Abortion: Teaching Why as Well as How

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As clinicians, scientists and educators, we are not accustomed to talking about our values and the spiritual aspects of what we do—particularly as regards offering and teaching about abortion care. Many of us feel shy about expressing personal feelings and uncertain about how nonscientific topics like morality and religion can appropriately be raised in a teaching setting. Nevertheless, many of our students would appreciate help with responding to religious criticism; they deserve an honest attempt to explain why we teach and provide abortion services, and why they might want to consider providing these services in their future practices.

For both of us, and for many of our colleagues, providing abortion care has been a positive career decision—not a negative one or one based on duty. It is positive because this service matters so much to the individual women for whom we provide care, and often to their partners and children as well. Providing abortion in our own communities connects our work with an issue of worldwide importance, because confronting at home the efforts to intimidate providers and limit access to abortion is part of an effort to overturn laws, policies and traditions around the world that control and harm women's reproductive lives.

Many medical educators, and even legislators, have come to recognize the importance of teaching about abortion, especially the technical skills involved—the "how." Medical and health science students also need education about the "who," "what," "when," "where" and, especially, "why" aspects of abortion. The exclusion of abortion from the services provided to women in teaching hospitals has meant that many students complete their training with little or no experience providing abortion care. Students may be unaware of the importance of this service in many women's lives. Furthermore, they may be unprepared to participate knowledgeably in the development of women's health programs, in public policy debate on abortion or even in discussions of abortion within their own institutions.

For many technical medical skills, the public health, ethical and historical aspects of care are integrated into the preclinical curriculum. However, in the case of abortion, it is not safe to assume that the curriculum includes these topics. In addition, clinical training schedules typically have so little time and place so much emphasis on building technical competence that ancillary education may not receive much attention. Furthermore, since abortion patients often receive counseling and education from lay staff and not from clinicians, students learning how to perform abortions may not have an opportunity to learn firsthand why individual women seek such services. And because of the religious and social context of abortion, the individual clinician's understanding of "why" is likely to be critical to whether he or she decides to provide abortion services.

Despite a lack of models for teaching "why," we have begun to address this with our students. Unlike their teachers, most students and residents today do not remember abortion practices before *Roe v. Wade,* or the public debate that led to abortion law reform. They have been busy learning science and medicine, and have had little opportunity to consider these issues. By summarizing our initial attempts to identify key points, we hope to encourage other colleagues to join the task and help shape a new and strong curriculum component for teaching "why."

BEYOND PUBLIC HEALTH

The public health aspects of abortion provide a clear starting place. A large body of scientific evidence creates a compelling argument for the public health importance of universal access to safe, legal abortion services. Maternal morbidity and mortality rates decline promptly when safe abortion services are made available,[1] and in many parts of the world, unsafe abortion still ranks as a leading cause of death and injury among women.[2] Concern about public health was a major focus of the initial state-by-state efforts in the 1950s and 1960s to reform abortion laws. Physicians led reform campaigns that won broad support from the medical community. Today, the public health perspective is an important reason for the strong and continued support for legal abortion from many medical organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association and the American Public Health Association.

A public health framework alone, however, may not be helpful to the student who encounters challenging moral or religious questions about abortion. In addition, considering abortion solely as a public health issue has the potential pitfall of reinforcing the view of abortion as a necessary but distasteful task. This has been a common view among clinicians whose involvement with abortion policy issues began during the reform era,[3] and it may have contributed to the professional marginalization of abortion services and providers in the subsequent three decades. A "duty to do your share" approach is unlikely to be an appealing or effective motivation for students deciding whether to provide abortion services in the future.

In moving beyond the public health benefits of abortion, it seems appropriate to focus first on the importance of abor-

tion access to individual women. The decision to become a mother has profound implications for the life and health of the woman. In an essay in the *New York Times,* Dr. Elizabeth Karlin, an abortion provider, eloquently expressed her moral conviction about taking the responsibilities of parenthood very seriously and how abortion plays a part: "I am an abortion practitioner because of my utmost respect for motherhood....I am convinced that being a mother is the hardest job there is....Even more than performing a religious ritual, being a mother requires precise abilities, arrangements, resources, and a community of support. Motherhood, then, is the true sacrament, and helping make it so is the essence of my work."[4]

Normally, a simple medical task does not matter so much, but this one does.

Women seeking abortions likewise take motherhood seriously. For some, the impact on family members, especially their children, is a primary consideration. For a few, health problems are the most important factor. And for many others, relationship, financial and educational issues are paramount. In our experience, however, women typically approach the decision with careful thought, and for many women (and couples), the moral importance of being the best parents they can be is a significant issue. They are determined to avoid parenthood in a situation that would make fulfilling their moral obligation unlikely or impossible. Although it may seem obvious, the weight of the decision about parenthood is an important topic for discussion because antichoice arguments often stereotype women who decide to terminate pregnancies as selfish and irresponsible.

It is true that some women seeking abortions do not seem to be making a careful decision or are unable to do so. However, consider these statistics: The U.S. annual abortion rate of 21 per 1,000 women aged 15–40[5] means that about 60 abortions occur for every 100 women over the roughly 35 years of their reproductive lives.[6] With so many women deciding to have an abortion, it is hard to imagine that a single stereotype includes them all. Women who have abortions are our neighbors, friends, mothers, sisters and daughters.

Although the U.S. abortion rate is lower than the worldwide average rate of 35 per 1,000 women, it is higher than rates in most other developed countries.[7] Does this difference indicate that American women are somehow less responsible or moral? Would restricted access to abortion lower the abortion rate? There is no evidence to support these conclusions. Practical steps to reduce unintended pregnancies and, therefore, the need for abortions are easy to identify: Women and men in the United States are much less likely to have had comprehensive sexuality education and more likely to face economic obstacles in seeking contraceptive care than their counterparts in developed countries with lower abortion rates. Furthermore, public funding in the United States covers family planning services for fewer than half of the low-income couples who need them.[8]

HEALTH BENEFITS OF ABORTION

As abortion providers, our interaction with a woman may be brief, but it is usually an opportunity to provide an immediate health benefit and reinforce positive health behaviors. Women planning their contraceptive use after an abortion often need to solve problems they have had with side effects or method use so as to improve their success with pregnancy prevention. For many young women, seeking an abortion is the first important health decision they have had to make; recognition of their own abilities to take charge of their health can serve as a basis for other important health decisions, such as practicing contraception.

It may be surprising to see "immediate health benefit" listed as one of the positive aspects of abortion care. Most women deciding what to do about an unintended pregnancy do not consider the relative health risks for full-term pregnancy versus early abortion, but clinicians recognize very significant differences. Women who continue their pregnancy to term have at least 10 times the risk of death of those who choose abortion,[9] as well as a significantly higher risk of morbidity—including a 20% risk for abdominal surgery (i.e., cesarean delivery). Is there any other medical situation in which a clinician would recommend that an option involving so much greater risk always be preferred?

But the decision to end a pregnancy is not directly parallel to other medical decisions: If a woman does not choose abortion, she will likely deliver a healthy baby, so the decision involves a potential life. Yet, religious opposition to abortion often considers only the potential life and ignores the woman's life and health risks. Women surely deserve some consideration in religious as well as medical thinking.

Just how the significance of potential life should be weighed in relation to the woman's (and existing family's) health and life provokes considerable disagreement.[10] Many religious groups have concluded that choosing abortion can be a moral decision consonant with religious teachings, and oppose efforts to impose legal or governmental interference. Examples include the American Baptist Churches, U.S.A.; Episcopal Church; Lutheran Church in America; Presbyterian Church, U.S.A.; Reorganized Church of Jesus Christ of Latter-Day Saints; Union of American Hebrew Congregations; Unitarian Universalist Association; United Church of Christ; and United Methodist Church.[11]

However, several religious bodies, such as the Roman Catholic Church and certain fundamentalist Christian groups, hold that abortion for any reason is unacceptable, or that it can be justified only in very limited situations. Although this conclusion represents the beliefs of a small minority of the U.S. public, the leaders of these religions have been extensively involved in efforts to restrict access to abortion services as a matter of public policy. They have been instrumental in achieving the virtual elimination of public funding for abortion services in many states, as well as for women who are federal employees or in the U.S. military. Many of these religious leaders also oppose the practice of contraception and comprehensive sexuality education for youth, and share the belief that pregnancy and childbearing should be determined by divine control. Included in this group are the leadership of the Catholic Church, Church of Jesus Christ of Latter-Day Saints, Lutheran Church–Missouri Synod and Southern Baptist Church.[12]

ABORTION SINCE *ROE*

The legal status of abortion is a related question. The 1973 decisions by the Supreme Court in *Roe v. Wade* and *Doe v. Bolton* made abortion legal throughout the country, and eliminated state requirements for justifying abortion on medical or psychiatric grounds. The Court ruled in *Roe* that during the first trimester, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician," and that during the second trimester, "the state, in promoting its interest in the health of the mother, may...regulate the abortion procedure in ways that are reasonably related to maternal health."[13] During the last trimester—after about 24 weeks—the Court ruled that "a state, in promoting its interest in the potentiality of human life, may...regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

In 1992, the Supreme Court discarded the trimester framework in favor of a more lenient standard for determining the constitutionality of abortion restrictions: whether they impose an "undue burden" on the woman. At the same time, the Court reaffirmed "the essential holding of *Roe v. Wade* that prior to fetal viability, a woman has a constitutional right to obtain an abortion."[14] Since *Roe*, the Court has upheld a variety of state restrictions on access to abortion, such as waiting periods and mandatory parental involvement for minors, and a ban on the use of federal funds for abortions for poor women under most circumstances. However, unless *Roe* is overturned, abortion will remain legal throughout the United States.

As much as safe abortion care means to American women, it means even more to women in less-affluent countries. Current U.S. policies for international aid include a gag rule intended to stifle efforts in other countries to establish access to safe, legal abortion; at the same time, family planning aid has been curtailed. This means that basic prevention services and contraceptives are not widely available in many countries, and unintended pregnancy rates, which are already high, remain so.[15] In less-affluent countries, maternal death is a substantial health risk, and the most powerful steps to reduce it include ensuring access to contraceptives and safe abortion care. Our restrictive policies and practices have found their way to countries where the women affected are among the poorest and least powerful in the world; the health consequences are severe, and often life-threatening.[16] Working here to change restrictive policies and laws, and to address the toxic political dialogue, could help poor women in the United States and women in developing countries as well. It seems the least we can do.

Unfortunately, even in the United States, many women seeking abortion care do not expect to find supportive or humane care. When they do find kindness, they are truly appreciative. An abortion provider interviewed in the mid-1990s expressed a common sentiment: "There is nothing else I do in my medical practice where people look me in the eye, in quite the same way, and say 'thank you.' I feel I am empowering women."[17]

CONCLUSION

For both of us, abortion has been a priority throughout our careers. It has been and is a positive and fulfilling professional and personal focus. Normally, a simple medical task does not matter so much, but this one does. The experience of women seeking abortion is so burdened by intimidation and shame that it takes a serious dose of kindness, respect and support to overcome the harmful effects of the political and social context in which we all live. Abortion care is one of the few medical services we provide that can quickly and effectively resolve a major problem in an individual woman's life. We can make sure that the experience that women or couples have validates them as human beings, supports their willingness to take charge of their lives and recognizes that decisions about pregnancy and parenthood are important moral choices.

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