001,” accessed March 10, 2018, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/one-year-later-medical-abortion-after-fda-approval-chart-pack.pdf>.

⁵² Ibid.

⁵³ Ibid.

pregnancy, and that medications should only be given after performing an ultrasound to rule out ectopic pregnancy, a potentially fatal complication.⁵⁴ A patient would also be required to come to the office three times: once to receive the mifepristone, once to receive the misoprostol, and a final visit to confirm that the pregnancy had been terminated.

The ACOG was optimistic about increased patient access to abortion. However, medical abortion legalization did little to encourage OB-GYNs to offer abortion services. Of the physicians who said they were willing to provide medical abortions, the cumbersome guidelines, namely the number of visits, were a disincentive.⁵⁵ The organization tried to remedy this, updating the practice bulletin in 2005 to emphasize how many patients could be served by providing medical abortion. According to the Centers for Disease Control, more than half of all abortions took place in the first seven weeks of pregnancy, when the drug combination was most effective.⁵⁶ The possibility of serving a significant number of patients, even without offering surgical abortions, had little impact.⁵⁷

A 2007 study in the journal *Contraception* looked at why the ACOG's goal of increased abortion accessibility had not panned out with the availability of medical abortion. While some physicians expressed continued concern about the number of patient visits, the study found that physician perception of complications was a major obstacle.⁵⁸ Despite having complication rates

⁵⁴ American College of Obstetricians and Gynecologists, "ACOG Practice Bulletin. Clinical management guidelines. Medical management of abortion, 2001," accessed March 20, 2018.

⁵⁵ Carole Joffe, "Reactions to Medical Abortion Among Providers of Surgical Abortion: An Early Snapshot," *Family Planning Perspectives* 31, no. 1 (1999): 35-38, JSTOR.

⁵⁶ American College of Obstetricians and Gynecologists, "ACOG Practice Bulletin No. 67: Medical Management of First-Trimester Abortion, 2005," accessed March 10, 2018.

⁵⁷ Ibid.

⁵⁸ Lawrence Leeman et al., "Can mifepristone medication abortion be successfully integrated into medical practices that do not offer surgical abortion?" *Contraception* 76, no. 2 (2007): 96-100, JSTOR.

comparable to surgical abortion, OB-GYNs believed a patient was more likely to need hospitalization after a medical abortion than a surgical one.⁵⁹

The last major revision to the ACOG practice bulletin occurred in 2014. New research indicated that mifepristone and misoprostol were effective up to nine weeks gestation.⁶⁰ They also demonstrated that it was no longer necessary for a patient to take the misoprostol in a doctor's office because misoprostol was as effective when taken orally as it was when it was inserted vaginally.⁶¹ This made the process considerably more convenient for both doctor and patient.

One of the major selling points for legalizing medical abortion was discretion. Patients could undergo the abortion process largely in the comfort of their own home, while doctors could provide them to their patients without drawing as much attention from anti-abortion forces. Medical abortion, however, never became integrated into private OB-GYN practice. It's possible to link lack of access to medical abortion to public policy; legislation placed significant restrictions on medical abortion almost immediately after FDA approval. But the larger issue is a product of how abortion is stigmatized generally within the medical community, in combination with factors specifically related to medical abortion.

Abortion is stigmatized both as a political matter and as a medical procedure. Given the volatility of public opinion, it seems reasonable that many doctors would not perform abortions simply to avoid making waves in their practice or community. This, coupled with the grotesque

⁵⁹ Ibid., 99.

⁶⁰ American College of Obstetricians and Gynecologists, "Practice Bulletin No. 143: Medical Management of First-Trimester Abortion, 2014," accessed March 18, 2018.

⁶¹ Ibid.

image of the pre-*Roe* “abortionist,” has led to a general stigmatization of abortion within organized medicine.⁶² This general stigma overlaps with medical abortion in a specific way.

Unlike surgical abortion, there is the potential for patient error when taking the misoprostol at home. Complications could occur that have little to do with the prescribing physician.⁶³ The suggestion that a medical abortion patient could develop complications and need additional treatment, irrespective of the provider’s care, reinforces the notion that abortion is inherently unsafe. This, in turn, again calls to mind the notion of doctors who provide abortions as unscrupulous butchers, a stereotype abortion providers have been fighting since 1973.

Similar to OB-GYNs who provide surgical abortions, the doctors most likely to provide medical abortions are ones who feel compelled by personal politics.⁶⁴ Despite the medical community’s initial optimism about mifepristone and misoprostol, the introduction of medical abortion did not increase availability, and OB-GYNs continue to exclude it from private practice. Like surgical abortion immediately after *Roe*, intra-organizational stigma and self-policing has interfered with access to medical abortion.

The Pro-Life Movement and Abortion Providers

The modern pro-life movement has its roots in activism that began even before nationwide legalization of abortion. Led predominantly by the Catholic Church, these groups formed to push back on the abortion reforms taking place in the states.⁶⁵ By 1972, the movement

⁶² Carole Joffe, “Normalizing the exceptional: incorporating the “abortion pill” into mainstream medicine,” *Social Sciences and Medicine* 56, no. 12 (2003): 2353-2366, ScienceDirect.

⁶³ *Ibid.*, 2361.

⁶⁴ *Ibid.*, 2362.

⁶⁵ Alesha E. Doan, *Opposition and Intimidation: The Abortion Wars and Strategies of Political Harassment* (Ann Arbor: University of Michigan Press, 2007), 70.

for reform of abortion laws had slowed considerably since the 1960s, leading anti-abortion advocates to believe abortion would not be legalized at the federal level. The United States Supreme Court decision in *Roe v. Wade* came as a shock and prompted pro-life groups to formally organize.⁶⁶

Immediately following *Roe*, the Catholic Church continued to lead opposition to abortion. In 1976, the election of Jimmy Carter, himself an Evangelical Christian, brought Evangelicals into the political mainstream.⁶⁷ The joining of Evangelicals and Catholics in the pro-life movement had the effect of shifting rhetoric in the movement, from language that stressed constitutional rights to emphasizing divine rights. Activists referred to clinics and hospitals as, “abortion mills,” and claimed that abortion providers, “brutally kill babies.”⁶⁸ This rhetorical escalation would presage an escalation in anti-abortion movement tactics.

In 1985, Joseph Scheidler, founder of the Pro-Life Action League (PLAL), published a pamphlet endorsing direct action, such as blockading clinics and mass protests, in addition to legislative efforts to criminalize abortion. Three years later, one of Scheidler’s PLAL lieutenants, Randall Terry, founded Operation Rescue. This organization abandoned legislative tactics and was devoted entirely to direct action meant to target both clinics and providers.⁶⁹ Under Terry’s leadership, Operation Rescue flourished. In 1989, the group staged 201 clinic blockades, leading to over 12,000 arrests.⁷⁰

The swift rise of the activist pro-life movement caught many pro-choice organizations and politicians off guard. Beginning in the early 1990s, pro-choice organizations began

⁶⁶ Ibid., 72.

⁶⁷ Ibid., 79.

⁶⁸ Ibid., 81.

⁶⁹ Ibid., 85.

⁷⁰ Ibid., 86.

mobilizing to protect clinics, culminating in the passage of the Freedom of Access to Clinic Entrances (FACE) Act in 1994. This law made Operation Rescue's favored tactic of clinic blockades illegal and allowed providers to sue protesters who violated it.⁷¹ The FACE Act protected facilities that provide abortions, however, it did little to stem threats and violence against providers themselves.

Seven abortion providers and medical personnel were murdered in the 1990s. The first was the 1993 murder of Dr. David Gunn in Pensacola, Florida. Dr. Gunn had been the subject of a wanted poster distributed by Operation Rescue in 1992.⁷² That same year, there was an attempt on the life of Dr. George Tiller in Wichita, Kansas. In 1994, Dr. John Britton, another Pensacola physician, and clinic escort James Barrett were killed, and in 1998, Dr. Bernard Slepian was killed in his home by a sniper.⁷³ The last murder of an abortion provider was in 2009, when Dr. Tiller, who had been wounded previously, was murdered at his church by a former Operation Rescue member.⁷⁴

While the assassination of an abortion provider is rare, threats of violence are commonplace. Beginning in 1995, the American Coalition of Life Activists (ACLA) began regularly publishing the names and personal information of providers, including their home addresses; they also released photos of the providers and their families. In 1997, an ACLA activist named Neal Horsley began publishing and updating this information on a website called "The Nuremberg Files."⁷⁵ In 1999, Planned Parenthood sued Horsley, winning a \$107 million

⁷¹ Ibid., 88.

⁷² Ibid., 109.

⁷³ Ibid.

⁷⁴ Liam Stack, "A Brief History of Deadly Attacks on Abortion Providers," *New York Times*, accessed January 12, 2018, https://www.nytimes.com/interactive/2015/11/29/us/30abortion-clinic-violence.html?_r=0.

⁷⁵ Doan, 185.

settlement. This was overturned by the Ninth Circuit Court of Appeals, however, who claimed the it violated Horsley's First Amendment rights.⁷⁶

There was a small but notable decrease in violence and harassment of abortion providers in the early 2000s. This has since abated and there has been an increase in harassment and threats of violence every year since 2010.⁷⁷ A professional organization for abortion providers, the National Abortion Federation (NAF), distributes an annual report on violence and harassment against abortion providers. In 2016, they found a substantial uptick in harassment compared to 2015. In 2015, providers reported 373 instances of harassment via phone; by 2016, that number was 896. Providers reported 25,839 instances of email/internet harassment and 21,715 instances of picketing; in 2016, those numbers were 42,796 and 61,562 respectively.⁷⁸

The factors contributing to the abortion provider shortage that has occurred over the last two decades are complex but there is some indication that the intimidation tactics of the pro-life movement have had their intended effect. In a 1993 study from the Alan Guttmacher Institute, thirty percent of doctors named anti-abortion threats and harassment as the number one obstacle to providing abortions.⁷⁹ More recently, political scientist Alesha Doan interviewed both abortion providers and doctors who have opted not to provide abortions. While only a third of the physicians who did not provide abortions cited anti-abortion harassment as their sole reason for abstaining, all admitted that it played some role in their decision.⁸⁰

In addition to the psychological effects on providers and would-be providers, the threat of anti-abortion violence exacts a financial cost. Providers must pay for enhanced security

⁷⁶ Ibid.

⁷⁷ National Abortion Federation, "2016 Violence and Disruption Statistics," accessed January 12, 2018, <https://prochoice.org/education-and-advocacy/violence/violence-statistics-and-history/>.

⁷⁸ Ibid.

⁷⁹ Doan, 117.

⁸⁰ Ibid., 151.

measures, often including costly security systems and on site security guards. These costs are more easily borne by clinics specializing in abortion but can be prohibitively expensive for doctors who want to offer abortion in a private practice. Consequently, access to abortion in a private medical practice has decreased even more rapidly than access in other facilities.⁸¹

Legislative Barriers in Private Practice

Efforts by abortion opponents to reduce access to the procedure began almost immediately after it was legalized. For example, the Hyde Amendment, which targeted the use of Medicaid funding for abortion, was passed for the first time in 1976 and upheld as constitutional by the United States Supreme Court in 1980.⁸² Like the Hyde Amendment, most of the earliest legislation to restrict abortion focused on patient access; in recent years, there has been a shift to target abortion providers and their ability to perform the procedure.⁸³

Not only has the target for abortion regulations changed, since 2011 the number of abortion regulations at the state level has increased dramatically. From 1985 to 2010, no single year saw more than forty abortion regulations enacted. Between 2010 and 2013, however, thirty states passed more than two hundred new abortion regulations.⁸⁴ The pace of the new regulations has continued. In 2017 alone, nineteen states adopted sixty-three new measures targeting abortion access.⁸⁵ These new regulations tend to fall into four categories: Targeted Regulation of Abortion Providers (TRAP) laws, restrictions on insurance coverage, restrictions on medical

⁸¹ Ibid., 152.

⁸² Heather D. Boonstra and Elizabeth Nash, "A Surge of State Abortion Restrictions Puts Providers - and the Women They Serve - in the Crosshairs," *Guttmacher Policy Review* 17, no. 1 (2014): 9-14, Gale.

⁸³ Theodore Joyce, "The Supply-Side Economics of Abortion," *New England Journal of Medicine* 365, no. 16 (2011): 1466-1469, ProQuest.

⁸⁴ Boonstra and Nash, 9.

⁸⁵ Elizabeth Nash et al., "Policy Trends in the States, 2017," accessed January 15, 2018, <https://www.guttmacher.org/article/2018/01/policy-trends-states-2017>.

abortion, and twenty week abortion bans.⁸⁶ It is the first two types of legislation that make it particularly difficult for physicians who would like to provide abortions within a private practice setting.

One of the most common types of abortion restrictions are TRAP laws. These laws regulate the facilities where abortions can be performed, requiring them to meet the exacting standards of an ambulatory surgical center, even though these requirements are unnecessary for patient safety; they had the effect of putting many abortion clinics out of business. In 2016, the U.S. Supreme Court's decision in *Whole Woman's Health v. Hellerstedt* struck down some of these regulations as unconstitutional, but while the case was a victory for abortion access, there remained significant obstacles for providers.⁸⁷

Although no longer required to meet ambulatory surgical center standards, many states still have regulations that go beyond what is necessary for patient safety. Twenty-three states require doctors of any specialty to obtain and maintain an additional license specifically to provide abortions. There is some variation in the requirements in these states. For example, in Texas, any facility or physician that performs or intends to perform more than ten abortions in a given month is required to have an additional license.⁸⁸ In Virginia, however, an additional license is required if intending to provide just five abortions per month.⁸⁹ While there is no evidence that licensing requirements like these make patients safer, it could be an obstacle for would-be abortion providers.

⁸⁶ Boonstra and Nash, 10.

⁸⁷ Y. Tony Yang and Katy B. Kozhimannil, "Whole Woman's Health v. Hellerstedt and the Current Implications for Abortion Access," *Birth: Issues in Perinatal Care* 44, no. 1 (2017): 3-6, Wiley Online.

⁸⁸ Texas Abortion Facility and Licensing Act, Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989, <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.245.htm%23245.004>.

⁸⁹ Virginia Administrative Code, Chapter 412. Regulations for Licensure of Abortion Facilities, <https://law.lis.virginia.gov/admincode/title12/agency5/chapter412/section10/>.

In addition to TRAP laws, legislation restricting insurance coverage for abortion has predominated in the states. As mentioned above, since 1976, states have restricted the ability of patients to pay for abortions with Medicaid funds. Currently, thirty-five states and the District of Columbia deny Medicaid coverage for abortion. Since nearly one out of seven women of reproductive age rely on Medicaid, these laws affect a substantial number of women.⁹⁰ On average, physicians in private practice see a limited number of Medicaid patients due to the lower reimbursement rate.⁹¹ The restrictions on public insurance funds for abortion further disincentivizes abortion care in private practice.

Given the low number of Medicaid patients seen by doctors in private practice, regulation of abortion coverage in private insurance is an even bigger issue. The insurance exchanges established by the Patient Protection and Affordable Care Act (ACA) were not operational until 2014 but, by 2010, states began passing legislation to restrict abortion coverage. In insurance plans offered on the ACA exchanges, twenty-six states have laws restricting coverage for abortion. Most of these states limit abortion coverage to victims of rape or incest and to threats to the patient's health or life. Two of these states deny any abortion coverage.⁹² While some patients will be able to pay out of pocket for their abortion, most will not. For most private practices, the expense and effort required to provide abortions may not be worth the trouble given the relatively few patients that could access care with them.

⁹⁰ All Above All, "Abortion Coverage Map 2016," accessed January 15, 2018, <https://allaboveall.org/resource/abortion-coverage-map-2016/>.

⁹¹ Genevieve M. Kenney et al., "Access to Care for Low-Income Medicaid and Privately Insured Adults in 2012 in the National Health Interview Survey: A Context for Findings from a New Audit Study," *Urban Institute Health Policy*, accessed January 15, 2018, <https://www.urban.org/sites/default/files/publication/22501/413089-Access-to-Care-for-Low-Income-Medicaid-and-Privately-Insured-Adults-in-in-the-National-Health-Interview-Survey-A-Context-for-Findings-from-a-New-Audit-Study.PDF>.

⁹² Guttmacher Institute, "Restricting Insurance Coverage of Abortion, 2018," accessed January 15, 2018, <https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion>.

Although not as recent as TRAP and insurance coverage restriction legislation, laws targeting informed consent practices also affect abortion providers, especially those in private practice. Proliferating after the undue burden standard was created in the U.S. Supreme Court decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, this type of legislation, known as Woman’s Right to Know laws, requires abortion providers to go beyond informed consent standards for other medical procedures. Twenty-three states have some variation of Woman’s Right to Know legislation. The most common requirements are mandatory counseling for abortion patients, requiring an ultrasound before an abortion may be performed, and compelling physicians to give their patients inaccurate medical information.⁹³

These regulations can present particular challenges for private practices. Some of these laws have requirements governing when the ultrasound and counseling must be performed (usually at least twenty-four hours before an abortion) and restrict what staff may do them.⁹⁴ Whereas a clinic may have the ability to support these requirements, most private practices do not have the resources to keep counselors and ultrasound technicians on staff. In states that require the abortion provider to perform the ultrasound and meet with a patient twice, this could be onerous for a doctor with a busy practice.

Practice and Institutional Restrictions

With the increase in abortion training in residency programs, more OB-GYNs have experience with abortion than at any point in the last two decades. As discussed in the previous chapter, this increase in training has also led to an increased intention to provide abortions after

⁹³ Scott W. Gaylord and Thomas J. Molony, “Casey and a Woman’s Right to Know: Ultrasounds, Informed Consent, and the First Amendment,” *Connecticut Law Review* 45, no. 2 (2012): 595-652, LexisNexis Academic.

⁹⁴ Gaylord and Molony, 595.

residency.⁹⁵ For many OB-GYN residents, however, joining a private practice, there can be significant challenges unrelated to the regulatory environment.

Most residents joining a private OB-GYN practice know the policies on abortion provision before they join. It is not uncommon for a practice that restricts their doctors from providing abortion services to state as much in the doctor's contract. But, as reported in a 2010 study published in the journal *Perspectives on Sexual and Reproductive Health*, just as many practices have no contractual policy regarding abortion care.⁹⁶ Residents joining these practices often do not discover abortion prohibitions until they begin practicing. In this situation, social sanction, rather than official policy, may govern a young doctor's decision to provide abortions. They may be told explicitly by senior physicians that they are not allowed to do them or may simply opt not to because of office politics.⁹⁷

Some larger private practices will offer abortion care in a limited set of circumstances. Like hospitals in the pre-*Roe* era, these practices convene abortion committees to approve a doctor's request to provide abortion on a case-by-case basis. In these practices, getting approval for an elective abortion can be difficult. More often, a practice's abortion committee priority is providing continuity of care for an established patient with a nonviable pregnancy or related complication.⁹⁸

It is not just individual private practices but the larger institutions they exist within that makes offering abortion services challenging. In recent years, there has been an increase in the

⁹⁵ Laura MacIsaac and Zevidah Vickery, "Routine training is not enough: structured training in family planning and abortion improves residents' competency scores and intentions to provide abortion after graduation more than ad hoc training," *Contraception* 85, no. 3 (2012): 294-298, ScienceDirect.

⁹⁶ Lori Freedman et al., "Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice," *Perspectives on Sexual and Reproductive Health* 42, no. 3 (2010): 146-151, JSTOR.

⁹⁷ *Ibid.*, 148.

⁹⁸ *Ibid.*, 149.

number of Catholic health networks in the United States. As of 2017, one of every six patients in the U.S. receives care from a Catholic affiliated institution.⁹⁹ Because of the Catholic Church's prohibition on reproductive health care, it can be difficult for private practices to provide abortions (and, in some places, contraception) if they have any relationship with these institutions. For example, many private practices are located in buildings owned by Catholic health networks.¹⁰⁰

Health Maintenance Organizations (HMOs) also make providing abortions difficult for OB-GYNs in private practice. Unlike Catholic health networks, HMOs block abortion provision for fiscal, rather than ideological, reasons. As shown earlier in this chapter, numerous factors make providing abortions at a clinic facility less expensive than providing them in a doctor's office. For this reason, HMOs usually require patients to use clinics when seeking abortion care.¹⁰¹ While the desire for HMOs to keep costs low is obvious and understandable, it is one more example of the challenges providers face if they want to offer abortion in private practice.

Conclusion

Even though recent years have seen increased opportunities for abortion training, the number of abortion providers in the United States continues to fall. This decrease is even more pronounced among physicians in private medical practice. There is strong evidence linking increased state regulation to decreases in the number of abortion providers. Specifically, funding restrictions, Targeted Regulation of Abortion Provider (TRAP) laws, and the costs associated

⁹⁹ Catholic Health Association of the United States, "U.S. Catholic Health Care: the nation's largest group of not-for-profit health care providers, 2017," accessed January 15, 2018, https://www.chausa.org/docs/default-source/default-document-library/cha_2017_miniprofile.pdf?sfvrsn=0.

¹⁰⁰ Freedman et al., 149.

¹⁰¹ Ibid.

with additional licensing create significant deterrents for physicians who would like to provide abortions.¹⁰² Additionally, threats of violence from anti-abortion groups work to keep abortion at the margins of medical practice.

Threats of violence are not the only obstacles to abortion provision in private practice. Opportunities to integrate abortion into private practice presented themselves in 1973, with nationwide legalization, and in 2000, when the FDA approved RU-486. However, integration never materialized. In 1973, this was largely attributable to stigma among physicians as well as the public; no doctor wanted to be associated with the illegal “abortionist.” This stigma still remained when medical abortion became available. Continued stigma, along with the potential for patient complication specific to medical abortion, meant another chance to incorporate abortion into the mainstream of obstetrics and gynecology had passed.

Abortion is one of the most common medical procedures performed in the United States, with about one-third of women having one by the age of forty-five. A comparable number of women will undergo a cesarean section. It would be considered odd if an OB-GYN did not provide cesarean sections to their patients but we have accepted it as the norm for abortion care. Relegating abortion to specialized clinics not only makes care more difficult for patients in need to access it, it contributes to the stigmatization of abortion within organized medicine.

¹⁰² Marshall H. Medoff, “The Relationship Between State Abortion Policies and Abortion Providers,” *Gender Issues* 26, no. 3 (2009): 224-237, SpringerLink.

CHAPTER THREE: ABORTION AND HOSPITALS

As previous chapters have noted, in the years before *Roe v. Wade*, hospitals dominated legal abortion provision. Within hospitals, access to abortion was strictly controlled by therapeutic abortion committees. These committees developed standards to evaluate whether a patient could undergo an abortion in their facility. Usually the only eligible patients were ones suffering from a very limited set of physical ailments.¹ In the two decades prior to legalization, however, many committees gradually expanded their criteria to include threats to the patient's mental, in addition to their physical health. Although patients still needed approval of the committee, it became significantly easier to obtain a legal abortion as the result of relaxed regulation.²

Prior to 1973, physician advocates for legal abortion disagreed about what the standard of care should look like once the procedure was legalized. Some believed that abortion could be integrated into private practice, while others maintained that only hospitals could provide the necessary patient safety.³ Despite this early debate, ultimately the non-hospital clinic model proliferated post-*Roe* and the role of hospitals was reduced dramatically.

A study published in 1975 found that between the first quarter of 1973 and the first quarter of 1974, there was a ninety percent increase in the number of abortions performed in non-hospital clinics; for the first time, the majority of abortions were performed outside of a hospital.⁴ What led to this abrupt shift in the abortion provision model and what does hospital

¹ Rickie Solinger, "'A Complete Disaster': Abortion and the Politics of Abortion Committees, 1950-197," *Feminist Studies* 19, no. 2 (1993): 240-268, JSTOR.

² *Ibid.*, 246.

³ David J. Garrow, "Abortion Before *Roe v. Wade*: An Historical Perspective," *Albany Law Review* 62, no. 3 (1999): 833-852, Gale.

⁴ Edward Weinstock et al., "Legal Abortion in the United States Since the 1973 Supreme Court Decisions," *Family Planning Perspectives* 7, vol.1 (1975): 23-31, JSTOR.

abortion provision look like today? How did physicians and organized medical bodies like the American Medical Association contribute to the shift away from hospitals and toward non-hospital clinics? This chapter will consider the historical and political factors that contributed to the post-*Roe* change in the model of care for abortion.

History of Abortion in Hospitals

Before *Roe v. Wade*, as discussed in detail in chapters two and three, legal abortions were largely unavailable outside of a hospital. Within hospitals, therapeutic abortion committees tightly regulated which patients could access abortions and under what circumstances. It was necessarily difficult to determine how many illegal abortions were performed each year. At a 1958 conference on illegal abortion, researchers estimated there were between 200,000 and 1,200,000 abortions performed illegally each year in the United States.⁵ Given the enormous range of the estimate, it was difficult for the medical community to accurately assess what resources would be needed post-legalization.⁶

According to the Centers for Disease Control and Prevention (CDC), approximately 587,000 legal abortions were performed in 1972. This number increased by twenty-seven percent in the first year of nationwide legal abortion and, by 1974, there was increase of twenty percent compared to the previous year.⁷ These increases were not evenly distributed; states that had maintained strict anti-abortion policies before *Roe* saw the most growth, while states with liberal pre-*Roe* policies saw a small decrease, as they were treating fewer out-of-state patients.⁸

⁵ Hillary Kunins and Allan Rosenfield, "Abortion: A Legal and Public Health Perspective," *Annual Review of Public Health* 12, no. 1 (1991): 361-382, Medline.

⁶ Weinstock et al., 23.

⁷ Ibid.

⁸ Ibid., 24.

The non-hospital clinic model dominated in states where abortion had been legal and was quickly emulated in states where the procedure was newly legally available. By 1974, only thirty percent of abortions were performed in hospitals and only two percent were performed in private practice. Within one year of nationwide legalization, the clinic model had come to dominant abortion provision across the country.⁹

The movement of abortion away from hospitals was swift, even though many hospital administrators revised their abortion policy in an effort to keep up. In the years immediately preceding *Roe*, fifty-two percent of hospitals provided no abortion services, thirty-nine percent offered therapeutic abortions, and nine percent offered elective abortions.¹⁰ Forty-nine percent of these changes came from hospitals expanding access by offering elective abortions.¹¹ Notably, a substantial number of these hospitals were institutions that had not offered even therapeutic abortions before *Roe*.¹² There were, however, a small number of hospitals who altered their policies to reduce abortion access. They did this mainly by eliminating all abortions services where they had once provided therapeutic abortions.¹³ By 1979, half of all hospitals provided elective abortions, seven percent provided only therapeutic abortions, and forty-three percent did not offer any.¹⁴

For hospitals that made changes to their abortion policy, the process of altering their policies was straightforward. In ninety percent of these hospitals, the decision to expand abortion services was made entirely by policymakers, not medical personnel.¹⁵ Fewer than fourteen

⁹ Ibid.

¹⁰ Jon R. Bond and Charles A. Johnson, "Implementing a Permissive Policy: Hospital Abortion Services After *Roe v. Wade*," *American Journal of Political Science* 26, no. 1 (1982): 1-24, JSTOR.

¹¹ Ibid., 3.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Ibid.

percent of hospital administrators reported “heated” resistance to the new policy from staff and another twenty-three percent of administrators reported no response, negative or positive, from their staff.¹⁶ Lack of dissent within the hospital, however, was not necessarily an indicator of successful policy.

For many hospitals, an increase in the availability of elective abortion did not translate into a decrease in red tape for patients. For example, in 1978, seventy-five percent of hospitals required parental notification for any patient under the age of eighteen and five percent required parental consent for any unmarried women, regardless of age.¹⁷ Additionally, eighteen percent of hospitals required patients to obtain spousal consent before an abortion.¹⁸ A large number of hospitals had physician consultation requirements as well, meaning a patient was required to meet with a physician a certain number of days before the procedure.¹⁹ All together, these policies had the effect of making hospital abortion provision more time-consuming than was necessary for both doctor and patient.

In many cases, hospital administrators saw these restrictions as a tool to keep their abortion rates low. While some hospitals had an official policy limiting the number of abortions permitted in their facilities, most wanted to do as few as possible without instituting a fixed quota.²⁰ Even though abortion was now legal, the stigma associated with illegal abortion persisted. Just as no doctor wanted to be thought of as an “abortionist,” no hospital wanted to be considered an “abortion mill.”²¹

¹⁶ Ibid.

¹⁷ Barbara L. Lindheim, “Services, Policies, and Costs in U.S. Abortion Facilities,” *Family Planning Perspectives* 11, no. 5 (1979): 283-289, JSTOR.

¹⁸ Ibid., 286.

¹⁹ Ibid., 288.

²⁰ Ibid., 286.

²¹ Johanna Schoen, *Abortion After Roe: Abortion After Legalization* (Chapel Hill: University of North Carolina Press, 2015), 25.

Few non-hospital clinics had these restrictive policies and, significantly, clinics provided an array of services not offered to a patient obtaining an abortion in a hospital. Unlike hospitals, a patient at a clinic would receive what were termed “supportive services,” meaning preoperative counseling and follow up care.²² In addition to abortion, clinics provided contraceptive counseling and birth control, testing and treatment for sexually-transmitted infections, and general sex education.²³ Because hospitals had neither the inclination or resources to offer these things, patients increasingly turned to these clinics to meet all their reproductive health care needs.

The failure to retain abortion patients was not entirely the fault of hospital administrators. With the exceptions of the American College of Obstetricians and Gynecologists (ACOG) and the American Public Health Association (APHA), no other medical organizations developed standards of care or best practices for hospital abortion services following legalization. After *Roe*, the largest medical organization in the country, the American Medical Association (AMA), issued a statement affirming their support for the decision but offered no guidance to administrators.²⁴ Potentially, these organizations could have helped hospitals develop and maintain the tools to compete with the comprehensive care provided by clinics. Without their support, however, hospitals ultimately ceded abortion care to non-hospital clinics.

While all of these factors played a role, the biggest contributor to the decline of abortion provision was likely cost. It was simply less expensive for a patient to get an abortion at a non-hospital clinic than at a hospital. Many clinics were the product of collaboration between medical

²² Lindheim, 288.

²³ Ibid.

²⁴ C.E. Joffe, T.A. Weitz, and C.L. Stacey, “Uneasy allies: pro-choice physicians, feminist health activists, and the struggle for abortion rights,” *Sociology of Health and Illness* 26, no. 4 (2004): 775-796, Wiley Online.

professionals and second wave feminist activists and were often founded more on philosophy than fiscal prudence.²⁵ Many feminists familiar with the horrors of illegal abortion wanted to make abortion as accessible as possible for their patients, by eliminating many of the barriers imposed by other facilities.²⁶ As a result, clinic prices were often kept artificially low, in the hope it would allow the maximum number of patients to access care.

Even if clinic prices had not already been deflated, hospitals would still have been at a disadvantage. In addition to the cost of the procedure itself, patients were charged additional fees for the required pregnancy test and anesthesia.²⁷ They were also required to pay a facility fee and a physician's fee.²⁸ These kinds of fees are not unusual from a hospital and, even today, it is often more expensive to get treatment in a hospital than a doctor's office or urgent care facility. Because abortion was already struggling to maintain a place within mainstream medical institutions, however, these fees necessarily had a greater impact on abortion provision than on other in-hospital procedures. This meant that, by the end of the decade, an abortion in a hospital was more than twice as expensive than one performed in a clinic.²⁹

Institutional policies played an outsized role in moving abortion out of hospitals but physician attitudes were not irrelevant; in fact, the two were connected. Hospital abortion policies were developed almost exclusively by administrators, not medical staff, meaning that physicians had little say in how permissive the policies became.³⁰ According to a study published in 1980, these policies influenced physician attitudes toward abortion: the more permissive a

²⁵ Schoen, 24.

²⁶ Ibid.

²⁷ Lindheim, 287.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Constance A. Nathanson and Marshall H. Becker, "Obstetricians' Attitudes and Hospital Abortion Services," *Family Planning Perspectives* 12, no. 1 (1980): 26-32, JSTOR.

hospital's policy, the more likely its physicians were to have a positive view of abortion and its place within the hospital.³¹ Permissive policies were most common at large hospitals (namely public teaching hospitals) and these hospitals were the most likely to continue offering abortion even with the dominance of the clinic model.³²

The same study found that physicians at hospitals with less permissive abortion policies were more likely to have a negative view of abortion or view it as unimportant.³³ To many doctors in these hospitals, restrictive policies signaled a lack of support for abortion care from the administration. As a result, doctors were less likely to wade into the potentially volatile waters of providing abortions. Even doctors who had no objection to providing abortions admitted that they did not want to, "risk arousing opposition from within the hospital."³⁴ Without doctors to advocate for expanding their policies further and only a small number willing to provide care, these hospitals rapidly lost patients to freestanding clinics.

The U.S. Food and Drug Administration's (FDA) approval of RU-486 in 2000 and the introduction of medical abortion did not present the same opportunity to reintegrate abortion into hospitals as it did to private practice. Because the practical obstacles to providing medical abortion in a hospital (like multiple patient visits with the same doctor) were similar to the policies that had driven patients away from hospitals in the years immediately after *Roe*, there was little incentive to offer them and there was virtually no effort to do so.³⁵ This meant that,

³¹ Ibid., 31.

³² Ibid.

³³ Ibid.

³⁴ Ibid.

³⁵ Stanley K. Henshaw and Lawrence B. Finer, "The accessibility of abortion services in the United States, 2001," *Perspectives on Sexual and Reproductive Health* 35, no. 1 (2003): 16-24, ProQuest.

ultimately, medical abortion was mostly confined to non-hospital clinics and occasionally private practices.³⁶

Institutional policies, lack of support from medical organizations like the AMA, and the affordability of non-hospital clinics combined to help push abortion provision out of hospitals after *Roe v. Wade*. By the end of the 1970s, hospitals had gone from being essentially the sole legal abortion provider to performing less than one-third of all abortions in the United States; these numbers have only fallen further in the intervening decades.³⁷ Between 1992 and 1996, as the number of abortion providers fell fourteen percent, the greatest decline came from hospital providers.³⁸ As of 2014, hospitals provided only four percent of all abortions.³⁹

Current Hospital Abortion Provision

In 2018, hospital abortion provision is rare; however, it has not been entirely eliminated. There is little reliable data about current hospital abortion policies. Major medical organizations to continue to decline to develop standards or best practices for hospital abortion provision and, as abortion care continues to leave hospitals, there is no reason to think they ever will. Considering how few abortions they perform, it is safe to conclude that current hospital abortion policies, whether official or unofficial, are quite selective.

Despite a dearth of information about the specifics of modern hospital abortion policies, there is some data on who is able to access care and why. According to a 2016 article in the *Journal of Health and Social Behavior*, plenty of patients attempt to access abortion care in

³⁶ Ibid., 23.

³⁷ Weinstock et al., 24.

³⁸ Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Family Planning Perspectives* 30, no. 6 (1998): 263-270, JSTOR.

³⁹ Rachel K. Jones and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2014," *Perspectives on Sexual and Reproductive Health* 49, no. 1 (2017): 17-27, Wiley Online.

hospitals, however, most are turned away. The patients who are able to get an abortion in a hospital are ones who have an existing relationship with a physician willing to provide or refer for an in-hospital abortion.⁴⁰ This is not dissimilar from hospital abortion provision before *Roe*: as long as a patient already has a foothold within the healthcare system, they will be able to get abortion care from a hospital.

According to the American Civil Liberties Union (ACLU) Reproductive Freedom Project, unlike other facilities, the majority of abortions currently performed in hospitals are done for medical indications.⁴¹ This means abortions done because there is a fetal anomaly or a threat to the health or life of the pregnant woman, formerly known as therapeutic abortions. Because these abortions often occur later in a pregnancy, it is possible that a hospital is the safest place for the procedure to be performed and thus they see a disproportionate number.

Although current abortion policies are opaque, it is unsurprising that medically indicated abortions dominate current hospital abortion provision. After *Roe*, many hospital administrators crafted abortion policies designed to keep the number of procedures they performed low, with the goal of arousing as little opposition as possible. Whether they are formal institutional rules or merely implicit guidelines, current policies that prioritize medically indicated abortions achieve the same aims because these kinds of abortions are both relatively rare and, compared to elective abortions, relatively uncontroversial. Given the continued stigmatization of abortion, an institutional preference for medically indicated abortions over elective ones seems inevitable.

⁴⁰ Katrina Kimport, Tracy A. Weitz, and Lori Freedman, “The Stratified Legitimacy of Abortions,” *Journal of Health and Social Behavior* 57, no. 4 (2016): 503-516, Sage Journals.

⁴¹ “Hospital Mergers: The Threat to Reproductive Health Services,” American Civil Liberties Union Reproductive Freedom Project, accessed April 10, 2018, <https://www.aclu.org/other/hospital-mergers-threat-reproductive-health-services>.

Hospital Mergers and Abortion

Even though hospitals have been providing limited abortion care since *Roe*, the last two decades have seen a continued decline in hospital abortion access. This is largely the result of hospital mergers. Economics were the main impetus for the surge in hospitals mergers, in part because they allow one institution to dominate a local market and negotiate better prices from insurers.⁴² Mergers also made it easier for hospitals and their associated facilities to save money via joint purchasing and shared administrative and billing services.⁴³

Since the trend began in the mid-1990s, the pace of mergers has only accelerated, most notably the merging of secular non-profit hospitals with Catholic affiliated ones. Between 2001 and 2011, the total number of acute care hospitals in the United States declined by six percent; in this same period, the number of Catholic affiliated hospitals grew by sixteen percent.⁴⁴ As of 2016, Catholic affiliated hospitals accounted for more than fifteen percent of all acute care hospitals and one in six acute hospital beds.⁴⁵

In Catholic healthcare institutions, all personnel, including doctors, nurses, and administrators are required to follow a series of guidelines known as the *Ethical and Religious Directives for Catholic Health Care Services*, regardless of their own religious affiliation. These directives both affirm the Catholic Church's teachings regarding health care and provide instruction on how to implement these teachings when serving patients.⁴⁶ While there can be

⁴² Lois Uttley et al., "Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care," American Civil Liberties Union, accessed April 12, 2018, <https://www.aclu.org/report/miscarriage-medicine>.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Maryam Guiahi et al., "What Are Women Told When Requesting Family Planning Services at Clinics Associated with Catholic Hospitals? A Mystery Caller Study," *Perspectives on Sexual and Reproductive Health* 49, no. 4 (2017): 207-212, ProQuest.

⁴⁶ Ibid., 207.

some variation in implementation across Catholic hospital systems, orders regarding reproductive health care are among the most universally enforced.

Regarding abortion, the Catholic directives make a distinction between what they term “direct” and “indirect” abortions.⁴⁷ Directive Number 45 addresses direct abortions, stating, “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo.”⁴⁸ Directive Number 47 addresses so-called indirect abortion, stating, “Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of the pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.”⁴⁹ Despite the use of the term abortion to describe both directives, Directive 47 effectively bans abortion, as it is traditionally understood, at Catholic healthcare institutions.

In 2015, the United States Conference of Catholic Bishops (USCCB), who authored the health directives, reaffirmed them and added that there was no such thing as a medically necessary abortion. According to the USCCB, “there is significant credible evidence that the universe of abortions ‘necessary’ to save a woman’s life comprises an empty set.”⁵⁰ This assertion, however, is contradicted by most of the medical community. There are numerous

⁴⁷ United States Conference of Catholic Bishops, “The Distinction Between Direct Abortion and Legitimate Medical Procedures,” June 23, 2010, <http://www.usccb.org/about/doctrine/publications/upload/direct-abortion-statement2010-06-23.pdf>.

⁴⁸ Ibid.

⁴⁹ Ibid.

⁵⁰ Julia Kaye et al., “Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women’s Health and Lives,” American Civil Liberties Union, accessed April 13, 2018, https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

conditions, according to the ACOG, that could require a life saving abortion; the most common are hypertensive disorders (like preeclampsia), which causes ten percent of U.S. maternal deaths each year, and premature rupture of membranes (PROM), which can cause massive, life-threatening infection.⁵¹

Conflicts between Catholic health directives and best medical practice regarding abortion are not uncommon. For example, a 2015 ACLU report included the case of a patient whose water broke prematurely, at fifteen weeks gestation, well in advance of viability.⁵² The pregnant woman was at risk of severe infection and, because there was nothing that could save the pregnancy, best medical practice would be to induce labor and deliver the fetus. But, because a fetal heartbeat could still be detected, any action to speed up delivery was considered an abortion and the hospital refused to do so. After ten days, the patient had still not delivered the fetus and was running a fever of 106 degrees. Eventually, she was able to obtain a transfer to a secular hospital, where she was able to get the abortion she needed, as well as treatment for the sepsis she had developed.⁵³ Over the last ten years, the ACLU has tracked and reported on dozens of similar incidents across the United States, as has the *American Journal of Public Health*.⁵⁴

In one regard, the patient in the aforementioned ACLU report was fortunate: she was able to transfer to a secular hospital. For many patients, this is not an option because the proliferation of Catholic affiliated hospitals has not been evenly distributed nationwide. In about twenty-five states, Catholic hospitals make up about fifteen to twenty-five percent of all hospitals; in sixteen states, fewer than ten percent of hospitals are Catholic; and in nine states, Catholic hospitals

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Uttley et al.

constitute over thirty percent of all hospitals.⁵⁵ Notably, this latter group consists of many of the most rural states, including Alaska and South Dakota.⁵⁶ As of 2016, there are forty-six Catholic hospitals that the federal government has deemed “sole community hospitals,” meaning they are the only hospital within seventy miles.⁵⁷ In these places, getting abortion care would be extremely difficult, if not impossible, simply because the patient would have no secular hospital options.

Even if there are nearby secular hospitals, patients seeking an abortion may run into other obstacles. For many women, insurance coverage can hinder their ability to access abortion care in a hospital, even if the procedure itself is covered. If their only in-network hospital is a Catholic one, they will be forced to decide whether to abide by Church Directives or potentially pay thousands of dollars out-of-pocket to go to an out-of-network facility.⁵⁸ This places the highest burden on low-income women, who are also more likely to live in rural areas with less access to secular hospitals.

Legislative Barriers to Hospital Abortion Provision

Legislative efforts explicitly targeting abortion provision in hospitals have been minimal, mostly because so few abortions are performed there. Although policies restricting insurance coverage and restricting medical abortion do have some impact, hospital abortion access is most affected by what are known as healthcare refusal laws or clauses. These laws allow healthcare

⁵⁵ Kaye et al.

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

providers to refuse to provide services related to abortion care without facing legal, financial, or professional repercussions.

The first conscience refusal legislation was enacted shortly after *Roe*, when a federal court ruled that any hospitals that received federal funding could not refuse to perform abortions or sterilizations.⁵⁹ In response to this court decision, the Congress passed an amendment by Senator Frank Church of Idaho, which said that receipt of federal funds could not compel a doctor or a nurse, “to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such a procedure or abortion would be contrary to his religious beliefs or moral convictions.”⁶⁰ While the amendment’s passage was nearly unanimous, there was some concern among lawmakers that the measure was too broad and would be used to diminish abortion access; its supporters insisted that the amendment would only apply to healthcare providers who performed or assisted with the procedure.⁶¹

Although the Church Amendment was in place, many states chose to enact similar healthcare refusal laws, including some that went even further than the Church Amendment. By the end of 1974, twenty-eight states had refusal laws that protected individuals and twenty-seven of these extended refusal rights to institutions like hospitals as well.⁶² After this initial post-*Roe* glut, states did not return to refusal laws until the late 1990s, when the legislation they passed greatly expanded the framework of those original laws.

⁵⁹ Douglas Nejaime and Reva B. Siegel, “Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics,” *Yale Law Journal* 124, no. 7 (2015): 2516-2591, Gale.

⁶⁰ *Ibid.*, 2536.

⁶¹ *Ibid.*, 2537.

⁶² *Ibid.*, 2538.

The major shifts in healthcare refusal legislation after the 1970s mostly concerned who the refusal provisions covered and what services they were permitted to refuse. This began with a 1996 omnibus appropriations bill, which stated that neither the federal, state, or local government could withhold funds based on, “an entity’s refusal to provide abortion services, abortion training, arrangements for abortion services,” and most crucially, “referrals to other entities that provide abortion services.”⁶³ This final provision, which protected healthcare workers who refused to perform abortions from providing referrals to physicians who did, would become the most contested element of healthcare refusal laws.

Where the 1996 bill expanded what services healthcare entities could refuse to provide, the 2005 Federal Refusal Clause (also known as the Weldon Amendment), broadened the definition of a “healthcare entity.” Up until this point, only individuals and hospitals were protected by refusal laws; after this bill, both health insurance companies and employers who provided insurance for their workers were now considered healthcare entities and thus exempted from providing anything related to abortion care.⁶⁴

While these refusal protections were implemented at the federal level, state legislatures pushed similar laws; in many cases, these state laws covered contraception as well as sterilization and abortion procedures.⁶⁵ As of 2017, forty-five states allow healthcare providers to refuse to provide contraceptive, sterilization, and abortion services and forty-four of these states

⁶³ Ibid., 2539.

⁶⁴ “Current Refusal Laws,” NARAL Pro-Choice America, accessed April 13, 2018, <https://www.prochoiceamerica.org/wp-content/uploads/2017/01/4.-Current-Refusal-Laws.pdf>.

⁶⁵ “Refusing to Provide Health Services,” Guttmacher Institute, April 1, 2018, <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>.

allow healthcare organizations to refuse offer these as well.⁶⁶ Notably, more than two-thirds of states with refusal laws allow healthcare workers to refuse patient referrals.⁶⁷

As with much legislation aimed at restricting access to abortion, the American College of Obstetricians and Gynecologists (ACOG) registered vociferous opposition. In 2007, the ACOG issued a committee opinion strictly defining acceptable refusal standards. The opinion argued that while, “respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient’s health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities.”⁶⁸ The organization also asserted that it was unethical to refuse to refer a patient to another provider, and that it was the duty of doctors who did not offer abortion or sterilization services to “practice in proximity to individuals who do not share their views or to ensure that referral processes are in place.”⁶⁹ To do otherwise, according to the ACOG, would violate the organization’s code of professional ethics.

Healthcare refusal policies pose a unique obstacle to hospital abortion provision when compared with their effect on other abortion facilities. According to hospital physicians, nursing and support staff attitudes are a distinct impediment to hospital abortion provision. A study published in the journal *Contraception* in 2003 found that more than half of all hospital abortion providers deemed the unwillingness of other healthcare staff to assist with abortion procedures “a moderate problem,” for hospital abortion provision; an additional twenty-five percent claimed

⁶⁶ Ibid.

⁶⁷ Olga Khazan, “When the Religious Doctor Refuses to Treat You,” *The Atlantic*, January 23, 2018, <https://www.theatlantic.com/health/archive/2018/01/when-the-religious-doctor-refuses-to-treat-you/551231/>.

⁶⁸ American College of Obstetricians and Gynecologists, “Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine, 2007,” accessed April 12, 2018.

⁶⁹ Ibid.

it was, “a large or very large problem.”⁷⁰ In the fifteen years since the study, ever-expanding healthcare refusal legislation has made it even easier for non-physician healthcare providers to limit hospital abortion care.

Conclusion

Despite their prominence in the pre-*Roe* era, hospitals make up a decreasing number of abortion facilities. Prior to 1973, many in the medical community believed that legalization would not change the model of care and that abortion would continue to be done predominantly in a hospital setting; some worried that if they were wrong, moving abortion out of hospitals would lead to its marginalization and inhibit patient access.⁷¹ Even with the medical community’s misgivings, the non-hospital clinic model took over legal abortion provision.

Although there were many, lack of instruction from major medical organizations about hospital abortion provision was an important factor in pushing abortion out of hospitals. Support from the AMA and similar organizations could have been useful in combating both internal and external anti-abortion dissent; in their absence, when faced with opposition, many administrators opted for the path of least resistance and either reduced or eliminated their abortion services.

⁷⁰ Kristy Kade et al., “Effect of nurses’ attitudes on hospital-based abortion practices in Massachusetts,” *Contraception* 69, no. 1 (2004): 59-62, Medline.

⁷¹ Garrow, 840.

CONCLUSION

As mentioned in the introduction, my on-the-ground experience working in an abortion clinic has provided me with valuable insight into modern abortion access and the practical implications of abortion restrictions. Going into this project, along with the patients who have to jump through hoops just to access basic healthcare, I had sympathy for the abortion providers I've gotten to know. Most of these doctors have chosen to run independent abortion clinics, bypassing more lucrative career opportunities. Additionally, I have seen the lengths they go to protect their families and staff from the small but very real threat of anti-abortion violence.

As a result of these experiences, my impression of the medical community was that it was as beleaguered as its patients in regard to abortion care, and that the real obstacle to improved abortion access was policymakers. The development of this project has disabused me of this notion. As the previous chapters have shown, the medical community has long played a role in the systemic marginalization of abortion in healthcare and its continued stigmatization as a political issue.

In years before abortion was legal nationwide, there was broad assumption in the medical community that once abortion was settled as a legal matter, it would no longer be a political matter, and the procedure would be as available as any other. This presumption was not unfounded. By the 1960s, abortion was relatively uncontroversial among medical professionals, even those who were not active in the repeal effort. After witnessing the horrors inflicted by illegal abortion, doctors regarded abortion as a public health issue, not a moral one.

The decade immediately after *Roe* likely offered the best opportunity for abortion to be brought into the mainstream. Stigma remained, but the public and political rhetoric around abortion was not as volatile as it would become. The Catholic Church had always opposed

abortion, however, the modern pro-life movement would not take shape until the 1980s. Nominal organized opposition made this period an ideal moment for providers to normalize abortion by incorporating it into their practices and hospitals. Although the medical community may not have realized it, the opportunity to integrate abortion with minimal controversy would not come again.

During the post-*Roe* period, there was little effort from the American Medical Association (AMA) or American College of Obstetricians and Gynecologists (ACOG), both advocates of repeal, to require the teaching of abortion procedures in medical schools and residency programs. This contributed to a dearth of opportunities for abortion training throughout the 1980s and early 1990s. After the ACOG's accreditation body mandated abortion training in 1995, access to abortion education improved, with a record number of programs requiring at least some training. These improvements are the result of a sustained effort from the ACOG and medical students themselves and might have been unnecessary if these organizations had made a greater effort to integrate abortion after *Roe*.

In the case of private practice, the post-*Roe* years were also an opportune time to integrate abortion care into the medical mainstream. Additionally, private practice was provided an opportunity not afforded medical schools and hospitals when the FDA approved RU-486. In both instances, integration never materialized. It is clear that stigma associated with illegal abortion kept doctors from offering abortion in private practice: at first, because they were not far removed from the image of the illegal "abortionist," and later, because they feared complications from medical abortion unwittingly reigniting those stereotypes.

Just as much as doctors wished to avoid the label of "abortionist," hospitals did not want to be thought of as "abortion mills." While there were several significant factors, the rapid post-*Roe* shift to a non-hospital clinic model was accelerated because hospitals were unsupported by

medical organizations during this transitional period. Hospitals are large, unwieldy systems and, without guidance, it was simply easier to allow abortion care to move to clinics.

Even acknowledging that the medical community did not cause the stigma that has long been associated with abortion, they have consistently chosen paths that deepened that stigma. The medical community's original sin was a lack of sustained effort to move abortion into private practice in the 1970s. Removing from private practice reinforced the perception that it was abnormal or unusual, when it was anything but.

Although abortion continues to be marginalized within medicine reform is possible. The example presented by medical schools and residency programs is instructive. With sustained effort from the various actors, including organizations like the ACOG, medical institutions, and individual physicians, abortion education has managed to recover from its 1990s nadir. There is no reason to think a similar effort could not result in improvements in private practice and hospitals.

After legalization, neither physicians nor hospitals were able to fully erase the memory of illegal abortion and the stigma that came with it. For doctors, this meant excluding abortion from their private practices; for hospitals, it meant gradually acquiescing to the non-hospital clinic model. Subsequent legislation has created obstacles for both private practice and hospital abortion provision. The exclusion of abortion care from private practice and hospitals stigmatizes a safe medical procedure that thirty percent of American women will need and makes it more difficult for those women to access it.

Even with legislative barriers, the medical community could develop its own reforms. As they did with medical training, the ACOG could make abortion provision a requirement for membership in their organization, with some exemption for the minority of physicians with

religious objections. Like the Ryan Program for students and residents, funding could be established to help practices overcome practical obstacles, like security upgrades and additional personnel.

Increasing abortion access in hospitals could prove to be more challenging, but is certainly not impossible. Organizations like the AMA and the American Hospital Association (AHA), as standard-bearers in the medical community, could exert pressure on hospital administrators. While the effect may not be as pronounced in hospitals, advocacy from prominent organization could be a vehicle for some improvement. Additionally, in the realm of public policy, these organizations could use their standing to advocate for public policy changes. Notably, they could pressure the Centers for Medicare and Medicaid Services (CMS) to issue a directive clarifying that all hospitals must provide necessary reproductive health care or provide patient transfer, as determined by medical personnel, not religious directive.

If they were to accept their role in marginalizing abortion after *Roe* and perpetuating its stigmatization, members of the medical community could make a sustained, deliberate effort to integrate abortion into mainstream medicine, an effort that could be successful, with minimal changes to public policy. Just as the accreditation requirements led to an increase in abortion training, these efforts could increase the number of providers and increase abortion access in the U.S. Regardless of geography or finances, women need access to abortion and the medical community has the tools to make expanded access a reality.

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