Maintaining access to safe abortion in the United States: a post-Gonzales primer and guide to action

Women’s health specialists were rightfully alarmed by the April 2007 Supreme Court decision in Gonzales v. Carhart. In criminalizing the “intact dilation and extraction” abortion procedure and banning its use even to protect a woman’s health, the U.S. Supreme Court has — with shocking ease — rejected science, overthrown legal precedent safeguarding women’s health and seized authority over medical professionals in determining best clinical practices. While the health and legal implications of the decision are deeply disturbing, its potential “chilling” effect on the number of providers may have very real and devastating consequences for patients.

1. Barriers to safe abortion in the United States

Practical implications of the Gonzales decision are best understood in the context of today’s shortage of abortion providers and the continued looming threats to safe abortion methods. Some effective longer-term strategies for change emerge once we better understand specific factors contributing to the decreasing number of abortion providers and potential restrictions on nonsurgical abortion methods.

1.1. Threats of violence and the new fear of criminal investigation

Many abortion providers face professional stigmatization and threats of violence. Now, with the Gonzales decision’s vague language and potentially weak scienter (intent) protection, providers are likely to worry about criminal investigation and the new threat of jail time. Understandably, some physicians offering second-trimester procedures may come to feel that their commitment to providing the full range of safe reproductive health options to women is simply no longer justified in light of these onerous realities and legitimate fears. Residents and students considering incorporating even first-trimester abortions into their future practices may also jettison such plans.

1.2. Declining numbers of abortion providers

At a time when the number of abortion providers is already dwindling, the Gonzales decision threatens to hasten that precipitous decline. The number of abortion providers in the United States declined 37% between 1982 and 2000. Currently, there are only about 1800 providers in the United States [1]. Furthermore, 57% are above the age of 50, suggesting an imminent threat of hastened decline in service when today’s providers retire [2].

1.3. Regional variability in the number of abortion providers

The impact of the provider shortage is compounded by the fact that providers are not distributed equally throughout the country. Women in rural areas and the South and Midwest are disproportionately affected. Eighty-seven percent of all U.S. counties lack an abortion provider, but nearly all rural counties (97%) are without abortion providers and almost half of women living in the Southeast and Midwest live in counties with no provider [1]. Nearly a quarter of the 1.3 million women annually who undergo an abortion must travel at least 50 miles to find a provider, and 8% must travel 100 miles for abortion services [3].

1.4. Limited access to second-trimester procedures

While close to 90% of all abortions in the United States occur within the first trimester, approximately 130,000 annually still occur in the second trimester, when the procedure is associated with more complications and a higher mortality rate [1]. The number of physicians performing second-trimester abortions is small: only a quarter of providers perform procedures up to 21 weeks, presumably because of the greater logistical hurdles including requirements for staff and facilities, technical challenges and inadequate insurance reimbursements [1]. Further reductions in the availability of second-trimester abortions following the Gonzales decision will disproportionately affect women requiring therapeutic abortions to protect their health, women with fetuses with severe anomalies and women who already have limited access to care. Low-income and minority women, women living in remote areas and women who have more difficulty navigating the health care system are more likely to seek later-term procedures than women living in urban areas [1,4].
1.5. Inadequacy of abortion education and training in medical school and residency

Today’s abortion providers play a crucial role by offering safe procedures to women in need and training the next generation of providers. Despite the high incidence of abortion in the United States, abortion education in medical school and residency remains far from adequate. In 2003, Espy et al. [5] surveyed all U.S. OB/GYN clerkship directors to assess the extent of abortion training offered at their medical schools. Of the directors who responded (representing 62% of medical schools), 25% of respondents reported that there was no formal education about abortion in the OB/GYN clerkship. Less than half (35 schools or 45%) of core OB/GYN clerkships offered clinical experience in abortion care for students rotating in the third year. Similarly, only about half of OB/GYN residency programs offer routine (or “opt out”) instruction in elective abortion for their residents [6].

1.6. The looming political threat against mifepristone

Political efforts to restrict safe abortion are expanding beyond surgical procedures and focusing on medication options. Strengthened by the Gonzales decision, antiabortion legislators, most recently in May 2007, tried again to refute strong science and long-standing clinical experience in their ongoing attempts to overturn the FDA’s 2001 approval of mifepristone.

Since mifepristone’s approval, more than 750,000 American women (and millions worldwide) have used the drug for a safe, effective and early medical abortion [7]. During the same period, antiabortion legislators have disregarded the drug’s safety record and the particularly painstaking steps already undertaken in its FDA approval process and have submitted more than six pieces of legislation to effectively remove it from the market. Thus far, each attempt has been unsuccessful.

Legislative threats to mifepristone jeopardize not only the full range of safe abortion options for women. Like the Gonzales decision, they also challenge the scientific and medical communities’ authority to determine best clinical practices.

2. Longer-term strategies for effective change

Bleak as the circumstances may seem for women’s health and rights, many clinicians, educators, activists and legislators are working arduously to increase the number of providers and protect safe abortion methods from further restrictions. We here provide a nonexhaustive list of several groups engaged in this work and a snapshot of some of their approaches.

2.1. Increasing the number of abortion providers

- Medical Students for Choice (MSFC), a grassroots student-led organization, works to make abortion and family planning standard components of medical education. With more than 10,000 student members at 126 medical schools in the United States and Canada, MSFC is working to reform medical school curricula, offer students training in abortion and contraception, promote leadership skills and foster the growth of a community of future physicians prepared to meet the full range of women’s reproductive health care needs. It also offers leadership training to students to develop their advocacy skills. Emerging data suggest that the group’s educational programs are increasing students’ intentions to provide abortions in the future. Learn more at www.ms4c.org.

- Association of Reproductive Health Professionals and Ibis Reproductive Health comanage the Curricula Group, a network of professionals representing more than 30 nonprofit organizations, universities and other institutions that are committed to improving the teaching of abortion care, contraception and other reproductive health topics to future health care professionals. The need to incorporate this information into mainstream curricula is underscored by the decreasing number of providers who offer truly comprehensive reproductive health services upon entering practice. Members of the Working Group share strategies for curricula reform through a listserv and periodic meetings. Learn more at www.arhp.org/curriculum/outreach.cfm.

- The Reproductive Health Access Project (RHAP) is a New York City-based nonprofit organization dedicated to expanding access to high-quality comprehensive reproductive health services in primary care settings. Through community workshops, mentoring and online networking and resource provision, RHAP supports primary care physicians and their offices as they implement abortion services into their practices. RHAP’s outreach is focused on family medicine physicians, most of whom work in medically underserved urban and rural communities. RHAP also supports initiatives allowing advanced practice clinicians to become abortion providers. Learn more at www.reproductiveaccess.org [8].

- Kenneth J. Ryan Residency Training Programs in Family Planning and Abortion is committed to increasing and strengthening contraception and abortion opportunities for OB/GYN residents. The program was founded in 1999, is coordinated from the University of California San Francisco (UCSF) and, as of Fall 2006, has 34 programs in 21 states as well as one training program in Canada [8].

- Fellowships in Family Planning, like the Ryan Residency training programs, are coordinated out of UCSF. Designed for family medicine and OB/GYN residency graduates aspiring to conduct family planning research, hold senior academic positions or be leaders in national or international family planning, the fellowship fosters the development of high-level research and
clinical skills in contraception and abortion. Learn more about both the residency and fellowship training programs at reprohealth.ucsf.edu [9].

2.2. Preventing further restrictions on safe abortion methods

Legislative attacks on mifepristone come in the form of various stand-alone bills as well as amendments to larger and sometimes unrelated bills. Meanwhile, women’s health, advocacy and legal organizations continue critical work with pro-choice members of Congress to remove or weaken such pieces of proposed legislation.

- **Physicians for Reproductive Choice and Health (PRCH)** is an advocacy-focused membership organization of physicians dedicated to providing active and visible leadership in support of universal reproductive health. Through Public Policy and Community Organizing, Communications and Medical Education programs, PRCH works to inform Congress, local government and professional organizations of the pro-choice position from the provider’s perspective. Learn more at www.prch.org [10].

- **Research exploring mifepristone’s diverse medical indications.** Mifepristone’s continued availability is by no means certain; its fate is tied to the political party in power. While pro-choice legislators have been critical in safeguarding the drug, clinical researchers exploring the full range of mifepristone’s therapeutic potential may provide a medical solution in the political battle to save mifepristone from being removed from the marketplace. Clinical trials exploring mifepristone as a treatment for ovarian cancer, prostate cancer, uterine fibroid tumors and endometrial cancer, among other diseases, offer exciting new hope for women and men with myriad life-threatening or debilitating conditions. Such research, which is currently being conducted, could enable mifepristone, like methotrexate, to enjoy an unthreatened place on the market. While methotrexate is used to treat various cancers, rheumatic conditions and skin conditions, it is also an abortifacient. Its numerous therapeutic indications safeguard its marketplace presence.

Ironically, women’s health clinicians in the United States and abroad can find solace and hope for change in the Gonzales decision, if only in that this unfortunate court action has helped mobilize clinician advocates, and long-term strategies are already underway to safeguard the number of abortion providers and the methods they may use.

If the decision offers any useful lessons, perhaps the most important is that the health community must continue to speak out and act on behalf of our patients and good medical practice. Through voicing our concerns, training students, educating our communities, informing our local and federal government policymakers and collaborating strategically within our field and with other similarly minded disciplines, our influence can promote the development of sound policies informed by scientific evidence, resulting in true public health benefits.

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[7] Personal communication with Danco Laboratories, LLC.