Roe v. Wade at 30: What Are the Prospects For Abortion Provision?

By Carole Joffe

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At the 30th anniversary of *Roe v. Wade,* it is time for the inevitable stocktaking by the prochoice movement. But rather than celebrating such a landmark anniversary, many in the movement appear grimly relieved that abortion is still legal at all in the United States. It was not supposed to be like this. Acknowledging such a milestone *should* involve looking back on the considerable advances in public health that resulted from legalization—the dramatic reductions in rates of abortion-related death and injury, and the enormous changes in American women's lives that were enabled, in considerable part, by the availability of reliable and safe abortion services.[1] Instead, the story is about how abortion emerged as one of the most divisive issues in American society, the target of a nonstop assault by its foes in Congress and in the streets—and seemingly everywhere in between.

As of this writing, in the immediate aftermath of the November 2002 elections, which gave Republicans control of both the House and the Senate, the situation looks particularly bleak. Antiabortion forces have introduced yet another "partial-birth abortion" bill (although the Supreme Court has found nearly identical bans unconstitutional);[2] President Bush has overruled his own State Department's recommendations by refusing to allow funding for international family planning; contentious hearings have been held for Bush judicial nominees seemingly chosen for their antiabortion record; and the antiabortion movement has trumpeted its newest tactic of videotaping patients as they enter abortion clinics and then posting the tapes on the Internet. And of course, the prochoice movement trembles while it waits for the proverbial other shoe to drop: When will George W. Bush have the opportunity to nominate a Supreme Court justice who could provide the fifth vote to overturn *Roe* altogether?

A similar feeling that things have not turned out the way they were supposed to pervades the medical wing of the prochoice movement. Certainly no physician could have predicted that providers would be harassed and violently attacked—including seven who were gunned down by antiabortion terrorists—in the years after *Roe*. Just before *Roe*, in 1972, 100 professors of obstetrics and gynecology wrote to their colleagues of the necessity to prepare for abortion's imminent legalization. Their statement confidently predicted that "if only half of the 20,000 obstetricians in this country do abortions, they can do a million a year, at a rate of two per physician per week....Independent clinics will probably not be necessary if all hospitals cooperate in handling their proportionate share of these cases."[3]

It is deeply frustrating to read these words today. Far from half of the some 48,000 practicing obstetrician-gynecologists[4] provide abortions, although the precise proportion is unknown. Currently, only 1,819 known facilities provide abortions—46% of these sites are clinics, 33% are hospitals and 21% physicians' offices.[5] Hospitals provide fewer than 5% of all abortions. The absence of a provider in some 87% of U.S. counties[6] has become the mantra of the beleaguered prochoice movement.

These figures reflect one of the greatest obstacles to legal abortion provision in the past 30 years: American medical culture itself. From the period immediately preceding *Roe* to the present, mainstream medicine has supported legal abortion—but not the individuals who provide it. As I have argued at length elsewhere,[7] physicians' discomfort with colleagues who provide abortion stems from the pre-*Roe* era, when the dominant image of the illegal provider was the inept and unethical "back-alley butcher." The reality, however, was that some of those offering illegal abortions were highly skilled and principled physicians, who risked their medical licenses and personal freedom to provide safe abortions.

A peculiar medical version of "not in my backyard" with respect to abortion developed from a combination of the stigma attached to providers, the antiabortion movement's record of harassment and violence after *Roe*, and the medical profession's historic discomfort with controversy (especially when it involves sexuality). Although most members of the profession, especially obstetrician-gynecologists, continue to identify themselves as "prochoice," in reality, this typically means that they are only willing to refer patients to freestanding clinics. The medical profession as a whole is reluctant to incorporate abortion training and services into hospitals or group practices, or to promote abortion-related activities in such forums as professional societies and journals.

SIGNS OF HOPE

Amid the usual signs of siege, however, several promising developments may herald a turning point. First, there is a newfound commitment to abortion training in key locales, which has received national attention. For instance, all public hospitals that offer obstetrics and gynecology residencies in New York City must now provide training in abortion methods, and the governor of California has signed into law, as part of a package of prochoice legislation, a similar measure covering state-supported residencies in California.[8]

Second, in a field that had seen few technological innovations since the introduction of the vacuum suction machine in the late 1960s,[9] several new technologies became

available in the mid-1990s. "Medical" abortion—that is, abortion via a drug rather than the more familiar "surgical" abortion—came to the United States in two forms. First, mifepristone, also known as RU 486, began U.S. clinical trials in 1996, and the Food and Drug Administration (FDA) approved it for general use as a method of medical abortion in 2000. Second, in the mid-1990s, many U.S. physicians began to use methotrexate, a cancer drug, for the off-label purpose of pregnancy termination.[10]

Simultaneously, manual vacuum aspiration,* a technology that permits very early abortion in a medical office setting, also reemerged. Its sudden and unexpected reappearance in the United States may have been an unanticipated result of the extended delay in FDA approval of mifepristone for general use: Some 12 years passed between French approval in 1988 and U.S. approval in 2000; during that period, both health care providers and patients became attracted to the prospect of very early terminations.

An unusual amount of mobilization by organizations, both old and new, is another positive sign.

The ability to act as quickly as possible has been enhanced by the widespread availability of reliable and affordable pregnancy test kits, which can detect a pregnancy as soon as seven days after fertilization. Taken together, these developments raise the prospect of changing the cultural and political landscape surrounding reproductive health decisions. Women have more contraceptive options,† which have succeeded in reducing the need for abortion in the first place, and they have the ability to detect a pregnancy sooner. Moreover, both medical abortion and manual vacuum aspiration offer the possibility of earlier abortions compared with surgical abortion. Given that abortion is generally more acceptable—among both the public and providers—the earlier it takes place, these new technologies together could eventually "change the conversation" surrounding abortion, as one observer put it.[11]

Of all these developments, perhaps none has raised more hope among abortion rights supporters than mifepristone, because it may directly affect the problem of accessibility. Since its provision does not require surgical training, the new regimen has a far wider range of potential providers—e.g., primary care physicians, family practice physicians, internists and adolescent health specialists. Moreover, because the key task involves effective counseling rather than surgical skill, advanced-practice clinicians (medical professionals other than doctors, such as physician assistants, midwives and nurse practitioners) may be logical providers. Mifepristone also raises prospects for the diffusion of abortion care to settings that extend beyond the freestanding clinic, where most U.S. procedures now take place.[12]

An unusual amount of political mobilization by prochoice medical organizations, both old and new, is another positive sign. Although groups advocating the expansion of abortion training and access largely target the medical community itself, they have also directed public relations offensives highlighting abortion's public health benefits to the general population.

Two groups—Medical Students for Choice and Physicians for Reproductive Choice and Health—were organized in the early 1990s in direct response to the excesses of the antiabortion movement. The murder of David Gunn, the first abortion provider to be killed, was a key event that spurred the formation of the medical students' group.[13] Notably, these organizations are composed not only of actual or potential providers, but also of individuals who support them and who want to counteract the stigmatization of both abortion and abortion providers.

Currently, much of what I label "political mobilization" centers on efforts to inform health care practitioners about medical abortion and to broaden its availability. Shortly after the FDA approved mifepristone, Physicians for Reproductive Choice and Health formed a consortium with three long-standing prochoice medical groups—the National Abortion Federation (NAF), the major professional association of abortion providers in North America; the Association of Reproductive Health Professionals; and the American Medical Women's Association. This umbrella group actively seeks opportunities to present information on medical abortion (e.g., during grand rounds) to a broad medical audience. NAF and Planned Parenthood have undertaken intensive training efforts to educate their memberships about medical abortion protocols and have engaged in an unusual advertising campaign using magazines and the Internet to promote awareness of mifepristone among the general public.

The Access Project, organized by a small group of family practice physicians in New York City, is another example of recent mobilization. This project was designed to develop strategies for family practice physicians, most of whom do not provide surgical abortion, to become medical abortion providers; the group has made numerous presentations at national and regional meetings of specialists in this field.[14] Another group, the Abortion Access Project, a grassroots initiative headquartered in Boston, has been successful in arranging medical abortion training for advanced-practice clinicians in New England; it also sponsored research that determined that abortion provision by such clinicians was legally feasible. Currently, approximately 30 of these professionals are involved in providing abortion services in New England.[15]

The new willingness of the movement's medical wing to seek out media opportunities is another indication of increased activism. Organizations have arranged media training for their members and prepared videos and public ser-

*This technology was used by lay feminist health activists in the United States for "menstrual extractions" in the 1960s; since then, it has been widely used for pregnancy termination in the developing world. (See: Dixon-Mueller R, Innovations in reproductive health care: menstrual regulation policies and programs in Bangladesh, *Studies in Family Planning,* 1988, 19(3):129–140.)

†The recent increased accessibility and visibility of emergency contraception in particular is a major breakthrough, one that has been linked to a reduction in the number of abortions in the United States from 1994 to 2000. (See: Jones RK, Darroch JE and Henshaw SK, Contraceptive use among U.S. women having abortions in 2000–2001, *Perspectives on Sexual and Reproductive Health,* 2002, 34(6):294–303.) Although many Americans continue to be confused by the differences between the "morning-after pill," as emergency contraception used to be called, and the "abortion pill" (mifepristone), steady progress is being made on educating the public about the two.

vice announcements to offer the public a positive image of both abortion providers and patients. Moreover, individuals who work in abortion provision have increasingly commented on developments in the abortion debate on radio and television and in print.

In short, these trends point to an extremely active movement of health care professionals, one that supports abortion provision—and the individuals behind it—from both within medical institutions and outside them. This situation stands in stark contrast to the period immediately after *Roe v. Wade,* when the medical wing of the prochoice movement essentially retreated in complacency.[16]

The creation of several new programs within leading medical institutions to promote abortion training and research is yet another step forward. One prominent example is the privately funded Fellowship in Family Planning,[17] established in 1992, which provides state-of-the-art training at selected medical schools in both research and clinical skills in family planning and abortion, and frequently includes an international experience. The fellowship is largely oriented toward physicians completing a residency in obstetrics and gynecology, but has been awarded to family practice physicians as well. Another well-known program is the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning,[18] which was established in 1999 and is also privately funded. This program is set up in various obstetrics and gynecology and family practice residencies across the country, and provides support and technical advice to schools that are committed to offering training. Given the historic antipathy toward abortion providers in much of mainstream medicine, these programs in first-tier medical schools will presumably increase the legitimacy of the field.

WHAT DIFFERENCE WILL IT MAKE?

In most branches of medicine, such positive developments might reasonably be expected to translate smoothly into more providers, a wider geographic range of services and increased accessibility for patients. In the highly politicized world of abortion, of course, nothing works smoothly. And despite the undeniable evidence of a newly energized prochoice movement, especially in the realm of training, many obstacles remain to seeing these efforts pay off in increased numbers of abortion providers and facilities.

To start, providers of surgical abortion face no shortage of problems—for example, the list includes onerous legal restrictions, uncooperative landlords and vendors, disapproving colleagues and the ever-present threat of harassment and violence. But most surgical abortions take place in freestanding clinics or office practices that do a high volume of procedures. Such facilities typically have specialized staff on-site to manage these problems and lawyers on call to handle the myriad legal issues that arise.

Thus, the many obstacles that pervade abortion provision are perhaps clearest among the pool of potential medical abortion providers, those who will ideally incorporate abortion into a primary care practice and perform relatively few procedures. This is precisely the group on whom the movement has pinned high hopes for expanded access. Briefly, here are some of the obstacles that these professionals have to overcome.

Malpractice and Insurance Issues

Malpractice insurance is a major stumbling block, particularly for providers other than obstetrician-gynecologists, who will likely see their premiums soar once they add abortion to their practice. The malpractice issue is especially difficult for physicians in private practice, who must negotiate policy terms on their own and deal with insurance companies that either are outwardly hostile to abortion or threaten to raise rates prohibitively.

Negotiating terms of reimbursement can be similarly complex. Those physicians who offered surgical abortion and added medical abortion typically found that both procedures were reimbursed at the same rate. But for new providers of medical abortion who have no experience with surgical abortion, negotiating with insurance companies has been especially cumbersome.

Legal and Regulatory Environment

The new provider of medical abortion must become conversant with a legal and regulatory environment that is like no other in contemporary medicine. For example, the provider must know about such regulations as parental consent laws, 24-hour waiting periods, abortion reporting requirements and rules governing the handling of fetal tissue. While ultimately the courts may decide that some aspects of the laws that regulate surgical abortion do not apply to medical abortion, the best legal thinking counsels would-be providers to assume that currently they do.[19] Moreover, new providers of medical abortion will have to contend with so-called TRAP (Targeted Regulations of Abortion Providers) laws, which place additional restrictions on the facilities or practices of physicians who provide abortion. Some of these laws' features are patently absurd in the context of medical abortion—for example, specifications for the widths of doorways.[20]

Restrictive Contracts

The potential provider of medical abortion may likely come up against employer contract restrictions that prohibit abortion. Many instances of restrictions on abortion have been reported, even when Catholic facilities have not been involved.[21] For example, some group practices prohibit abortion provision out of fear of controversy; these restrictions can even extend to prohibiting a doctor from providing abortions off-site at a freestanding clinic.[22] Similarly, some landlords of private offices prohibit abortions on their property, because of personal objections or fears of picketing and disruption.

Complexities of the Mifepristone Regimen

A number of features of the mifepristone regimen make it quite costly—in terms of time, energy and sometimes money—for a new provider. First, whereas most approved

drugs can be obtained by the patient from a pharmacist, the unusual terms of the FDA's approval of mifepristone stipulate that the prescribing physician order it directly. For some physicians, especially those planning to offer only a few medical abortions, this means paying in advance for more medication than may be needed and risking expiration of any unused drugs on hand. At the same time, getting hold of this drug has proved surprisingly cumbersome for individual doctors who work in hospital-based residency programs, who depend on drugs that are ordered by a central pharmacy.

Second, the new abortion provider needs to arrange backup surgical abortion services for the 1–5% of mifepristone patients who will need them.[23] Moreover, although ultrasound examinations are not required for medical abortions under the FDA protocol, they are widely used before and after the procedure; given the special scrutiny that abortion services are always subjected to, the majority of new providers will likely choose the most conservative course.[24] Thus, if the provider does not have an ultrasound machine, an efficient and affordable option for having an ultrasound performed off-site must be found.

Assuming that Roe v. Wade remains the law of the land, there are grounds for both considerable concern and cautious optimism.

THE CONFINES OF A CONFLICT-AVERSE MEDICAL CULTURE

Surely, these obstacles can be expected to lessen over time. Although the uptake of medical abortion by new providers has been slower than some had anticipated, mifepristone is now well integrated into the services of veteran abortion providers and has increased access to abortion overall. For example, a number of Planned Parenthood clinics that had not provided surgical abortion now offer medical abortion, and clinics that offer both procedures have found it easier to integrate medical abortions into their schedules than surgical abortions.[25] Presumably, malpractice insurance and reimbursement problems will be solved by creative new solutions. The greatest obstacle to expanding abortion services, however, may be the medical culture itself—one that supports legal abortion, but has always stayed at arm's length from actual providers and services.

The responses of various medical institutions to mifepristone's potential to expand abortion provision show just how problematic integrating abortion into mainstream medicine can be. For example, the American College of Emergency Medicine prohibited NAF from exhibiting at the college's annual meeting in 2002, stating, according to a NAF spokesperson, that "NAF would not have significant educational value to the practice of emergency medicine."[26] Given that some medical abortion patients with heavy bleeding can be expected to show up in hospital emergency rooms and that emergency physicians need to know how to manage such complications, it is hard to interpret this policy as anything other than a political statement.

Providers of medical abortion, like the generation of surgical abortion providers before them, have complained about the difficulty of publishing articles on the subject in professional journals.[27] In some hospital settings, scheduled grand rounds on medical abortion have been abruptly canceled because of the discomfort of one or two individuals. Major textbooks on women's health—written for clinicians—have been recently published with no mention of abortion, medical or surgical.[28] And on and on.

Perhaps even more dispiriting from a prochoice viewpoint, even the "success stories" show the ever-present taint of controversy that hovers around abortion. In one family practice residency with which I am familiar, the undeniably positive news is that several faculty members have begun to provide mifepristone to patients and to train their residents in its use. The protracted efforts it took to make this happen and to sustain the agreement, however, seem unlike those needed in any other branch of medicine: Hospital administrators agreed to this innovation only after numerous hours of meetings and only with the stipulation, as summarized by a faculty member, that there be "no picketing...once there were picketers out there,...the deal would be off." When the proposal to add medical abortion training was first presented to residents, a few became outraged at the prospect and claimed, as my informant put it, that "had they known this was to be part of their training, they would not have come to this program." The final compromise involved a dedicated beeper for all calls concerning medical abortion patients, which would go directly to the attending faculty member who had agreed to handle them.

CONCLUSIONS: A CUP HALF FULL?

In assessing where the medical community now stands vis-à-vis abortion after 30 years of legalization, one can see strong parallels with the position of American society as a whole. The antiabortion movement has not succeeded in turning people against legal abortion; polls repeatedly show that a majority do not want *Roe v. Wade* overturned.[29] Nonetheless, the antiabortion movement has succeeded in making many people feel very ambivalent about abortion (which explains the majority support for numerous restrictions on services) and, perhaps more important, in reframing abortion as an issue that supporters need to apologize for.

Similarly, within medicine, no evidence suggests that the larger antiabortion movement or the "prolife" caucuses of various medical groups have succeeded in making the majority of U.S. physicians opposed to legal abortion. What opponents of abortion *have* accomplished, however, is to convince the medical community of just how costly—in terms of time, energy and expenditure of political capital—incorporating abortion provision into mainstream medicine can be.

What, then, are the prospects for abortion provision in the United States in the next 30 years? Assuming that *Roe v. Wade* remains the law of the land, there are grounds for both considerable concern and cautious optimism. The opponents of abortion are not going away, and battles will continue to be waged on many fronts—vociferously in the halls of Congress and in front of clinics, and more quietly in hospital administrators' suites (as decisions are made about incorporating abortion services) and in offices of the small businesses (such as laundries) that are pressured by

antiabortion groups not to service local clinics.

Prochoice forces will win some of these battles and lose others. Certainly, new technologies that have the potential to expand abortion access and to facilitate earlier abortions (and thus, perhaps, change the cultural meaning of abortion) are an important development, as are the numerous activities of newly energized prochoice medical organizations. Ultimately, however, the prochoice movement's greatest asset in this ongoing struggle is the extraordinary dedication of the health care professionals who have—in spite of everything—taken on abortion provision and developed a passion for their work that one rarely hears about in other areas of medicine.

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